

CoE



Centers of Excellence

Geriatric Medicine and Training

# Managing Programmatic Growth and Development in Academic Geriatrics



American Federation for **Aging** Research

# MANAGING PROGRAMMATIC GROWTH AND DEVELOPMENT IN ACADEMIC GERIATRICS

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**A Report of the  
John A. Hartford Foundation Centers of Excellence  
in Geriatric Medicine and Training  
Network Resource Center**

**April 2009**

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American Federation for **Aging** Research

**This is the third in a series of publications on academic geriatrics career development, based on the work of the John A. Hartford Foundation Centers of Excellence in Geriatric Medicine and Training.**

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University of Texas Health Science Center at San Antonio  
University of Washington  
University of Wisconsin-Madison  
Wake Forest University  
Yale University

## PREFACE

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The impetus for creating this report was the recognition that there were few formal mechanisms among the John A. Hartford Foundation Centers of Excellence (CoEs) in Geriatric Medicine and Training to share their expertise with colleagues throughout the CoE network. With a grant from the Hartford Foundation, the American Federation for Aging Research (AFAR) established the Hartford CoE Network Resource Center to collect and disseminate successful approaches to geriatrics recruitment and to the growth and development of academic geriatrics programs.

In 2006, an *Inventory of CoE Geriatrics Career Development Initiatives* was conducted, together with a review of recent literature on recruitment and academic program development in geriatrics and related disciplines, and interviews with 12 CoE faculty and staff. From this work, a comprehensive list of recruitment and career development strategies was compiled and distributed to the CoE directors in November 2006.

After reviewing these strategies, the CoE directors identified three key areas as the highest priorities in supporting the CoEs' efforts to enhance the development of academic geriatrics:

- Recruiting premedical and medical students and residents to careers in geriatric medicine
- Recruiting candidates to advanced fellowship training and faculty positions in academic geriatrics
- Managing programmatic growth and development in academic geriatrics.

The CoE directors recommended that creating a report or "manual" on each of the above topics would support and enhance their recruitment and training efforts.

The goals of this third report are to aid in the transfer of "best practices," and to foster further discussion, information sharing, and collaboration across CoEs and other academic geriatrics programs. First-hand views of CoE directors about their strategies to support the growth and development of their programs are at the heart of this report.

Based on the *CoE Inventory* results, interviews with selected CoE directors were conducted by telephone using semi-structured protocols for gathering consistent information while providing flexibility to explore particular issues raised by participants. This report provides a snapshot rather than a comprehensive picture of management strategies, and clusters together CoEs that use similar strategies to solve a common challenge. A few leaders discuss their overall vision for their programs to introduce readers to some of the thinking behind CoE management strategies.

In addition, the report includes views of academic deans (or former deans) about making the case for additional resources, a fundraising expert, and other leaders with a background in geriatrics who are in a position to provide a big-picture perspective on the challenges facing geriatric medicine.

Finally, the report references some relevant journal articles, reports, on-line publications, and web sites related to academic geriatrics programmatic growth and development.

This report is available as a downloadable .pdf file at [www.geriatricsrecruitment.org](http://www.geriatricsrecruitment.org), where it is also available in an interactive online format. Some additional resources, such as slide presentations, are only included in the online version of this report.

## INTRODUCTION

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### Environmental Challenges

Fewer physicians are being recruited into academic medicine in general and geriatrics in particular. The 2008 Institute of Medicine report, *Retooling for an Aging America: Building the HealthCare Workforce*, leaves no doubt about this challenge: “As of 2007, there were 7,128 physicians certified in geriatric medicine and 1,596 certified in geriatric psychiatry. According to one estimate, by 2030 these numbers will have increased by less than 10 percent; others predict a net loss of these physicians because of a decreased interest in geriatric fellowships and the decreasing number of physicians who choose to recertify in geriatrics. According to the Alliance for Aging Research, by 2030 the United States will need about 36,000 geriatricians.”

Contributing factors are many. Low physician reimbursement by Medicare (on average 8 percent less than managed care reimbursement), and the additional time needed to provide care for frail elderly patients have resulted in low salaries and other factors that discourage physicians-in-training from pursuing careers in geriatric medicine.

For those hardy individuals who make it through to academic geriatrics, challenges related to variable funding streams from the National Institutes of Health (NIH) and other federal, local, and private sources mean that CoE directors must piece together funding for geriatrics fellowships and other activities from a variety of sources.

### Programmatic Challenges

Leaders of CoEs are challenged to build the capacity of junior faculty to become the teachers and researchers of tomorrow, to address the shortage of senior faculty, and increasingly, to expand geriatrics expertise beyond academic geriatrics programs. As champions of geriatrics training and research, program directors are looking closely at how they can optimize resources and embed sound management practices. Many are working to develop internal marketing strategies, and some have increasingly explored fundraising strategies for local support and beyond.

### Common Themes

A few common themes, or key points, emerged from interviews with CoE directors around the country:

***Leadership and management skills are not taught in medical school.*** Most CoE directors have had to learn management skills and business-oriented strategies primarily on the job. Many of those interviewed credited leadership training received after completing their medical training for strengthening their management skills and stimulating them to think in new ways. That additional training, advice from peers, plus experience, have taught them to think strategically, a critical component of smart growth for their programs.

***Geriatrics is Collaborative.*** In order to address the complexities of caring for older patients, clinical geriatrics is by necessity collaborative and multidisciplinary. Academic geriatrics is also collaboratively oriented with regard to aging-related research and expanding geriatrics training into other subspecialties and disciplines. Long before the NIH formally recognized a new roadmap for collaboration and cross-specialty and cross-disciplinary engagement, geriatrics “got it.” Leaders interviewed in this report include some who have found ways to simultaneously strengthen geriatrics and build bridges with other disciplines to expand resources and develop new approaches.

***The personal connection is powerful.*** CoE directors frequently emphasized the importance of the mentoring they received as they were forging their careers, the support and role modeling they received for building their programs via on-site consultations with senior leaders, and their own satisfaction in mentoring others. Many advocated for broader programs for mentoring and consultation. For programs to thrive, leaders stressed building strong relationships with senior management, including keeping deans and other administrators up-to-date about successes and goals, but also asking how geriatrics could be helpful to them and the institution.

***Build a diversified portfolio.*** Expand the number and variety of funding sources to ensure longer-term stability and growth.

***With CoEs, one size does not fit all.*** In terms of the management strategies described in this report, not all “best practices” are easily transferable from one setting to another. This is due to differences in the programmatic focus; maturity of the program; size and interests of faculty; sources, kinds, and depth of resources for geriatrics; and a variety of institutional characteristics. Nevertheless, it is hoped that the views and information shared here can stimulate discussions and opportunities.

***Resource:*** To access the report, *Retooling for an Aging America: Building the HealthCare Workforce*, a related PowerPoint, and other materials, see the Institute of Medicine web site: <http://www.iom.edu/?ID=53452>

## 1. Internal Marketing to Institutional Stakeholders

**The challenge: To seek funding to support the growth and development of academic geriatrics programs within a tight federal, state, and philanthropic funding environment**

### Summary

A common goal across the Hartford Centers of Excellence (CoEs) in Geriatric Medicine and Training is persuading academic leadership that geriatrics is a wise investment. This means you must work on many fronts to garner new support for programs, even where one or more large funding sources are already in place. A mixed portfolio of sources is more stable, and can withstand the loss of individual funders and downtimes. What guides the building of this portfolio should be the program's strengths, the institution's mission, and a strategic approach that will allow program directors to make their case well.

Also key is building trust with the institution's administration, getting to know them, and letting them get to know you and what your program can bring to the dean's office and the institution. It is important to understand how academic leadership thinks and to use effective strategies to make the case for funding. For example, use a concise yet nuanced message that is backed up with a brief written document including a budget and specifics. The goal is to make it easier for the dean (or chair) to say yes.

***Make yourself indispensable by achieving visible excellence in education.***

"If you start winning the teaching awards, and become one of the more valuable programs to do the high level teaching, it makes it harder to cut back geriatrics when the time for cutbacks comes."

Christine Cassel, MD, American Board of Internal Medicine

### Strategies

**Link your program to the institutional mission.** Understand what pushes the buttons of your institution. At institutions where the focus is more on research, success will be measured in part by building strength in that arena. At other institutions education is the pivotal point. So, if you are focusing on education in a place that values research more, be sure to present your programs in the most effective way.

"The CoE is not just an isolated faculty development project," observed Brown University's Richard W. Besdine, MD. He described the CoE's role as the glue that holds disparate aging-related pieces together, not only in a department of medicine, but also throughout the university. "This cohesion gives identity and substance to the geriatrics program, allowing leadership to find multiple points of leverage for geriatrics within the research, educational, and clinical elements of the institution."

**Seek funding based on your program's strengths.** Avoid spending resources pursuing funding for areas where you have minimal expertise or manpower, as they are difficult to sustain.

**Create a diversified portfolio.** Build program support based on multiple sources of funding by taking advantage of local/regional and institutional opportunities. Don't just aim for big awards—smaller grants can lead to larger ones. Understand your current support, where it comes from, and how long it lasts. Avoid becoming complacent about money that has been available for a while, as some sources of funding can be variable or dry up. Make sure that no single source of funding represents the majority of an annual budget.

**Show a return on investment.** Fiscal management is important to administration. Yet few physicians are trained in that area or learn skills, such as "mission-based accounting." (See Resources below.) Back up requests for program support with numbers, and show a return on the administration's investment. When preparing an annual report, explain how you have used dollars wisely and what the return is for time spent with junior faculty, for example, in terms of grants, publications, national recognition, or other contributions to the institution.

**Build mutually supportive relationships with deans and other administrators.** Deans and chairs can support geriatrics in a variety of ways: matching dollars for training, providing seed money for new initiatives, allowing a program to capture more of the "indirect costs" on grants, and supporting new training and research initiatives. In turn, support your deans and administrators by helping them accomplish their goals. For example, line up your mission with theirs, be accountable, and meet or exceed your budget projections.

**Match your style of asking to the person.** Individual deans vary in how they prefer to be approached for additional resources, so find out how they want the process to unfold. For example, some want a concise description of your proposal linked to the dean's and other institutional goals, with specific budget and timeline details in writing before a face-to-face meeting. Others may prefer a more informal initial discussion.

**Get to know how academic leadership thinks.** Pursue opportunities to participate in institutional level activities, such as strategic planning, to gain perspective on the challenges facing high-level administrators and how they make decisions. To expand leadership skills, and learn more about how academic leadership thinks and how to relate to them, many CoE directors recommend external leadership training programs. (See Resources below.)

***Make management a fundamental function.***

"Management takes real thought and skill. It is important enough to the future of geriatrics that we should be thinking more about how to train people better than we do now."

Seth Landefeld, MD, University of California, San Francisco

**Keep your eye on the reporting structure.** High-level reporting and administrative structures vary from institution to institution. These differences have implications for how geriatrics programs are managed. In many institutions, a supportive dean can make a major difference within the academic realm, but not necessarily within the clinical area. One trend, the single CEO model for a medical school

and its affiliated hospital(s), has the potential to create a more supportive environment for training and academic initiatives at academic medical centers. At one institution, for example, the hospital administration was moved under university management, with a dean overseeing both institutions. As a result, the hospital is becoming more supportive of training in general. As an added benefit to geriatrics, a new palliative care initiative, which the dean had supported all along but which had not been supported by the hospital administration, is now better positioned. At another institution, geriatrics faculty are employees of a hospital or clinical practice, rather than the university or medical school. This reporting structure has been particularly relevant to discussions with clinical administrators about getting faculty time away from clinical responsibilities for the purpose of grant writing.

**Market geriatrics to chairs and peers in other specialties.** Strong collegial relationships can open the door for training and research collaborations and even university-wide initiatives that can have a positive impact on geriatrics programs' growth and development.

### **Close-ups**

**Build management and leadership skills.** When she first took the reins of the geriatrics program at the University of North Carolina (UNC), Jan Busby-Whitehead, MD, concluded that her program was not leveraging its portfolio well. State funds were 75 percent of total budget; over time she has reduced that to 25 percent. "State money may not always last. In many years we have had large cuts to our state funds. This situation spurred me not to be complacent about this money. You have to grow research and education funds, develop a multi-part mission, and identify multiple sources of external and internal funding (we competed for internal money and got four grants funded, each for about half a million dollars)," she said. Dr. Busby-Whitehead added that small grants can have a snowball effect, and that no source is too small.

"When I became an administrator, I was not trained in fiscal management. No one had shown me the metrics of a budget. I received help from the dean's office, and learned 'mission based accounting.' (See Resources below.) In my annual report I have to show how I have used dollars wisely, what the return is, and what I have spent on support for junior faculty to write successful grants. For example, 'Over the past six years, these junior faculty members have delivered a ten-fold return on investment dollars. They received grants, published their work, and achieved national recognition.' Never use the 'we are wonderful' argument without also showing the importance of the work you are doing, how you are supporting the school's mission, and how you are meeting the metrics. It is not all about the dollars, but the dollars are important.

"It is critical to have strong working relationships with your department chair and dean. You have to build those ties, line up your mission with theirs, and be accountable. Work hard to hold up your end by being fiscally responsible and meeting or exceeding your budget projections," she said. Dr. Busby-Whitehead recently participated in the strategic planning process for UNC's academic health center. "The Hartford Geriatrics Leadership Development Program was transformative for my career and for geriatrics at UNC. (See Resources below.) The funding allowed me to attend a two-week course at the Harvard School of Public Health designed for physician executives where I acquired academic leadership and strategic planning skills."

**Think like a dean.** Robert Golden, MD, is Dean of the School of Medicine and Public Health and Vice Chancellor for Medical Affairs at the University of Wisconsin-Madison. (In 2007 the university received a Hartford CoE grant directed by Sanjay Asthana, MD.) Dr. Golden offered the following advice about leaders seeking resources, with a proviso: "What works for me might not work for other deans and medical schools. If you have seen one dean, you have seen one dean."

Deans' priorities can vary according to the type of institution. As a dean of a public university, Dr. Golden recommended emphasizing the "overwhelming public need for an expanded workforce in

geriatrics due to the demographic trends, an evidence base for best practices, and the far greater need for institutional support in geriatrics than in other—sometimes better compensated—specialties. Acknowledge the realities of the flow of funds, and that geriatrics, like pediatrics, is underpaid and reimbursed at a lower level by the federal government and other third party payors. So focus on existing strengths and opportunities in the academic and public service missions.”

Dr. Golden shared how he prefers to be approached with proposals:

- Provide the dean with background information prior to the meeting, including a lead letter with the “ask,” (the request) and supporting documentation.
- At the meeting, assume the dean did not have time to read everything. So start from scratch and build a case, using real numbers and statistics. Be specific. For example saying, “We have a year or two to submit an application, and it will bring in a lot of money, but we need a little bit of space,” is less convincing than, “I am coming now because we have 12 months before we submit, we need from your office between \$100,000 to \$300,000 over two years, and will need new office space for five new FTEs. I will share with you why this is an important opportunity.”
- Even if you have sent information earlier, bring materials to the meeting that you can leave behind. This way, when the person you’re meeting has time to get back to your idea 48 hours later he will have concrete, specific information close at hand.

## Resources

For more on mission-based accounting, how to report the contributions of faculty teaching and research, and the arena of mission-based management of academic medical centers, see resources on the Association of American Medical Colleges (AAMC) web site: <http://www.aamc.org/members/msmr/measuringfacultycont.htm>

For information about Hartford Foundation’s Geriatrics Leadership Development Program, see the Association for Directors of Geriatric Academic Programs (ADGAP) web site: [http://www.americangeriatrics.org/adgap/leadership\\_dev\\_program.asp](http://www.americangeriatrics.org/adgap/leadership_dev_program.asp)

## 2. Building Clinical Revenue

***The challenge:* To explain the longer-term financial benefits of geriatrics to hospitals and outpatient clinical services**

### Summary

Mastering and communicating the financial side of clinical services is an increasingly prominent aspect of being an academic geriatrics manager. Some geriatrics leaders successfully make the case that a strong geriatrics program has long-term benefits for a hospital and the larger institution (for example, lower rates of re-hospitalization). This has created a stronger bargaining position for geriatrics. Some leaders have conducted formal reviews of their clinical services and have refocused them so they are better linked to academic and institutional missions and priorities, such as the competitiveness of the local market or the value of downstream revenues generated by geriatric primary care services. Geriatrics leaders are developing or expanding new venues for clinical care, adding contracts with continuing care communities, hospices, home medical care services, and inpatient assessment units.

As opportunities grow for geriatricians to blend their expertise with subspecialty colleagues in the care of sick older patients, leaders may seek to change longstanding institutional arrangements in order to make geriatric care financially viable. For example, at one medical center, a geriatrician with expertise in oncology persevered in his goal of joining an oncology clinic. At another medical center, the geriatrics program embarked on a new clinical program focusing on dually eligible patients. As a result, clinical revenues grew substantially. Palliative care services are another example. Many leaders have already established such services in hospitals and some are working to expand them into outpatient settings.

New clinical initiatives often meet with resistance from hospital and institutional administrators. To strengthen their case, geriatrics leaders are adding clinical budgeting and financial and clinical data tracking to their management skills. In addition, they are seeking assistance from consultants and other outside experts to enrich their strategies and develop more sophisticated business plans. Start-up funding is necessary because gathering crucial information to demonstrate value and viability depends on initiating services. At institutions where clinical administrators have balked at providing that initial support, leaders have acquired seed money from their chairs, foundations, or other sources.

Regardless of the clinical setting or type of services, leaders stressed that generating clinical revenue must never take priority over the quality of care provided. Clinical faculty should not be stretched so thin that they cannot do a good job of taking care of patients.

## **Strategies**

**Pay attention to the bigger bottom line.** When reporting on costs and benefits of geriatrics services, don't just look at immediate financial data—seek information that addresses the impact of geriatric clinical services on the institution over time. Take into account bigger picture issues that may be of particular interest to institutional leaders. Examine a variety of variables, such as lower re-admissions of patients cared for by geriatricians, and increased patient satisfaction. And, consider cost-saving strategies such as:

- improving discharge planning to reduce the likelihood of readmission within 30 days
- reducing the number and cost of medications used during the hospital stay
- reducing duplication of services such as laboratory tests and radiology through better coordination of information across inpatient and outpatient settings.

**Enhance geriatrics' visibility in the hospital setting.** Geriatrics in-service programs and clinical revenue can be enhanced by increasing the visibility of senior faculty throughout the hospital so they can interact directly with other specialists. Don't rely solely on geriatrics fellows to provide in-patient care, with senior faculty involved only behind-the-scenes. Opportunities for closer contact between senior faculty and other specialists can help to increase geriatrics consults, particularly in relation to discharge planning. A senior faculty member can make the case to peers that geriatricians have the most knowledge and experience with care transitions, and understand what is possible (after discharge) in home care, nursing homes, and other long-term care settings.

**Control of your money is extremely important, so negotiate.** At one institution the geriatrics leader negotiated the clinical budget with administration. This allowed him to create an account that could be used in any way within legal limits. He discontinued the practice of supplementing clinical losses with medical administrative fees. Instead, he arranged to allocate contracts separately within the clinical budget by establishing three distinct funds:

- a university account for dollars from outside entities, such as grants and other sources
- money for the clinical budget, such as medical director fees that include overhead costs
- revenue generated from seeing patients.

The healthcare system supplemented outpatient care activities. One benefit of such an approach is that when you are applying for a matching grant, you can use some of your administrative support as your share of the match.

**Whether division, department, or interdisciplinary center, ensure that geriatrics has a place at the leadership table.** The structure of a geriatrics program may vary depending on institutional history, resources, and other factors. Gregg Warshaw, MD, director of geriatrics at the University of Cincinnati College of Medicine, emphasized that no matter what the structure, the geriatrics program director's status needs to be equivalent to a department chair, in a setting where he is recognized as a program leader and is included at the table with cancer center directors, chairs, and others. Dr. Warshaw noted that the Hartford CoE and Donald W. Reynolds Foundation Aging and Quality of Life grants have been very helpful in positioning geriatrics at this level in the medical school administrative structure. This support has enabled deans to accord geriatrics this stature.

**Conduct a strategic review of your clinical services.** Having a huge clinical program can detract from the basic missions of teaching and research. Some leaders have purposely limited clinical services to better meet geriatrics program and institutional missions as well as local market factors. An in-depth review can generate stronger, smarter programs by: (1) tapping the experiences of faculty, trainees, colleagues, and administrators; and (2) gathering strategic data focused on efficiencies, quality, and revenues. A review at one institution led to changes including greater integration of clinical services with training and research; more efficient use of faculty time; improved care quality; heightened visibility of clinical services, research, and senior faculty; and enhanced revenue generation. Be sure to incorporate your institution's mission, priorities, and activities into your review. In situations where high-level administrators value "downstream" revenues generated by geriatrics clinical services, where a highly competitive market exists, or where there is a high penetration of managed care, there is the potential for enhanced institutional support for expanded geriatrics clinical services. Therefore, make the case for how your program can provide value through more efficient and high quality care.

***Put quality first.***

"When you are starting a new clinical service, be sure it is a top quality service, and that will build momentum for you. Quality is much more important up front. Then you can work on the efficiencies."

**Steven Counsell, MD, Indiana University**

**Build on your own prior experiences and the successes of others.** Leaders who have begun clinical programs at other institutions take their best ideas with them to new positions. This could include outpatient or inpatient consultation services, an Acute Care of Elders (ACE) unit, a post-hospitalization medical house calls program, or a geriatrics medical home program. If yours is a new program, review the literature, but also visit model programs for each of the service areas you are contemplating. Learn first-hand from others who have worked out the kinks so you can avoid unnecessary steps while identifying best practices and putting them in place. One leader who had started an ACE unit

recommended visiting several model programs, identifying the best ones, and asking their leaders to come to your hospital to help you implement yours. Sometimes doctors don't ask for help, he noted, but it can save a lot of time, such as when his program adopted a strategy used successfully by another program—initiating team rounds for complicated cases.

**Explore new clinical opportunities in long-term care.** The expansion of Continuing Care Retirement Communities (CCRCs) across the country offers academic geriatrics advantages over freestanding nursing homes. CCRCs can:

- support an outpatient as well as a nursing home practice
- generate more substantial revenue for geriatrics through significant medical director contracts
- offer expanded opportunities for training and faculty involvement
- reduce clinical overhead compared to office-based outpatient geriatrics (One leader estimated the overhead costs for office-based outpatient geriatric primary care at about 60 percent.).

Keys to success include identifying the right kinds of CCRCs and addressing competition with community physicians. Generally, nonprofit CCRCs recognize the value of a link to an academic geriatrics program. Such relationships are often more stable and fruitful.

Another opportunity: Providing caring for nursing home patients in sub-acute units (following hospitalization), as you can see the patient and bill more frequently. One area to pay close attention to is faculty supervision in long-term care settings. While geriatric medicine fellows at some programs operate more independently, some leaders have been told by their risk management staff that faculty need to be on site. Moreover, faculty involvement is required for billing. Many programs have structured clinical time so faculty and clinical learners are there at the same time. Despite scheduling challenges within a substantial clinical practice, fellows, residents, and students can learn a lot and have the added benefit of interactions with the rehabilitation team.

**Consider other opportunities, including an outpatient “medical home” model, home-based medical care, and medical directorships of hospices.** Many programs have initiated or revitalized home medical programs. One university has established a highly structured home follow-up program post-hospitalization. A business model is crucial for these programs. Engaging nurse practitioners and physician assistants is an important part of the model. These programs can work without hospital support because of low overhead, but they have to be run efficiently. Some academic geriatrics programs that offer outpatient services (often considered “loss leaders”) have begun to develop medical home models, which are particularly attractive for patients with chronic illnesses. Such programs are in the early stages. However, medical practices that are willing to develop electronic medical records and incorporate social workers and patient educators (if rewarded through extra reimbursement), can have a positive effect on quality of care as well as on the bottom line, by making outpatient practice more viable. Medical directorships of hospices are another option.

**For new clinical services, use all available resources to create a strong business case.** Present your information in a business-like manner. Understand how budgeting works at your particular institution. Understand the essentials of facility and professional fees. Back up your budgeting with strong presentations to the individuals who can either support or block the initiative. At one institution, a geriatrics leader who was looking for hospital support for a new palliative care medicine program made his case with new services and a written business plan. The plan identified staff by name, their relevant experience and specialized training (the program leader was a hospice-trained geriatrician), and

made the business case for the initiative for the hospital and the larger institution. Many leaders use the Center to Advance Palliative Care (CAPC) for management and business planning as well as for extensive clinical training and support. One leader, for example, learned specific strategies for making the case to hospital leadership, including some of the more difficult arguments for cost-savings. (See Resources below.)

**When the hospital won't provide start-up support, find it elsewhere.** Hospitals are often reluctant to take a chance on important new clinical services that don't have a proven track record of generating revenue. Begin a pilot project with alternative funding, such as a foundation grant or support from a chair. It can be an essential strategy for demonstrating value. At one medical center, leaders in geriatrics and oncology who proposed a new palliative care service were able to secure a foundation grant to start a consulting service. At another institution, the department of medicine viewed the proposed palliative care program as crucial to its institution, which the leaders saw as falling behind comparable institutions nationally. They made the argument that the palliative care service would save in-house costs. Midway through the initial funding period, the program had already improved the institution's national standing, high quality clinical leadership had been secured, and the program was on its way to demonstrating its benefit to the hospital.

**Don't stop thinking about tomorrow: Continue to make the business case.** Pilot projects lay the foundation for new clinical services. However, leaders in both of the above examples have had to continue demonstrating the growth and success of the program over time to hospital administration. The initial investment of time and effort to prepare the business case will pay off again and again for new initiatives.

***Spread the word about good outcomes.***

"We brought our information about positive outcomes for geriatric patients into the board room. Once the board can see the quality and cost data from its own institution, it's much easier to make the case that geriatrics should be a major player rather than a luxury."

Neil Resnick, MD, University of Pittsburgh

**Focus on quality in patient care.** Leaders emphasized repeatedly that the quality of patient care must come first. "Train higher" and train the right people; make the effort to put policies and procedures in place that reinforce quality. One leader emphasized the importance of instilling a culture of quality first. But to do that you need well-trained doctors, nurse practitioners, physician assistants, and other providers.

**Share positive results.** Take your good news to deans, chairs, and higher-level administrators. Consider a request to speak to board members of the hospital.

## Close-ups

**Make an end-run around clinic deficits.** Dr. Neil Resnick, CoE director at the University of Pittsburgh, reported that he changed the framework for making the case for geriatrics with hospital CEOs. While losing money is inevitable when providing care in the clinic for the frailest patients, he avoided using an older strategy that highlighted “downstream revenue” (for example, saying that geriatrics opens the door to elderly inpatient revenues.) “Elderly patients will come to the system whether or not we are here,” he said. Instead, he focused on outcomes, without waiting to hear that geriatrics generated a deficit. He looked at every patient over age 65 who was discharged, and compared cost and performance. He found that for hospital discharges, the geriatrics program generated better results than other departments. “We were better per patient than other areas. Thirty-day mortality was the same, but patients of the geriatrics program had reduced readmission and shorter lengths of stay by a third.” Geriatric medicine had a “lower complication rate and highest patient satisfaction, best quality, and lowest cost, of any other group,” he said.

**Persevere, line up supporters, and don’t forget billing!** William Dale, MD, PhD, CoE co-director and section chief at the University of Chicago, persevered in his efforts to provide outpatient care to older cancer patients in the university oncology clinic because, “being there and being a part of the oncology team is five times as valuable as seeing the same patients in an off-site clinic,” Dr. Dale said. However, he faced significant challenges with billing and setting up this clinic. “This was considered valuable space, and hematology/oncology was initially reluctant to allow a geriatrician to use it.” He spent six months learning about billing to create a “revenue neutral” clinic and to avoid losing revenue for geriatrics, without upsetting hematology/oncology. “I had to work out facilities fees and professional fees, which I had never paid much attention to, and I asked for one room on Fridays when no one else wanted to work, so the space was underutilized.” When nothing further happened, he gave a research talk to hematology/oncology and emphasized complicated technical details and his Beeson funding. “The hematology/oncology section chief attended the talk and loved it. I was offered clinical space and time within a week. Suddenly they decided I was a good bet—a funded researcher with interesting ideas,” Dr. Dale said. By then he had already worked out the billing and had a collaborator in hematology/oncology to advocate for the clinic to his chief. As a result Dr. Dale was able to establish the Specialized Oncology Care and Research in the Elderly (SOCARE) clinic. “If the section chiefs are neutral on a proposal, they ignore it and most of the time it will go away. You have to persevere and do high quality work until the timing is right. My advice is to stick with it and assume the burden of proof that what you do matters! Eventually it will be recognized.”

**Rightsizing and refocusing clinical services.** The geriatrics program at Indiana University School of Medicine has significant scope. It provides clinical services at Wishard Health Services, Clarian Health, and the Roudebush Veterans Administration Medical Center; conducts extensive health services and aging research; and does all the geriatrics education for the state. Program director, Dr. Steven Counsell, knew that faculty was spread thin. “At one point, as we were not going to hire more people, we needed to realign clinical activities with our education and research missions.” He and faculty undertook a year-long intensive internal review and refocusing to address questions such as: “How could we attract more key stakeholders to support clinical geriatrics? How could we better train people and attract people to careers in geriatrics?” During the first three months they conducted focus groups with trainees, faculty, and others, examined data, and held a faculty retreat. The next three months were spent planning changes, which laid the groundwork for a six-month period of implementing them. They also evaluated changes one year later.

Among their findings were that half of faculty’s clinical time was spent following nursing home patients, spread across approximately two-dozen nursing homes, some with only a few patients. None of their students or residents participated in those services, which were not part of the teaching program. Nursing home services were subsequently reduced by 50 percent to concentrate on homes with the largest number of patients.

On the inpatient side, “we increased the ACE program and made it more attractive,” he said. Previously nurses followed up on patients along with residents and fellows, while senior geriatricians participated mainly in team conferences, seeing patients only briefly. “We found it would be better to have face-to-face contact with colleagues and trainees—giving geriatrics faculty more visibility.” So faculty began “better tailoring of recommendations [about patients] and increased talking with doctors,” he said.

This established early, positive doctor-to-doctor experiences, and increased exposure to faculty and research opportunities.

They also beefed up their home medical care service, which has about 200 people on its rolls. “We got good reviews for house calls, which have met the needs of homebound seniors and decreased unnecessary hospitalizations, length of stay, and emergency department visits. Indirectly there are a lot of benefits.” In terms of the geriatrics research group: “No one knew we had one—so as part of a rotation, residents are going to the Indiana University Center for Aging Research, getting more of a sense of what we do,” he said.

For others contemplating such a review, Dr. Counsell emphasized: “It is tough! Be open to findings, because some things really surprised us, and it is hard to implement certain changes. We thought nursing homes were favorites of the hospitals, but we found that administrators believed hospital admissions from these institutions would happen anyway, and we could partner with private practice groups working in nursing homes that send those patients to our hospital. It was painful for us to hear that we weren’t that visible, and no one had heard of our research group, but sometimes you have your head in the sand. We tried to evaluate excellence of clinical services, and how they were perceived. Our first goals were getting high patient satisfaction, providing excellent quality of care, and being viewed positively by physician colleagues.”

## Resources

For more information about the impact of geriatrics services on the bottom line, see the Hartford Foundation action brief, *A Shared Bottom Line: Effective Geriatrics Services Improve Patient Care, Hospital Finances*. <http://www.jhartfound.org/pdf%20files/Business%20Case.pdf>

For information about developing a business plan, see: Goodwin, JS. Developing a geriatric business plan for an academic medical center. *Journal of the American Geriatrics Society* 2002;50(4):755-760.

For information about making the business case for palliative care services, and for other palliative care resources, see the Center to Advance Palliative Care (CAPC) web site: <http://www.capc.org/>

For information on cost savings of palliative care consultation, see Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with U.S. hospital palliative care consultation programs. *Archives of Internal Medicine* 2008;168(16):1783-1790. <http://archinte.ama-assn.org/cgi/content/abstract/168/16/1783>

For information about geriatrics clinical services in an urban public health system, see Callahan CM, Weiner M, Counsell SR. Defining the domain of geriatric medicine in an urban public health system affiliated with an academic medical center. *Journal of the American Geriatrics Society* 2008;56(10):1802-1806.

For information about ACE implementation, see Palmer RM, Counsell SR, Landefeld CS. Acute Care for Elders (ACE) units: Practical considerations for optimizing health outcomes. *Disease Management and Health Outcomes* 2003;11(8):507-517.

### 3. Fundraising Strategies

#### ***The challenge: To add local philanthropy to the mix of funding sources***

##### **Summary**

Across CoEs, there is tremendous variation in fundraising activities among geriatrics programs, in part because it can be daunting to find one's way through the development maze at some institutions. Institutional rules for approaching donors and channeling donations vary. For example, at one university, all gifts must be directed to the sole fundraising arm of the university, its 501(c)3 foundation.

Most institutions have development departments. However, geriatrics leaders report varying degrees of fundraising support for geriatrics and aging-related programs. Geriatrics programs also have to contend with the fundraising competition between the medical school and hospital development departments. This can lead to grateful patients and families overlooking the contributions of the medical school in favor of the hospital. Some programs with more resources, including those with high-profile centers on aging, have undertaken their own fundraising activities.

While some leaders are actively engaged in fundraising, others shy away from it because they are uncomfortable asking patients, family members, or community members directly for donations. Only a few geriatrics programs have dedicated development staff (either in the institutional development department or the geriatrics/aging program itself) who are available to manage fundraising, bridge the connections between potential donors and geriatrics leaders, and prepare physicians to talk to donors in an effective manner.

The approaches described here suggest ways that geriatrics leaders might become more actively engaged in local fundraising.

##### **Strategies**

**People donate for excellence, not to pay the rent.** People don't like to give money for basic needs. Many donors already know from their experiences that a geriatrics program makes a valuable contribution. They may want to help develop excellence in a particular area, so pleading poverty is not a good way to raise money. These views are echoed by healthcare fundraising gurus and authors Fitzpatrick and Deller, who observed: "People give when there is a vision; need alone is not sufficient." (See Resources below.)

**Accentuate the positive.** Be firmly convinced that what you are doing is a worthy cause to support. Don't get into a bunker mentality about caring for aging patients and geriatrics. People want to hear why you are so hopeful—that geriatrics has so many opportunities—not that it's so bad. And practice that!

**Foster relationships with development officers and educate them about your program.** Even where there is not an active officer focused on aging, development departments have lists of potential donors about whom they have gathered significant information, including their donor history, level of wealth, and particular interests. Development officers work in a highly competitive environment and are under tremendous pressure. Geriatrics leaders who stay in touch, share information about program successes, and in other ways make it easier for development officers to function, may receive more attention. For example, one geriatrics leader e-mails the development staff at her institution

with updates on aging-related projects. She also includes development officers in funded project site visits, which is a perfect way for the officers to learn about the program. Another leader has an annual meeting with faculty and development staff to update them about new geriatrics initiatives, successes, and opportunities.

***Give credit where credit is due.***

“We want development officers to know that we see them as a friend and we give them public credit for any gift that is sizable. I write a letter to the dean and mention the specific development officer who helped us get the gift.”

**Jeff Williamson, MD, Wake Forest University**

**Build a foundation of reciprocity.** Recognize opportunities to establish a give-and-take with development officers. For example, if a development officer asks for a geriatrician referral for a donor or donor’s family member, use this as a time to reinforce your partnership with them. Remind them that when they encounter donors wishing to support geriatrics, they need to honor those wishes and not divert the donors to other areas.

**Get word of your accomplishments out to development departments.** Because development officers often look to public relations to highlight particular areas of interest to donors, send PR staff your program newsletters and press releases. Also, take advantage of the expanding media coverage of aging-related issues and geriatric medicine. (See Resources below.)

**Take credit where credit is due.** When the opportunity arises, make sure that patients and families, who are potential donors, recognize which program is responsible for the care received. A little PR about geriatrics is in order. The boundary between the medical school and the hospital is blurred in the patient’s or family’s mind, so the gift is often directed to the hospital. Even faculty can be seen as part of the hospital. This is particularly important because many hospitals have their own development staff who target the same potential donors.

**Engage your audience.** Be sure to speak to potential donors in lay terms and connect your work to something that is meaningful to them. Develop straightforward explanations of what you do, why you do it, and why it is important. At one institution, a development specialist observed, “We prep clinicians along with our aging center’s administrator. If we are introducing a physician to a donor, we give the physician personal and business background information on the donor. We also coach doctors to speak in lay terms, and tell them to limit graphs, which can be difficult for people to follow.” Physicians who are more at ease with donors are called on more often to discuss their work.

**Train clinical faculty so they won’t be tongue-tied with potential donors.** Develop practice sessions to help clinical faculty overcome their discomfort with discussing money with patients. Help them learn what to say when grateful patients and/or families express an interest in contributing money to geriatrics, and give them information materials that they can pass on to potential donors.

**Create a geriatrics fundraising brochure.** Develop a brochure to give to grateful patients and families that identifies opportunities to contribute to the geriatrics program. It should emphasize that any level of funding can make an important difference. Such a brochure can be a useful aide for clinical staff who

may be uneasy speaking directly with patients and families about contributions. The brochure can give potential donors something to hang on to after discharge. It should include the contact information of whom to call (a program leader or designated fundraiser) for a detailed and personalized discussion about specific areas and levels of contributions. Ensure that such a brochure is readily available to clinical staff and visible to patients and families at key outpatient and inpatient sites.

**Tune in to donors' interests.** Avoid trying to steer a potential donor towards a favorite project that may not be what the donor is ultimately interested in. Instead, tune in to donors' own interests and find a match.

**Offer a variety of opportunities to give.** To the extent possible, provide options for different ways to give. One useful strategy is to set up targeted accounts with the development department so donors can direct their donations to areas that interest them, such as specific research areas, fellowship or junior faculty training, or clinics. At one institution, a year-end solicitation letter is accompanied by a wish list of specific items needed by researchers. When a specific option catches a donor's attention, a \$100 check could turn into a \$400 fax/copier or a \$1,000 chair scale, particularly for an older person who has previously teetered on a standard stand-up scale.

**Get up close and personal.** While mounting a gala event can generate large dollars, it also demands tremendous resources. An alternative—or additional—approach is to offer opportunities for more intimate discussions. At one institution with an active center on aging, small groups of potential donors are invited to meet with junior researchers, hear presentations about their research, ask questions, take a tour of a lab, and have lunch with them.

**Find someone who is comfortable talking money if you are not.** Some programs are able to afford at least a part-time dedicated fundraiser. But if you cannot count on your institution's development department to manage fundraising for geriatrics, consider getting the names and information about potential donors and then creating your own fundraising opportunities. Some programs gently yet enthusiastically guide the potential donor(s) from the front-line clinical staff to the program leader, who is more comfortable talking about money.

***Learn to be comfortable asking for money.***

"Geriatricians create tremendous good will, yet are uneasy asking people for money, creating a group of donors from family members, or cultivating wealthy family members. My advice is, get over it! Wealthy people want to give, and they will give to someone!"

Christine Cassel, MD, American Board of Internal Medicine

**Engage and educate estate lawyers.** Geriatricians sometimes work on competency issues with lawyers who also do bequests and trusts. Ask lawyers you work with to keep your program in mind when they are discussing bequests with clients. At one institution, a leader reported that the largest gift it ever received was a settlement from a lawsuit in which the client wanted the money to go to the medical school to help the geriatrics program. When you get a call from a lawyer about a possible donation, give her very specific information about how to direct the donation to your program and not to the institution at large.

## Close-ups

**An activist for fundraising.** For the University of Hawaii's geriatrics department, fundraising from local donors accounts for 15 percent of their overall funding. The department chair, Patricia Blanchette, MD, stays actively engaged with the university's development staff, because at times there is no development officer assigned to the medical school. "I continuously build relationships and send e-mails about important goings-on within our department. They say that I am one of the few department heads that keeps them in the loop, so they think of us when there is a potential major donor who is not committed."

To address competition from the hospital's development department, Dr. Blanchette teaches junior physicians that "if a family sounds grateful, one of the things they can say is, 'I don't know a lot about donating to the medical school, but may I introduce you to the school's foundation officer?' Even though our geriatrics ambulatory clinic is 'very small potatoes,' it has generated several large gifts given its size." She believes this clinic and another small clinic dedicated to Alzheimer's disease have received donations because of clear communication with the public. For example, signs identify that care is provided by the University of Hawaii School of Medicine, and that the clinics are part of the medical school and train practitioners. As a result, "grateful patients have come to us to support our clinical operations with both small and large gifts," she said.

While the typical fund-raising process involves introducing families and patients to foundation officers, sometimes Dr. Blanchette takes the lead. "I have learned that it is important to know the donor's wishes, and whether they may want to work directly with me rather than with a development officer. A particular donor did not like the way the university's foundation wrote their thank-you letters, so now I write my own thank you worded in a way that I know she will appreciate. She now gives quite a lot of money and our program is in her will." Dr. Blanchette also consults with estate lawyers on guardianship issues. "Because they know about our program, they have directed contributions from other clients' estates or from lawsuits to our program." Her largest gift to date—\$600,000—came in this manner.

**Allies in fundraising for aging and geriatrics.** At the Baylor College of Medicine, the Huffington Center on Aging gives 100 percent of funds it receives to geriatrics education and research. Supporting clinical fellows has become the shared mission of George Taffet, MD, Baylor's CoE director, and the Huffington Center director, Roy Smith, MD. "We have developed relationships with members of the development board and provided clinical care for them and their families," Dr. Taffet explained. Along with funding second-year fellows, money raised by the Huffington Center has supported research. "We had a young Alzheimer's researcher whose lab received \$200,000 from local donations, Huffington Center money, families and others, including funds raised from the Huffington Gala, its Spring Forum, and a raffle." Dr. Taffet works with a part-time, salaried development specialist at the Huffington Center. She has established cordial working relations with the college's development department, which provides names of (and information about) potential donors to the center. For their part, she and center leaders keep development department staff informed and work to ensure that they "do not step on anyone's toes."

The Huffington Center's development board, which is made up of prominent leaders in the community who meet four times a year, also plays an important role, particularly in supporting second-year geriatrics fellows. To give potential donors a choice and allow flexibility, the center has a variety of donation opportunities. A year-end solicitation letter, sent to approximately 3,000 former and potential donors, includes a "wish list" of specific items needed by the researchers in aging, such as a microscope.

The center's face-to-face meetings between geriatrics leaders, junior faculty, and potential donors are a highly successful effort. The largest event is an annual luncheon called the Women's Health Summit, which raises money for fellows. Prior to the luncheon, physicians from Houston and elsewhere speak to the lay audience about aging-related topics. To make things "more real," the center hosts small

luncheons that incorporate several consecutive lab tours and a talk by a researcher. These well-received and highly appreciated meetings usually attract 15 to 20 people, including new potential donors recommended by the center's board. The development specialist added, "We bring in a young physician to speak to the board about what they are working on. It could be someone who is treating their family members. This makes the results of donations tangible. A young physician doing research is an easier sell than speaking about aging in general. It is a struggle to get people interested in aging, and there are other competing local charities, such as the MD Anderson Cancer Center and a children's hospital. We also have a newsletter and we feature updates on fellows' research."

**A low-key fundraising strategy that works.** At Wake Forest University, Dr. Jeff Williamson, CoE director, has created a fundraising process that:

- respects the doctor-patient relationship
- minimizes the potential conflict of interest faced by physicians thrust into the fundraising role
- addresses physicians' discomfort with directly asking for money.

The strategy is a response to patients and families who wish to support the mission of the geriatrics program "because they believe in what we do," Dr. Williamson said. "While clinical faculty have never asked one person for money, over the past eight years our program has garnered \$7.5 million in philanthropic gifts." Contributions range from \$100 to \$500,000.

Dr. Williamson holds an annual session with clinical faculty to help them respond to inquiries from patients and families who wish to donate to geriatrics. He uses practice scenarios of patients/families who inquire about making a contribution—situations in which faculty might get tongue-tied and miss an opportunity. Faculty members are given a script to work from that begins with expressing gratitude to the potential donors. They then share a brochure that describes opportunities to contribute to the geriatrics program mission, with Dr. Williamson's contact information. Patients and families are reassured that Dr. Williamson will be happy to talk with them about the program's needs. The program brochures are also displayed prominently in waiting rooms, clinics, and the hospital's acute care unit.

"When potential donors call, I explain that without community support we could not do what we do and there are a number of ways to support us." He mentions a range of options, such as "training doctors about caring for older adults, interesting scientific pilot studies that are 'shovel ready' but do not require a lot of money to get started, and major programs we want to develop." He tells them he will send information and also asks what they are interested in. When they tell him, he responds, "I would love for your [patient's] doctor and me to put together a list of possible things you could support, and we could have lunch with you in the next month or so."

Before introducing the potential donor to the development office, Dr. Williamson prefers to wait until he has a pretty firm idea about what the donor wants to support. Sometimes he invites a development officer to the lunch to underscore the donor's commitment to geriatrics. Each year, he also arranges for the development office to meet with faculty to hear what they are doing individually and what the program's needs are. In turn, Dr. Williamson periodically speaks about geriatrics at one of the quarterly dean's donor forums or the annual planned giving advisory board meeting. "Identify a development officer who will work closely with you, and be very generous with your credit to them in particular. Our VP for development has become such a strong believer in our work that he developed a named fund in honor of his parents. This fund sponsors a junior faculty member's research project each year—evidence that we are on the same team." He recalled advice from one of his mentors and former chair, William Hazzard, MD: "Always make sure that whatever you accomplish, the people supporting you feel that your success is their success."

Dr. Williamson urges his colleagues to stay true to the primary mission: “To provide the best care and exemplary research and teaching, not convert to being a fundraiser.” He sees his program’s fundraising success as “30 percent brochures and 60 percent learning what to say, in the context of superb research, education, and clinical care.” He also urges his faculty to view gifts as donations to the entire group. “While much of a gift might go toward a specific person, no one is an island and sharing success across all missions is part of the fabric of our program. You might call it ‘translational fundraising!’ ”

## Resources

For more about coverage of aging issues in the media, see *The New Old Age Blog of the New York Times*: <http://newoldage.blogs.nytimes.com>

See also the American Geriatrics Society’s Press Room on its web site: <http://www.americangeriatrics.org/news/>

For resources on fundraising for health, see the *Getting Started: Fundraising for Health* resource list at the Foundation Center web site: <http://foundationcenter.org/getstarted/topical/health.html>

See also a book from two development specialists: Fitzpatrick JJ and Deller SS. *Fundraising Skills for Health Care Executives*. New York, NY: Springer Publishing Company, Inc.; 2000.

## 4. Using Consultants

**The challenge: To call in outside help—or not—when your program’s growth and development hits a roadblock**

### Summary

CoEs sometimes encounter roadblocks or reach plateaus. Leaders may wonder if it would be helpful to bring in outside consultants. In fact, a number of CoE directors have used consultants strategically; some thought their use should receive greater support because of the benefits.

Among the most popular consultants were senior geriatrics leaders who: (1) had extensive program development experience and were also knowledgeable about other CoEs; and (2) had specific areas of expertise, such as business models to establish palliative care services. External advisory committees were also mentioned by several leaders as sources of guidance and insights that have proved invaluable for early planning and during critical junctures when a change of course might be in order. Consultants can also be extremely helpful when embarking on a new initiative that is meeting resistance.

### Strategies

**Use a consultant for objective insights.** A consultant with expertise in academic geriatrics can bring a reality-based perspective to your program. They can help you make crucial decisions about goals based on: (1) other successful programs; (2) their own program’s particular stage of development; and (3) roadblocks they have faced. A consultant can hold up a mirror and provide an objective perspective on what your program looks like from the outside. Consultants don’t always tell you what you want to hear, but the lessons are valuable by providing objectivity and advice on future directions.

***A small investment can yield a big return.***

“A consultant is a relatively small investment to obtain an external calibration of your program’s strengths and weaknesses.”

Christopher Callahan, MD, Indiana University

**Use a consultant when you want your leadership to really hear what your program needs to succeed.** A consultant from another well-established, highly regarded program can help get your dean’s or chair’s ear. Even if the consultant tells the leadership the same thing you have been telling them, they hear it in a different way. A geriatrics leader who has served as a consultant visited a CoE and met with the dean and the chair of medicine. Having been an interim dean himself, he was able to talk with the leadership in their own language about how to help their new division chief succeed, and how to position geriatrics within the larger institution.

**Use a consultant to tell uncomfortable truths to administration.** Senior consultants from well-established geriatrics programs can sometimes better explain and sell what a dean may not want to hear. Academic administrators are often focused on programs becoming financially self-sufficient, an outcome that relies, in part, on strong reimbursement for clinical services—clearly not the case for geriatrics. Nevertheless, while “self-sufficiency” may not be a realistic goal for academic geriatrics, a consultant can identify steps administration can take to ensure a robust program that contributes to the institutional mission.

**Use a consultant to help launch new (or misunderstood) programs.** Several CoEs have used consultants to help launch palliative care programs, particularly when meeting resistance from hospitals concerned with losing revenue. According to leaders who have brought consultants to their campuses, hospital administration was able to hear “the same message a little better” when it came from a consultant specializing in creating business plans for palliative care rather than when it came from geriatrics staff engaged in palliative care. There was a “180 degree shift,” noted one leader. (See Resources below.)

***Close-up***

**A steady diet of consultants.** Dr. Christopher Callahan reported that Indiana University’s geriatrics program used Harvey Cohen, MD, from Duke University as a consultant. Dr. Cohen had “an interest in providing advice and cheerleading for expanding the nation’s aging centers.” In turn, he recommended George Maddox, PhD, from Duke, who focused on Indiana’s aging research initiative. Drs. Cohen and Maddox helped geriatrics leaders understand various developmental phases, starting with the need to build a strong foundation. Their messages included the need for consistent leadership and investment over a long period with incremental growth, and for building on local strengths and local culture.

Dr. Callahan recalled that “consultants can also ‘speak truth to power.’ When asked by Indiana’s administrative leadership how long it would take our program to become self-sufficient, Dr. Cohen—director of one of the most successful programs in the country—answered, ‘Never.’ You could have heard a pin drop! However, Dr. Cohen explained what the institution could expect out of this endeavor in the short run, if they wouldn’t saddle it with too many research themes or curriculum development. Although it sounded shocking when he said it, it worked and was extraordinarily important,” he said.

Dr. Callahan also noted the contributions of other senior leaders, such as Jeffrey Halter, MD, from the University of Michigan, who served on Indiana University CoE's external advisory committee for the first few years.

## Resources

For a case study of a palliative care consultation, see: *Two struggling academic palliative care centers get management advice to help stabilize* on the Robert Wood Johnson Foundation web site: <http://www.rwjf.org/reports/grr/046742.htm>

## 5. Big Picture Perspectives on Expanding Geriatrics Programs

### **The challenge: To incorporate big picture trends into strategies for academic geriatrics programmatic growth and development**

#### Summary

Leaders are challenged not only to improve core training, research, and clinical services, but also to think and act strategically regarding big picture trends that are likely to shape the future of academic geriatrics. "If you stay the same you fall behind — everybody has to compete just to maintain and to compete at every level," stressed one geriatrics leader. Getting ahead of the curve requires building on program strengths, and being aware of how to align national trends with your institutional mission and locale. While no one can predict which trends will emerge as the most important in the field of aging and geriatrics, several physicians, whose careers in academic geriatrics have led to leadership roles at national organizations and major programs, urge an activist role for academic geriatrics in the following areas:

- The growing quality care movement
- Engagement with policymakers regarding key issues, such as "medical home" legislation, increased funding for training, and enhanced reimbursement based on credentialing
- New partnerships with schools of public health.

Such challenges, along with others addressed elsewhere in this report, suggest the timeliness of creating a national center, as proposed by Dr. Christine Cassel, dedicated to enriching academic geriatrics management and leadership skills.

#### Strategies

**Capitalize on the quality care movement.** Dr. Cassel, who is executive director of the American Board of Internal Medicine (ABIM), suggested a focus on quality issues in geriatrics. "Any way in which geriatricians are seen as vital resources for hospital problems and challenges will help the field. This may mean that academic geriatrics programs will have to develop skills they don't have, recruit those in quality improvement science and measurement, and develop a more sophisticated understanding of Medicare and other payers in their area."

### **Engage legislators.**

“Make legislators feel that what is going on in academic geriatrics and research is part of their community, part of something of national interest that should be high on their radar screens.”

Judith Salerno, MD, MS, Institute of Medicine

**Engage in the public policy arena.** Demonstrate excellence in key policy issues, raise the visibility of geriatrics in those areas, and enhance relationships with legislators. For example:

- **Develop expertise in policy issues.** “The collective body [of academic geriatrics] needs to have more impact,” Dr. Cassel said. “But as we look at these struggling academic centers, I suggest that each program has a couple of people working on policy.” She notes the advantage to geriatrics of having faculty who can help the dean figure out how to utilize new opportunities. For example, although Dr. Cassel does not see academic leaders paying attention now, “as soon as there is money on the table, they will say, ‘Why can’t we be a medical home?’ Geriatrics programs need someone inside who goes to policy meetings to learn about the issues, and who can be valuable on their own campus.”
- **Increase the visibility of geriatrics in the policy arena.** “The policy arena is very hot right now,” Dr. Cassel said. “We really need new blood, as well as sustained senior leadership in this area.” She strongly supported efforts to enhance the role of board-certified geriatricians in forthcoming Medicare demonstration programs, so that the primary care field does not dominate initiatives directed at frail older adults. “We [at the ABIM] are studying the primary care shortage with policymakers. Everyone has focused on the decline in primary care. What is happening in geriatrics is part of the same phenomenon, but more so.”
- **Focus on tying reimbursement to credentials.** Jack Rowe, MD, professor at the Mailman School of Public Health at Columbia University (and retired Chairman and CEO of Aetna, Inc.), argued that the only way for the academic geriatrics model to become self-sustaining is to improve reimbursement. Referencing the April 2008 Institute of Medicine report, *Retooling for an Aging America: Building the Healthcare Workforce*—for which he served as chair—he emphasized that an “increase in payments is not only essential but also realistic. Senators are usually ‘allergic’ to increased payments, but substantial increased payment for those who are qualified is not really going to cost anything because of the small number of board-certified geriatricians.”
- **Don’t neglect modification in compensation schedules.** Dr. Rowe’s interest in geriatrics “led me to get Aetna more involved in the Medicare program. I hired a geriatrician to be the head of Aetna’s Medicare and disease-management programs. Some of these programs focused on frail older adults are very promising. Coming out of Aetna, I saw the incredible power of modification in compensation schedules. Physician behavior is incredibly influenced by even small changes in compensation levels, and those in academic geriatrics have not focused on that.” (For further information on geriatrician compensation see Resources below).
- **Bring legislators to the academy.** Dr. Judy Salerno, who became executive director of the Institute of Medicine in 2008, noted: “When Congressional representatives are in their Washington offices, you might get in the door if you are from their districts. But you can have an even greater impact if you interact with them when they are in their district offices, where they can see the connections between academic geriatrics programs and community services. Invite them into academic settings to give a talk or have a tour.” (See Resources below.)

- **Create teaching moments.** Dr. Salerno, whose background includes leadership of a multi-city program linking medical students and active older adults, *Vital Visionaries*, suggests seeking “ways to spotlight what you are doing through community-based programs. Those are teaching moments for the geriatrics community to educate members of Congress.” She also suggests a “National Take Your Senator to Home Care Day” to show them how “fundamentally important to quality of life and aging the geriatrics care team can be.”

**Expand partnerships with schools of public health.** Several CoEs utilize their schools of public health for research training for fellows. Some geriatrics faculty have MPH degrees and/or conduct collaborative research with public health colleagues. Two deans envision further connections. Linda Fried, MD, MPH, who left the geriatrics division at Johns Hopkins School of Medicine in 2008 to become dean of the Mailman School of Public Health at Columbia University, emphasized, “There needs to be intentional investment. I took the job at Columbia because I felt that in parallel with clinical geriatrics, we had to have public health embracing geriatrics, which is not done currently.” Dr. Robert Golden, dean of the School of Medicine and Public Health at the University of Wisconsin-Madison, reported that his school is going through a unique transformation: “It is the first in the country with a combined School of Public Health and Medicine that melds together the full continuum of basic science and clinical care. We have a geriatrics center and cancer center, and want to link community-based screening programs with molecular biology programs.” Crediting his predecessor, he reported, “This whole vision was crafted even before the National Institutes of Health Clinical and Translational Science Awards (CTSAs).” (See page 34 for more on the CTSAs.)

**Create a National Center for Academic Geriatrics.** Dr. Cassel suggested creating a national center specifically focused on management issues necessary to develop and expand academic geriatrics programs. Geriatricians not only “need a broad spectrum of medical knowledge, but are also asked to be good systems managers, manage teams, and deal with managed care,” she explained. “These are all skills that require a lot of training, which most physicians don’t receive.” As a model she suggested the Center to Advance Palliative Care, which combines training, consultation, networking, and other resources.

## Resources

For the Institute of Medicine’s 2008 report, *Retooling for an Aging America: Building the Healthcare Workforce*, and related PowerPoint and other materials, see the IoM web site:  
<http://www.iom.edu/?ID=53452>

For information on geriatrician compensation and other geriatrics workforce issues, see the Association of Directors of Geriatric Academic Programs (ADGAP) *Status of Geriatrics Workforce Study* web site:  
<http://www.adgapstudy.uc.edu/Home.cfm>

See also the Health and Human Services Bureau of Health Professions National Center for Health Workforce Analysis web site at: <http://bhpr.hrsa.gov/healthworkforce/>

For information about Medicare’s Pay-for-Performance (P4P) programs, see the American Geriatrics Society web site: [http://www.americangeriatrics.org/policy/2006p4p\\_index.shtml](http://www.americangeriatrics.org/policy/2006p4p_index.shtml)

For information about geriatrics and health policy and advocacy, see the American Geriatrics Society web site: <http://www.americangeriatrics.org/policy/>

For information about a geriatrics and healthcare quality scholars program, see: the Special Fellowship Program in Advanced Geriatrics of the Center for Primary Care and Outcomes Research of the Stanford School of Medicine and the Center for Health Policy of the Greeman Spogli Institute for International Studies web site: [http://healthpolicy.stanford.edu/fellowships/special\\_fellowship\\_program\\_in\\_advanced\\_geriatrics/](http://healthpolicy.stanford.edu/fellowships/special_fellowship_program_in_advanced_geriatrics/)

For information about geriatrics quality assessment, see The RAND Assessing Care of Vulnerable Elders (ACOVE) project: <http://www.rand.org/health/projects/acove/>

### 1. Build an Administrative Infrastructure

***The challenge:*** To build support for administrative infrastructure that allows faculty and fellows to do what they do best—research, training, and clinical care

#### *Summary*

A crucial but frequently underdeveloped component of academic geriatrics programs is a sound administrative infrastructure—the basic organizational structures and services needed to support the academic enterprise. Sound infrastructure contributes to longer-term stability, although planning far in advance can be challenging because of staffing and other issues. One leader referred to his own early efforts to build his program’s infrastructure as more “ad hoc” than “strategic.” Certainly, infrastructure is often the most difficult piece of the academic enterprise for which to build support, as until recently, many funders have been relatively uninterested in supporting it.

Nevertheless, building administrative structures and services must become a more strategic process in an increasingly complex and interconnected academic environment. While program and institutional resources, and even institutional culture, may influence how administrative function is structured, trends are evident. These include pooling resources from grants and other sources to support a more stable infrastructure, and the hiring of non-physician experts for higher-level management/administrative positions and specialized activities.

#### *Strategies*

**Combine programs, share administrators.** Some leaders are sharing administrative positions, including higher-level coordinators and managers, across programs. One leader assumed responsibility for both her clinical program and the institution’s aging center, which focuses on education and research, and shared staff for the two programs. The staff included an administrator/manager, an accountant, several administrative support staff, and an academic coordinator. That coordinator works with junior faculty, educators, and researchers on their projects; coordinates all education programs; and, with the program director overseeing educational and research endeavors, is project coordinator for the Hartford CoE.

**Pool financial resources.** Support for administrative staff and other infrastructures within academic geriatrics comes through combining dollars from various sources. For example, the academic coordinator mentioned above is jointly supported by the aging center and the dean’s office. Funds for other administrative staff come from a mix of recurring annual state funds; clinical contracts (Continuing Care Retirement Communities, for example); and grants, such as the Hartford CoE, which pays for infrastructure and an accountant; and a Donald W. Reynolds Foundation Aging and Quality of Life grant, which helps support administration.

**Share administrative resources with affiliated programs.** At one institution with a small geriatrics program that has its own administration, a leader is able to draw informally on administrative resources from programs with which he is affiliated. For example, a center with more resources might provide his geriatrics program with a computer, a programmer, or a research assistant for a particular project. When

institutional leadership sanctions a culture of sharing administrative resources, barriers are reduced. The flexibility and availability of such resources allows faculty to access them when they are most needed and make the most sense, so administrative support can be built around the needs of individual projects.

***Change an old mindset.***

“Physicians are trained to think they should do everything themselves. Instead, they need good smart hiring and a cultural change in thinking. Our program needed people with different skills sets than physicians usually have.”

Rosanne Leipzig, MD, PhD, Mount Sinai School of Medicine

**Make the case for supporting specific administrative and management functions.** Some funders have begun to support administrative components of a grant. Making the case to funders involves articulating how non-clinical staff brings special skills to administrative and management positions that contribute to the overall effectiveness and efficiency of the initiative and maximize the capacity of physicians (and other clinicians) to carry out their roles. One leader, who has seen an increase over the past decade in funders’ willingness to support non-medical experts and administrative staff, recalled that early on, they “didn’t recognize how much further it would get us to use the money for someone who was not a physician.”

***Close-ups***

**From “ad hoc” to “strategic” management.** With regard to building an Academic Affairs Resource Center, Dr. Seth Landefeld, at the University of California at San Francisco, recalled, “When we started the center 10 years ago, we were a small geriatrics division with one administrator. We recruited and retrained one staff person at a time to meet various needs as we identified them.” The center has grown and currently has three groups of staff:

- Grants managers to provide pre-award assistance with budget and personnel and with navigating the university structure for submission; and post-award assistance on budget issues, hiring, and reports
- General administrative staff to organize meetings, grand rounds, schedules, visitors’ itineraries, and other logistics
- Research assistants (supported by research grants).

In addition, center staff assists with coordination of fellow activities and job placement. Plans are underway to add the center’s first evaluator for education grants. To support the growing staff, funding has been combined from various sources: the Hartford CoE award; a Reynolds Foundation Aging and Quality of Life grant; the Health Resources and Services Administration (HRSA) Bureau of Health Professions (Geriatric Academic Career Awards and Geriatric Education Center award); local philanthropy; clinical revenue; and the VA Medical Center, which provides about a third of the budget and where a number of faculty hold positions. (See Resources below for information on these funding sources.)

**Two trainee tracks across two campuses.** Joseph Ouslander, MD, currently at Florida Atlantic University, recalled that during his tenure at Emory University, when the Southeast Center of Excellence in Geriatric Medicine (SCEGM) received administrative support for the creation of a more flexible training pathway, he and the CoE's co-director Richard Allman, MD, at the University of Alabama at Birmingham, created separate tracks and resources for two different career goals: (1) research; and (2) clinical service and teaching. They also created two positions for management support: a research advisor and an associate director of curriculum and education. A PhD coordinator assists trainees in both tracks with mentoring and the review of grant proposals by both institutions. Some trainees are from other subspecialties. "Some mentors' salaries are supported by the Hartford CoE grant, plus leverage with a Reynolds Foundation grant, which provided the infrastructure to implement educational interventions." (For more information see the SCEGM Program Profile in Section IV.)

**To build administrative infrastructure, retrain, specialize, and share.** The Mount Sinai School of Medicine CoE in New York City focuses on training clinician educators, reports Dr. Rosanne Leipzig, CoE director. The CoE offers a variety of intensive training programs, including fellowships, mini-fellowships, and board review courses. To manage the growing enterprise, Dr. Leipzig said she hired "a deputy director with a background in organizational development, who knows how to manage people and put programs together; education specialists; and three administrators/project managers who work at a higher level, including one who has become pretty expert at organizing educational events."

They also retrained in-house support staff to gain expertise in areas such as publishing software and graphics. The CoE shares four positions with other departmental programs, including a statistician. "Professionals with these skills are hard to find," Dr. Leipzig explained. "The nature of our work is that there are crunch times and down times. A benefit of our infrastructure is the greater potential to 'recycle.' We develop programs that can be used in more than one venue. For example, we can use the same talk for fellows and for the mini-fellowship course so faculty aren't creating a new presentation each time." Administrative and other support comes from the Reynolds Foundation for a train-the-trainer leadership center; the Hartford CoE award; a number of education grants; and from a Special Projects Unit, which manages continuing medical education programs, CoE programs, and pieces of the fellowship program. A recent Reynolds Foundation award supports the development and staffing of the Portal of Geriatric Online Education a clearinghouse for geriatrics educational materials and competencies. (See Resources below).

## Resources

For more on the Reynolds Foundation Aging and Quality of Life Program, see: <http://www.dwreynolds.org/Programs/National/Aging/AboutAging.htm>

For more on the Health Resources and Services Administration (HRSA) Bureau of Health Professions Geriatric Academic Career Awards, see: <http://www.hrsa.gov/grants/gaca/>

For more on the Health Resources and Services Administration (HRSA) Bureau of Health Professions and Geriatric Education Centers (GECs), see: <http://bhpr.hrsa.gov/interdisciplinary/>

For educational resources developed by the GECs, see: <http://bhpr.hrsa.gov/geriatric/resources/HRSAdefault.asp>

For a clearinghouse of geriatrics educational resources, see: the Portal of Geriatric Online Education: <http://www.pogoe.org>

For additional educational resources, see the MedEd Portal: <http://www.aamc.org/mededportal>

## 2. Centralize Grants Management: A Closer Look

**The challenge: To utilize research resources most efficiently and effectively**

### Summary

A number of geriatrics leaders are pursuing management strategies directed at economies and efficiencies of scale. One model that was developed for more efficient and effective grants management has grown into a larger enterprise at UCLA's Multicampus Program in Geriatric Medicine and Gerontology. The Research Operations Core (ROC) was one of the first to centralize staff responsible for data collection, data management, data analysis, systems development, and program evaluation. The program director, David Reuben, MD, said he noticed that "the nature of research is surges and slower periods for each project, and some smaller projects don't need and can't afford full-time staff." He concluded that it was easier and more efficient to centralize the process, and designed a business model that works. Dr. Reuben acknowledged that a lot of his "entrepreneurial strategy" came from management training, which included a two-year leadership program through the California Healthcare Foundation, where he received business training, including quality improvement models. (See Resources below.) Because UCLA's model has been so fully realized and may hold promise as institutions increasingly focus on multi-program collaborative initiatives, it is presented in detail below.

### Strategies

**Align research goals with a business model that works.** Goals for the ROC include:

- Make it as easy as possible for investigators to do research ("This is a competitive environment, and faculty want to have lives outside of work," noted Dr. Reuben.)
- Share staff across projects
- Ensure that data collection, entry and management are as accurate as possible
- Have the right professional for each job for an efficient operation.

**Find a superb administrator.** "I was fortunate to start with an excellent PhD faculty member, Teresa Seeman, PhD, who had extensive prior experience leading field data collection for large studies, and who had an overall vision for our undertaking. She hired an associate director, Heather McCreath, PhD, whose primary responsibility is to administer the research operation. Dr. McCreath reports to the associate chief for research and ultimately to the division director," Dr. Reuben said.

**Invest in start-up and market broadly.** Some start-up money was provided by a Pepper Center grant, and Dr. Reuben steered new people and resources to the ROC, making sure that support for research operations was included in grants. The ROC now serves a variety of groups, including core division faculty, especially junior faculty; faculty in the nursing school; other divisions in medicine; and other departments. In 2008, the ROC provided support for the Pepper Center plus 20 different grants that each contribute to the ROC.

**Think "one for all, all for one."** Because of the ROC's centralized and shared research infrastructure, "we can apply for larger grants and we can attract new investigators who are now conducting aging research because they like working with us. We have also provided a model for the department of medicine to use core labs," Dr. Reuben said. He cited the example of an AIDS researcher who added a description of

ROC services to his grant, which facilitated grant preparation and improved the quality of the submission. “With the ROC up and running, researchers have an operation they can trust that supports multiple research functions; they aren’t afraid that if they get a grant award they won’t be able to do the work.” The economies of this centralized, shared approach to research infrastructure include that, “personnel can pinch-hit for others, pregnancies and illnesses can be accommodated, and, given that research demands fluctuate, we can reassign staff to other projects during down-times.” Another benefit is that there is an infrastructure for other projects that are important to the geriatrics division. This includes maintaining a mailing list of people for investigators to contact for recruitment into studies and a software program for tracking teaching time of faculty that was developed by the ROC with an education grant.

**Customize services to enhance buy-in.** The ROC offers customized, menu-driven service options for senior investigators. It also facilitates research by junior faculty, who are building their careers and want to begin to hire staff who will be with them for the long run. In this model, those staff are employed, trained by, and responsible to the ROC and have offices in the ROC space. Yet, dedicated research staff can continue to work on the junior faculty member’s grant and any shortfalls in coverage for their time can be picked up by other grants.

**Provide a service for your department with a business model that works.** As a result of the ROC’s success, Dr. Reuben was asked by his department chairman to take over a research unit that was off-campus. “It was ethnically diverse and had a wonderful population to draw from. However, while that unit was good at recruiting people for studies, they lacked an efficient organizational structure. They were spending lots of money and did not have a business model that worked.”

**Anticipate challenges.** The large-scale ROC enterprise has presented several challenges:

- Supervision is essential and requires significant staff time. However, it is easier to obtain support for research data collectors than supervisors.
- Start-up is the hardest period. Until the ROC was able to support a fairly large number of grants, it suffered the same ebb-and-flow problems as individual grants do, only more so. Supporting many grants is much easier.
- Rent increases and the need for better space are other areas where the ROC can “get into trouble.” Estimating space needs beyond one or two years and negotiating long-term contracts is extremely difficult in the face of uncertain future funding. However, “the division and department help us out,” said Dr. Reuben.

## Resources

For information about the California Healthcare Foundation’s Healthcare Leadership training program, see: <http://www.chcf.org/topics/view.cfm?itemID=19722>

For information on the UCLA Research Operations Core, see the UCLA GeroNet web site at: [http://www.geronet.ucla.edu/centers/pepper/pepper\\_rops.htm](http://www.geronet.ucla.edu/centers/pepper/pepper_rops.htm)

### 3. Pool Resources to Fund Fellows and Junior Faculty

**The challenge: To pursue funding strategies for fellows and junior faculty that reflect programmatic and institutional strengths**

#### Summary

The challenge of funding training for fellows and junior faculty research has generated some innovative approaches. These often involve blending sources of funding. Joint fellowships are becoming more common, and geriatrics programs have found ways to fund and manage them. Some institutions have established a tradition of flexible fellowships where they offer joint training with other specialty programs. Targeting fellows who bring their own funding can relieve some of the financial burden. One collaborative CoE draws funding and other resources for training and research from both partner institutions. Philanthropy can also play a role. At one institution, the directors of the geriatrics program and a high profile aging center have designated second-year fellows to receive awards from the center's fundraising activities.

#### ***Use philanthropic dollars for geriatrics fellowships.***

"The fundraising board for the Huffington Center on Aging includes families of former patients or people linked to our mission on aging."

George Taffet, MD, Baylor College of Medicine

#### Strategies

**Start a tradition of joint fellowships.** Some geriatrics programs have a well-established history of joint fellowship training with other specialties. At Duke University, "we have had geriatric medicine fellows train with us and then do training with another program, or fellows from another specialty do some training in geriatrics," reported CoE director Ken Schmader, MD. "Either way, our aim is to keep them in academia, teaching and doing research in areas such as geriatric oncology or cardiology." Funding for internal medicine specialty fellows who are interested in aging issues currently comes from the T. Franklin Williams Scholars Program. (See Resources below.)

**Recruit fellows from other specialties who bring their own funds.** Yale University focuses on fellows who have completed their clinical training and want to do their research training in an area that combines their specialty with aging. These fellows are already funded through the training program in their specialty, so their salaries are paid by their own training grants or their sections, reported CoE director, Mary Tinetti, MD. Two or three specialty fellows each year receive support through the geriatrics training grant. "We give them money for research training and the CoE provides resources to carry out the research project. They are co-mentored by geriatrics faculty and may also participate in ongoing geriatrics clinical activities." (Thomas Gill, MD, directs the geriatrics training grant.)

**Blend sources of funding to create protected time for junior faculty.** At Duke University, leaders draw on money from the CoE as well as funds and other resources from the Reynolds Foundation, the Pepper Center, and the VA Medical Center, specifically the Geriatric Research Education and Clinical Center (GRECC).

**Find philanthropic dollars for fellowships.** At the Baylor College of Medicine, the fellowship program has benefited from the philanthropy of its highly visible Huffington Center on Aging. Dr. George Taffet reported that the center helps raise targeted funds in a unique way: 100 percent of the money raised goes to geriatrics education or research. He works with the center’s director to set funding priorities, which now include funding second-year fellows with money raised at the center’s annual gala. He also has former, current, or potential academic fellows speak to the Huffington Center development board. “The board members would rather hear from an enthusiastic young person than from me,” said Dr. Taffet.

### Close-up

**Partners “piece it together.”** Dr. Richard Allman, University of Alabama at Birmingham and co-director of the Southeast Center of Excellence in Geriatric Medicine (SCEGM), reported that to fund fellows and junior faculty he pools resources with Emory University, and the VA. Funding from the Hartford Foundation secures prestige within the university (as is the case at other institutions). “Both the financial support and the branding help us to secure additional funds and attract the best fellows and faculty.” (Between 1998 and 2008, the SCEGM provided support for 32 Hartford Foundation Scholars.) “Using division funding, the VA, community partners, and contracts with nursing homes, for example, we piece funds together, we leverage, and we match a job with pay,” he said. Dr. Allman added that when they interview someone they really want but they do not have the money themselves, they have candidates meet with people who have the resources. “If the junior faculty gets a grant, that will open the door—we are planting the seed; there are synergies here.”

### Resources

For information about career development awards for junior faculty focusing on the geriatrics aspects of their disciplines, see:

The T. Franklin Williams Awards for specialties in internal medicine:

<http://www.im.org/CareerDevelopment/GrantsandScholarships/TFWS/Pages/default.aspx>

The Dennis W. Jahnigen Awards for surgical and related medical specialties:

<http://www.americangeriatrics.org/hartford/jahnigen.shtml>

## 4. Develop a Strong Mentoring Program

**The challenge: To develop an effective, efficient, and replicable mentoring model that builds on faculty and program strengths**

### Summary

Mentoring, whether for students, residents, fellows, or mid-career faculty, has become a cornerstone of geriatrics training programs. The role of mentoring has expanded at times due to the increased numbers of trainees; changing training needs (dual training tracks or training fellows from other specialties); or enrolling trainees with widely different goals, skills, and interests.

Mentoring has also become more formalized, with more clearly delineated roles and responsibilities for faculty and trainees. One impetus for formalizing mentoring programs has been the availability of funding, such as research training dollars from the NIH and elsewhere, for structured mentoring of students, fellows, and junior faculty. The following mentoring models all aim to draw on faculty and programmatic strengths, to cope with limitations (for example, lack of enough senior geriatrics faculty to serve as mentors), and to become sustainable, so that today's trainees who remain in academic geriatrics become tomorrow's mentors.

## Strategies

**Formalize responsibilities for mentors and trainees.** For some geriatrics programs, a more formalized mentoring strategy has been spawned by necessity. At UCLA, an interdisciplinary mentoring model was already in place. It included a mentoring committee, a primary mentor, a content mentor, and a methods mentor outside of the trainee's discipline. However, between 1999 and 2000, "a bumper crop of fellows arrived to become physician-scientists, and the program did not have an adequate number of mentors," Dr. David Reuben said. To address this gap, he wrote a proposal for a National Institute on Aging (NIA) K-12 Mentored Clinical Scientist Development Program Award. As a result of this grant "the mentoring committees got teeth—they met quarterly and had to prepare reports, and that kept things on track." At Yale University, mentors work with subspecialty fellows and junior faculty, providing consultation and hands-on support in the design, implementation, and analysis of their Hartford CoE projects. Mentoring extends to clinical and teaching activities, for which some fellows have developed aging-related curricula based on their subspecialty.

**Identify a leader to keep mentoring on track and to build trust.** Mentoring programs require ongoing oversight to keep them functioning well. At the Southeast Center of Excellence for Geriatric Medicine, leadership oversees the overall mentoring process, including timelines. Dr. Joseph Ouslander, former co-director, observed that leaders "stay on top of trainees and require structured reports signed by mentors." For successful group mentoring, the model used by UCLA, Dr. Reuben cited the importance of centralized, committed leadership, a role he played for the first six years and recently turned over to another faculty member, Alison Moore, MD. "I got to know people really well and built trust and a very cohesive group. Managing mentoring programs requires someone who will take ownership and thinks it is important."

**Make a match based on faculty expertise and trainee goals.** Several leaders emphasized the importance of identifying for candidates, particularly those who want to become academic geriatricians, faculty who have the expertise to assist trainees with their research. Moreover, some programs are called upon to mentor trainees at very different levels of training and with diverse skills and goals. At Yale University, Dr. Mary Tinetti and her colleague Dr. Tom Gill match young subspecialist investigators (fellows or junior faculty) with mentors who include geriatrics faculty with K, T32, and Pepper Center funding. Trainees with clinical interests can take advantage of Pepper Center research cores, and can assist investigators with study design, data collection and analysis, subject recruitment and enrollment, and other services. Trainees with basic science interests can assist Pepper Center basic scientists with research design and help them identify sources of cells from older people.

**Focus on relationships.** "Whatever the structure," said Charles Reynolds, MD, director of the University of Pittsburgh's CoE in Geriatric Psychiatry, "there is no substitute for relationships. We have multiyear mentoring relationships and mentoring teams. We also have small multidisciplinary research teams to inculcate values." As an example, he described a geriatric psychiatry fellow who has "two gurus," himself and a geriatric medicine faculty member. "The three of us are in constant contact. We meet once a

month, work with the trainee on his grant application, and have more frequent informal meetings.” In terms of building relationships, the Pittsburgh geriatric psychiatry program recruits early and often. “Some Hartford fellows were already identified as medical students and they came to our residencies and fellowships and have become faculty.”

(See Resources below for a description of a junior faculty mentoring program designed to navigate the transition from post-doctoral fellowship to junior faculty.)

**Consider alternative models for mentoring.** Here are additional approaches to dealing with a shortage of faculty mentors within an academic geriatrics program:

- **Group mentoring.** This approach can extend resources when time and faculty are limited. UCLA holds one-hour group mentoring sessions twice a month with about 15 participants and at least one senior mentor. Participants discuss their research questions and problems. Dr. Reuben was surprised at how much information can be conveyed in these sessions by drawing on the anecdotes and experiences of senior faculty. Although these meetings require a time commitment for all involved, there is no prep time for senior faculty, and there is strong group support. Some tips on logistics for this approach include:
  - Identify a convenient and consistent meeting time
  - Early-morning meetings generally have better attendance but note that 8 a.m. meetings are difficult for those with young children
  - Serve food.

However, these sessions can be successful only if junior faculty participate. Dr. Reuben recommends using the leverage you have to require participation for those receiving salary support. At UCLA, this is done for faculty supported by grants including the Hartford CoE, Pepper Center, and NIH K-12 grants.

- **Multidisciplinary group mentoring.** Whether academic trainees are nurses, physicians, or psychologists, they all have professional tasks in common, such as grant writing, preparing budgets, and serving on committees. So the UCLA program set up a group mentoring process called Academic Advancement. These multidisciplinary groups have some pros and cons. “Some disciplines have more research training than doctors, and they have different insights,” Dr. Reuben said. “This has allowed researchers to collaborate on projects and meet outside of sessions. But, if a content area is too far afield from medicine, the geriatrician may not be interested.” Nevertheless, he cited the group’s “magnanimity of spirit,” even if the research presented is not in their area. “They have found that they grow through these multidisciplinary exchanges.”
- **A collaborative approach to mentoring.** The SCEGM mentoring program combines senior faculty from both partner institutions. They help trainees formulate early ideas and offer additional pairs of eyes and ears. Trainees, whether in the research or the clinician-educator track, have at least one primary mentor. Some have mentors from both institutions who review all grant proposals. Salaries for some mentors have been supported by the Hartford CoE grant with additional leverage from the Reynolds Foundation Aging and Quality of Life grant for infrastructure to implement educational interventions.
- **A national mentoring program.** An ambitious national approach to an insufficient number of local mentors is the model used by the Beeson Career Development Awards, which are supported by the Hartford Foundation, the Atlantic Philanthropies, and the NIA. Members of the Beeson Program Advisory Committee, who are senior geriatrics faculty from institutions across the country, volunteer to serve as confidants, counselors, and advocates for the Beeson scholars. They agree to meet with

their scholars (who may have as many as four mentors) at each Beeson Scholars annual meeting, and to be available between meetings as needed. Mentors offer advice on navigating the pitfalls of an academic career, ensure that scholars link with other scholars, support a continued aging focus in the scholar's research, and try to ensure that scholars have the protected time they need for their research activities.

**Teach mentoring skills.** A senior leader acknowledged his surprise at how poorly prepared junior faculty are to assume mentoring responsibilities. Even those who had gone through fellowships knew little about mentoring. To build a cadre of skilled mentors, teaching mentoring skills to junior faculty is critical, as senior faculty cannot do all the mentoring. (See Resources below for suggestions.)

**Motivate mentors.** To motivate faculty to mentor well, leaders often employ the “carrot *and* the stick,” observed Dr. Reuben. He recalled that when UCLA's mentoring program first got started, they had between six to eight mentors, drawn primarily from junior and senior faculty. Currently, the approximately 30 mentors are drawn from senior and junior faculty, Pepper Center awardees and CoE grantees, and more recently, aging-related research scholars outside of the geriatrics division. Junior faculty can opt out after two years and are replaced by new junior faculty. Beyond requirements, however, he noted how important the program has been to the mentors themselves.

**Mentoring: a growth industry.** CoE directors who are former Beeson scholars credit the program with contributing to their careers, creating opportunities for collaboration, and laying the groundwork for their own role as mentors for Beeson scholars and their own geriatrics programs. Mentoring also keeps senior researchers, whose primary focus is outside of geriatrics, more closely connected to the field. The UCLA program is one example of this, reports Dr. Reuben. “Many assume more senior leadership roles. Mentees become mentors.”

### Close-up

**Structure, flexibility, and making a match.** Finding the right mentors can be challenging, said University of Pittsburgh's Stephanie Studenski, MD, MPH, who described herself as “the 21st century equivalent of a matchmaker.” In their mentoring program, trainees are asked to present their research ideas. Dr. Studenski and colleagues then consider potential mentors from a list they maintain to develop an individualized plan for the trainee. In addition to an oversight group, each trainee has a team of primary and secondary mentors who bring different areas of expertise. Pittsburgh has created a common platform for mentoring and tracking trainees. It is tailored to trainees, who develop personal career goals and plans for achieving them. In medicine, some fellows are entering advanced fellowships with no research training, while others are taking time off to do combined research and medical school training. Pittsburgh's approach incorporates reasonable milestones and goals for each trainee, regardless of how much time the trainee spends with the mentor, and uses common axes along which levels of knowledge and mechanisms of learning can be plotted. These include:

- Human studies research, which includes a foundation in epidemiology and statistics
- Aging
- Oral and written communication, grant writing, and research
- Professionalism, teamwork, and ethics.

## Resources

For descriptions of successful CoE approaches to research training and mentoring, see the companion publication to this report: *Recruitment of Candidates to Advanced Fellowship Training and Junior Faculty Positions in Academic Geriatrics*: <http://www.geriatricsrecruitment.org/ManualTwo>

For extensive resources on mentoring related to geriatric psychiatry, many with broader applications to geriatric medicine, see the MedEd web site: <http://www.mededmentoring.org/medicalupdates.asp?source=newsletter>

For information on how institutions can advance their efforts to support research mentorship, see: Keyser DJ, Lakoski JM, Lara-Cinisomo S, et al. Advancing institutional efforts to support research mentorship: A conceptual framework and self-assessment tool. *Academic Medicine* 2008;83(3):217-225.

For information on a mentoring program designed to navigate the transition from post-doctoral fellowship to junior faculty, see: Reynolds CF, Pilkonis PA, Kupfer DJ, et al. Training future generations of mental health researchers: Devising strategies for tough times. *Academic Psychiatry* 2007;31(2):152-159. <http://ap.psychiatryonline.org/cgi/content/full/31/2/152>

For information about mentoring, see: Studenski, S. Chapter 9: Mentoring. In: *Multidisciplinary Guidebook for Clinical Geriatric Research*. Washington, DC: Gerontological Society of America, 2006.

For information about the Beeson Career Development Awards, see: <http://afar.org/pdfs/2008BeesonReport.pdf>; [www.beeson.org](http://www.beeson.org)

For the Beeson program's history, see: *Leading Science: 10th Anniversary Report: Paul B. Beeson Career Development Awards 1994-2004*. American Federation for Aging Research: New York, NY. [http://www.beeson.org/tenth\\_anniversary\\_beeson.pdf](http://www.beeson.org/tenth_anniversary_beeson.pdf)

## 5. Expand Training Opportunities through Interdisciplinary Research

**The challenge: To create interdisciplinary research activities to enhance funding and training opportunities in academic geriatrics**

### Summary

Interdisciplinary research and related funding is in the spotlight and offers opportunities for academic geriatricians. Collaboration is not new to academic geriatricians, who view it as essential to approaching complex problems related to aging. What is new is the growing number of funding opportunities (federal and foundation) that require evidence of collaboration, and the range of discussions at institutions across the country about how to enhance collaborations. At the federal level, the NIH Roadmap Initiative is an ambitious redesign of the approach to science. According to its web site (see Resources below) the roadmap is intended to move from the "cottage industry" approach to biological sciences, where "the traditional divisions within health research may in some instances impede the pace of scientific discovery," towards greater interconnectivity and collaboration. Funding is nested in specific strategies and tools (for example, multiple PIs) that aim to build bridges across disciplines, programs, and institutions. The Hartford Foundation has supported a number of successful interdisciplinary initiatives, including one described below to specifically address institution-wide capacity for interdisciplinary aging research. Geriatrics leaders have been active in a number of collaborative initiatives, three of which are discussed below. Additional resources on these initiatives can be found at the end of this section.

## Summary

This initiative seeks to promote interdisciplinary geriatrics research by improving institutional capacity to conduct such research, focusing on the development of innovative clinical and health services interventions for older adults that can be translated into real-world practice, and providing interdisciplinary education, training, and mentoring opportunities for new and established investigators. Harold Pincus, MD, director of the RAND Coordinating Center, observed, "Institutions that are strong in geriatrics by necessity will have some kind of history in interdisciplinary activity. The question is one of degree and how to strengthen it." Applying for the award has given people "a reason to get together to go after this opportunity. The award enforces shared goals and stimulates processes and structures to reinforce them." Currently in its second round of funding, centers funded through the initiative have brought people together in new ways and have created the foundations and linkages for future collaborative work. Dr. Pincus and the RAND team, who provide technical support for the development of centers and their investigators, have identified the following strategies for establishing, expanding, and sustaining interdisciplinary geriatrics research centers.

## Strategies

**Begin by conducting an organizational needs assessment.** Identify key areas of strength within the departments, schools, and participating organizations that will support the development of the center. Where do you find complementary areas between geriatrics and other disciplines? How can you advance interdisciplinary collaborations? How do they leverage your institution's strengths? Identify the factors that could threaten your short- and long-term success, including barriers to developing and/or implementing interdisciplinary collaborations, as well as solutions for overcoming them.

**Aspire to achieve true collaboration across multiple geriatrics disciplines within and beyond your institution as you develop your center.** Collaboration should include the core geriatrics disciplines (i.e., medicine, nursing, social work) as well as related disciplines, such as dentistry, nutrition, pharmacy, psychology, public health, public policy, and rehabilitation. Also consider involving trans-institutional arrangements or non-university organizations.

Cary Reid, MD, PhD, noted that Cornell's RAND/Hartford Interdisciplinary Geriatric Health Care Research Center, for which he serves as one of the PIs, is a "marriage between geriatrics and home care." The center blends expertise from geriatrics with that of researchers at the Center for Home Care Policy and Research at the Visiting Nurse Service of New York, and in Ithaca, at Cornell's Institute for Translational Research on Aging. Citing a recently submitted joint proposal, Dr. Reid noted how the initiative has "opened up opportunities to work with good researchers who are not in an academic setting."

**Emphasize interdisciplinary research projects that build partnerships that will expand research foci and methods.** Develop projects that enable researchers from different disciplines and various career levels to work together on new research ideas that bring multiple theories, skills, and data to bear on a common problem. Encourage researchers to develop unique methodological approaches that integrate conceptual, operational, and analytical components from multiple disciplines, and actively engage investigators holding a variety of professional degrees in the design, implementation, and analysis of the research.

### **Provide opportunities to promote interdisciplinary geriatrics education, training, and mentoring.**

Career development training sessions can help educate and train junior faculty to conceptualize interdisciplinary projects and develop fundable proposals. Through these sessions, junior faculty can gain experience presenting their research ideas and receive useful feedback from mentors and peers. Research mentorship can also serve as an important catalyst for providing researchers with the skills they need to advance successfully in their careers, enhancing the institutional environments within which they work, and fostering the highest levels of professional practice. Interdisciplinary mentorship programs (both formal and informal) can improve interdisciplinary knowledge and skills of junior faculty by allowing them to work with teams of senior mentors from multiple disciplines. Co-mentoring by experts in two disciplines has significant advantages, and is also used by the Clinical and Translational Science Awards. (See below for more information on CTSA.)

### **Based on your needs assessment and the approaches described above, create a business plan for how your research center will operate, including:**

- Roles and responsibilities of co-principal investigators from two or more disciplines as well as other investigators to be involved
- Types of interdisciplinary projects to be pursued
- Target groups for the interdisciplinary training and mentoring activities and how they will be implemented
- Structures and methods to strengthen interdisciplinary connections, and formal and informal opportunities to bring people together around an interdisciplinary geriatrics research agenda (for example, retreats that convene broad communities of researchers and provide them with opportunities to build new professional relationships and discuss potential projects and grant applications)
- An evaluation strategy to guide your center's development and ensure its sustainability over time, including ongoing plans for assessment and specific milestones and measures of success
- Administrative, financial, and coordination processes that will support participation of different types of players, such as institutions/organizations, departments and schools
- Current, renewable, and future funding sources for infrastructure support, and plans for sharing resources, indirect costs, and credit for products across the center's partners.

## CLINICAL AND TRANSLATIONAL SCIENCE AWARDS

### **Summary**

Two geriatrics leaders were interviewed about the NIH-funded Clinical and Translational Science Awards (CTSAs) that support institution-wide efforts to translate bench science into clinical applications. In terms of that broad goal, these leaders viewed these awards as promising initiatives, but not yet transformative. They described CTSAs as closer to a repackaging of funding with new strategies to disperse money, rather than as an initiative that introduces a great deal of new money. University of Michigan's Dr. Jeffrey Halter observed that the CTSAs put together "several NIH funding mechanisms that were not directly funded together, such as a clinical research center and career development awards, and then run this package of funding in somewhat different ways with somewhat more money." Yale University's Mary Tinetti, MD, concurred, adding that the CTSA program is "getting scientists to translate their findings into clinical relevance, with scientists focusing on aging who otherwise would not have." However, she added, "Most of the resources are helping to bring molecular level and animal models into human research, but getting that into practice will take longer. When you divide up \$45 million dollars, it

doesn't generate as much change as was hoped for. However, overall, the CTSA grant has helped advance translational science and, at some institutions, has brought a greater focus to aging-related research."

## **Strategies**

**Build capacity in human research, which can make a special contribution.** Dr. Tinetti recalled, "When the CTSA was first proposed at Yale, the Program on Aging was the largest human research center. The institution needed the program's unique resources, as others in the institution mainly did basic science research. Maybe [those researchers] would not have focused on aging, but as a result, aging is seamlessly integrated into the CTSA, and we have helped researchers move from basic science into clinical research. The CTSA provides a big pot of money that gets distributed in a lot of different ways including training, funding younger researchers, biostatistics, and human research management. The Program on Aging helped open the door with our human research focus."

**Work with CTSA collaborators to expand geriatrics research support.** While the Michigan Geriatrics Center has had pilot grants for more than 20 years (with Hartford and NIA funding), Dr. Halter explained that with the CTSA award, "we partner with CTSA leadership and together look at who has applied to the geriatrics center and CTSA, and jointly fund some pilot grants. This provides a greater source of funding for geriatrics than we would have otherwise. Instead of funding four aging awards, we could fund seven, because we funded collaboratively. In addition, the CTSA has funded the career development of junior faculty. The Pepper Center and Hartford CoE have a similar interest, so two junior faculty are partially funded by the CTSA now. This is not written into the CTSA grant. Our junior faculty apply like anyone else, but we encourage them to do so."

## PROGRAM/PROJECT CENTER (P) GRANTS

### **Summary**

Program/Project Center (P) Grants have been used for some time by geriatrics leaders to fund larger-scale projects. More recently some geriatrics leaders have used them for community-focused interdisciplinary research. This arena offers rich opportunities for geriatrics. But success involves more than expertise in human subjects research. It also requires a keen understanding of local politics and the willingness to build long-term relationships with community organizations. When the community becomes the laboratory, it opens the door to new research approaches that require an interdisciplinary effort.

### **Strategies**

**To galvanize investigators, go into the community.** A shift in focus from institutionalized older patients to community residents often stimulates investigators to develop new approaches to research and collaboration, which are more likely to incorporate functioning, safety, and quality-of-life issues into disease-specific research.

**Collaborate strategically.** Partner with community organizations that have mutually compatible goals. Community agencies and organizations can: (1) smooth your entry into the community; (2) lend credibility to your project; (3) act as intermediaries with community residents who might participate in research; (4) connect you with politicians and other power brokers; and (5) help you to translate your research into terms that are meaningful to community members. However, community groups can also

impede your project. Negotiations between researchers and community leaders are likely to be ongoing throughout the life of the project. They should begin with clearly written agreements that identify each partner's expectations for the project including benefits, resources to be contributed, specific responsibilities, and a timeline for implementation. They should also include an evaluation plan that anticipates challenges, identifies red flags, and addresses problems as they arise. Learn how, when and where to persevere, and when to move on.

**Work to build trust.** Begin with the assumption that you will need to earn the trust of community members and organizations. Many low-income communities have seen academic research programs come and go with no visible short- or long-term benefits for the community or its residents. This can lead to a disinterest in or even mistrust of academic researchers. Find out from key community insiders what you need to do to build trust and plan ways to invest in the community over the long haul. Create a community advisory board and use it as a sounding board.

***Build community partners' trust.***

"A school principal I became close to said she would take a chance on *Experience Corps*. When she saw the first team of older adults arrive at her school, including one in a wheelchair, she almost cried from worry about her decision. However, this same principal's views were transformed several months later—this was pretty radical. Project leaders started partnering with city organizations. I was having to be a politician—a huge hurdle for a clinician."

Linda Fried, MD, MPH, Columbia University School of Public Health

**Words count, so avoid jargon.** Several leaders spoke about learning how to communicate more effectively with members of the community, whether potential donors, agency staff, or the public. In a community initiative, scientific language, acronyms, jargon, and other shorthand that physicians use among colleagues does not translate well for community leaders and residents. Use straightforward, everyday terms. Align and explain your objectives in ways that resonate with the values and needs of those you want to engage. Test your main ideas with a core group of community members to see if they understand your objectives. Ask for their help in crafting your messages for the community.

**Hire a savvy project manager who has worked with both medical researchers and community groups.** This person can help broker agreements between researchers and community organizations, resolve problems, sidestep conflicts, and keep the project and your team on track.

***Close-ups***

***MOBILIZE Boston.*** At the Institute for Aging Research of the Hebrew Rehabilitation Center of Boston, a major change in research focus occurred during the early 2000s. Lewis Lipsitz, MD, recalled, "We moved from frail nursing home patients to patients in the community. For the renewal of our Research Nursing Home grant [an NIH Program/Project grant], we wanted to branch out beyond disease-specific studies in nursing home populations, and recruit prospectively for falls in community-dwelling older people, to study novel risk factors for falling. We looked at the role of chronic pain, blood flow to the brain, foot disorders, and peripheral neuropathy in falls, and investigated the effects of vibratory shoe insoles to prevent falling. This galvanized the investigators in our institute—epidemiologists, nurse

investigators, statisticians, and population researchers—as each one could participate in this initiative. We created multidisciplinary teams rather than a group of separate investigators doing their own thing and benefiting from our research cores.”

To build trust in the community, Dr. Lipsitz and his team, which includes outreach and clinical staff and a community advisory board, actively engaged with the community, provided education, created a newsletter and opportunities to learn about aging through Boston-wide seminars—in 10 different languages. Since the early 1990s they had worked to establish a good relationship with the community. They built the Multi-Cultural Coalition on Aging, whose 60 agencies meet monthly and represent health centers, senior centers, and housing officials, and a variety of ethnically and religiously focused organizations.

To let the community know that their research was a collaborative effort and should not pose a threat to participants, they matched actions with words. They named their program project the *MOBILIZE Boston Study*. *MOBILIZE* stands for: Maintenance of Balance, Independent Living, Intellect and Zest in the Elderly of Boston.” They named their outreach effort the *Harvard Cooperative Program on Aging*. By mid-2008, they had established a database of nearly 800 individuals. “Members of the Multicultural Coalition on Aging now ask us if they can participate in research,” Dr. Lipsitz said. “We built a registry of volunteers who were willing to receive offers to participate in research. We encouraged other investigators to recruit through us, and advertise their studies to our registry volunteers.”

**Experience Corps.** Dr. Linda Fried had many reasons for co-founding *Experience Corps*, an outside of the box way of doing health promotion for older adults. During her tenure as director of the geriatrics division at Johns Hopkins, she saw “patient after patient who was depressed and had no reason to get up in the morning. I used to write prescriptions to ‘do something meaningful.’ That was my experience as a geriatrician.” But as a population scientist, she said, there were other converging reasons for creating *Experience Corps*, such as keeping older people healthy at the community level, “to complement what I could do as a doctor.” The program embeds social, cognitive, and physical elements of health promotion by creating opportunities for older adults to give back to society, and in this case, make a difference in the lives and literacy of school children.

In the first iteration of her project, Dr. Fried and her colleagues discovered that “politicians and bureaucrats had their own ideas; they did not like science and scientists, and they made it hard for us to collect data.” Dr. Fried’s team reassessed the program and found a major partner in a community corporation whose primary goal was improving schools and educational outcomes. While the community-based organization had tried a number of programs that had failed, Dr. Fried recognized that “they offered us trust and links with school principals.” In 1998, the team launched a successful demonstration project, and *Experience Corps* expanded across Baltimore. Eventually they got huge community, city, and state support, and it became a collaboration between Johns Hopkins and Columbia University, the City of Baltimore and its school system, and the community corporation. “The mayor of Baltimore saw this as signature program.” Fast-forward to 2008, *Experience Corps* has since become a national organization in 20 cities that is supported by numerous national government, corporate, and private partners.

Nevertheless, Dr. Fried acknowledged, “It is still hard to piece together support. Like many best practices with strong evidence, there is no sustainable funding.” She cautioned that, “when you envision something that other people don’t see, it takes years of steadily plodding ahead. In the early years, we could not get anyone to pay for the research and development. I wrote a minimum of 100 proposals. For the first eight years, the NIH would not talk with me. The program was not their thing; it was too outside of the box, there was no program that it matched, and I had no evidence. Foundations that

supported programs for older adults said no kids, and children’s foundations said no older adults.” What helped the project turn the corner, along with a belief in their vision and perseverance, was an early (and small) foundation grant that they used to hire recruiters, and pay for a little data collection. Dr. Fried emphasized, “It is only because I had 10 faculty who worked their tails off with no support—that is the reason the program is alive.”

## Resources

For information about the RAND/Hartford initiative, including descriptions of CoEs that have received awards, see: Pincus HA, Keyser DJ, Schultz DJ. RAND/Hartford Initiative to Build Interdisciplinary Geriatric Health Care Research Centers. *Health Affairs* 2007;26(1):279-283.

For a report on Phase One of the RAND Initiative, see: [https://www.rand.org/health/projects/geriatric/rand/programeval/report\\_v8.pdf](https://www.rand.org/health/projects/geriatric/rand/programeval/report_v8.pdf)

For additional information on the RAND initiative, see: <https://www.rand.org/health/projects/geriatric/>

For information about the NIH Roadmap and specific funding initiatives for interdisciplinary research, see: <http://nihroadmap.nih.gov/interdisciplinary/>

For information on Clinical and Translational Research Awards, see: <http://www.ctsaweb.org/>

For more information about *MOBILIZE Boston*, see: <http://mobilizeboston.org/>

For information about the impact of *Experience Corps* on volunteers and students, see: <http://www.experiencecorps.org/publications/research.cfm>

For information on strategies for effective community partnerships see analysis of 23 initiatives supported by the Robert Wood Johnson Foundation: Bazzoli GJ, Casey E, Alexander JA, et al. Collaborative initiatives: Where the rubber meets the road in community partnerships. *Medical Care Research and Review* 2003;60(4):63S-94S; and web site link: <http://www.rwjf.org/programareas/resources/product.jsp?id=14412&pid=1142&catid=15>

## 6. Build Collaborative Programs

**The challenge: To expand opportunities for geriatrics to collaborate with others and contribute to institution-wide efforts to build a culture of collaboration**

### Summary

Collaborative and interdisciplinary research is one of the most important directions for the future. The NIH has launched its Roadmap for Medical Research that ties major funding to institution-wide models for and evidence of collaboration across departments and disciplines. Foundations such as Hartford have funded initiatives to strengthen collaborative relationships and research. However, even for some highly successful institutions, the trend towards greater collaboration across programs and departments has not been easy for geriatrics programs to incorporate. Some institutions are better positioned. They have been making investments for some time that have served to build and reinforce a collaborative climate and institution-level planning with incentives backed up with dollars and, sometimes, with significant changes in overall direction. Whatever their institutional environment may be at present, geriatrics leaders have continued to find ways to expand their research and clinical horizons through

collaboration. Some leaders are also playing an active role in institution-wide planning to tear down barriers across programs and open the way for faculty to discover new partners and opportunities for research, teaching, and clinical services.

## Strategies

**To build a national profile, find local collaborators.** Dr. Harvey Cohen of Duke University recommends that CoEs and other geriatrics programs take advantage of everything their institution has to offer. “Recognize the strengths of the institution; look around the nooks and crannies to see what is going on and what can be leveraged for extra resources. Convince someone to get together and collaborate, and create programs.” His message is similar for interdisciplinary grants and Clinical and Translational Science Awards: “These big programs are looking for people who can bring something to the table. It is a negotiation, so show how your program can be of value. Start with what you have to offer; it may come from your education faculty, for example, if that’s needed for the larger grants. From there you can broaden the relationship. Look for a way in!”

**Look across disciplines for others working in aging.** When Dr. Jeffrey Halter came to the University of Michigan, the medical school didn’t have an academic geriatrics program. “So I looked around to see where there were good people, resources, and interest, to build a program. It takes time to develop a range of people with various levels of responsibilities and seniorities, so I looked for others working in aging and related areas. We now have very active participation between the schools of public health, engineering, with basic science in the medical school and others in the schools of nursing and social work.”

### **Cultivate Collaborators.**

“When I go on site visits, I try to help programs focus on where they can collaborate or take advantage of another existing program to provide broad levels of expertise. Sometimes leaders don’t immediately recognize the role that other programs or individuals might play.”

Harvey Cohen, MD, Duke University

**Find partners whose strengths complement yours.** Noting that one of Michigan’s research strengths is in improving mobility and preventing falls, Dr. Halter described the development of a successful collaboration that began more than 20 years ago as a result of working with senior faculty in engineering, and connecting junior faculty and fellows to get careers started and people trained. “The collaboration evolved over time, so now Neil Alexander, MD, the GRECC director, who has an interest in mobility and falls, and a laboratory, collaborates with engineering. Engineering does some of the more basic methods development, and Dr. Alexander does application to humans. Engineers need clinical input, and a physician-scientist can provide the disease orientation. Otherwise engineers would focus only on healthy people.” Geriatrics has a similar collaboration with faculty in public health, who have served as mentors for junior faculty in geriatrics. “Public health faculty don’t see patients; they read about them, so they benefit from the clinical expertise of geriatrics faculty and geriatrics faculty get wonderful scientific training, methods, and application from their public health mentors.”

**If you want to take a new direction, it is up to you to pave the way.** The University of Chicago's Dr. William Dale described how his relationship with the hematology/oncology department has evolved over time. He participated in a Hartford-American Society for Clinical Oncology funded geriatrics-oncology joint fellowship program. After graduation he continued to collaborate with many fellows who ended up in academic environments elsewhere, where he was invited to present to their sections. While he jokingly admits there were "two strikes against him" from the hematology/oncology perspective—first being a geriatrician (and therefore not a "real" physician; and second, a social scientist with a PhD in public policy (and therefore not a "real" scientist)—he has more than demonstrated his value. He now has a joint appointment in hematology/oncology and receives 10 percent of his salary from them. His contributions include assisting the cancer center to achieve comprehensive status from the NIH using his social science training to enhance the center's expertise in cancer control and prevention, its weakest area. He also built a geriatrics-oncology clinic (see p 9), which served as the model for two other geriatrics-subspecialty clinics. "I also recruit patients onto my research protocols, which are some of the highest accruing 'trials' in genitourinary oncology and demonstrate the value of what we do in geriatrics," Dr. Dale said. He also works on several collaborative research projects and has access to oncology's social work staff and use of IV therapy services through his geriatrics-oncology clinic. He has been joined by a recently graduated geriatrics-oncology fellow to create a two-physician care team. "Once you reach a 'tipping point' the up-front investment gets rewarded," Dr. Dale said.

### **Close-ups**

**A strong collaborative culture supports academic geriatrics.** Dr. Neil Resnick made his move to the University of Pittsburgh because he was drawn to its culture. "You not only need a fertile seed, but also fertile soil, and I found both at Pittsburgh. If we collaborate on research with someone here, both divisions get paid according to the level of effort, whereas at some institutions, there is only one PI, and most of the credit and indirect costs go to just one department or division. The sharing of professional credit and indirect costs is a real benefit, and has existed for decades at Pittsburgh, where people believe that together we can accomplish what no individual can alone." This collaborative culture is also visible in the Institute on Aging. Dr. Resnick established it six years ago to function as an umbrella for age-related programs throughout the university and the health system. Its Academic Advisory Council and Clinical Advisory Council each work strategically to integrate geriatrics into institutional programs. There are also rare collaborative opportunities provided by having two Hartford CoEs (the other, in geriatric psychiatry, led by Dr. Charles Reynolds, was funded in 2005), a GRECC, Geriatric Education Center, Alzheimer's Disease Research Center, Cancer and Aging Center, Geriatric Mood Disorders Center, and Pepper Center. Pittsburgh's geriatrics division has grown from seven faculty when Dr. Resnick first came, to more than 30 fellowship-trained faculty, most with an MPH and/or additional specialty training. Many are actively engaged in collaborative research, training, and mentoring. There is also a high level of cross-specialty and cross-disciplinary research funding for aging. "Pittsburgh is open to new ways of looking at things. The bar is high here, but the door is open," Dr. Resnick said.

**A geriatrics safe harbor from which to launch collaborations.** For Dr. Lewis Lipsitz, being at Hebrew Senior Life in Boston has been an advantage in advancing academic geriatrics. It is an independently run, private hospital with a closed medical staff and board, licensed as a chronic-care hospital. His program has close relationships with Beth Israel Deaconess Medical Center. “Since 1965, our staff has been on the medical staff of Beth Israel [now Beth Israel Deaconess Medical Center] and could qualify for Harvard faculty positions. In 2008, we became formally affiliated with Harvard Medical School, as we were able to convince the new dean that we do more of the geriatrics teaching and clinical geriatrics research than any other hospital in the Harvard system. At other hospitals geriatrics must compete for resources and space with other divisions and departments. But at Hebrew Senior Life geriatrics is the only show in town. Therefore, the mission of our academic program and that of the hospital are closely aligned. “I have the luxury of working in an institution that cares about aging, supports our faculty, and raises funds for geriatrics. That is the secret to what has kept our program going and growing,” Dr. Lipsitz said. As for collaboration, Dr. Lipsitz observed: “The independent nature of our institution has meant that we could work with anyone. We have collaborations with Boston University, Brown University, the University of Michigan and many others—we are not locked in.”

### 1. Joint Fellowships and Junior Faculty Support

**The challenge: To diffuse geriatrics knowledge throughout academic medicine by engaging subspecialty fellows and junior faculty**

#### Summary

Efforts are underway across CoEs and other geriatrics programs to diffuse geriatrics information and skills into clinical teaching and research across subspecialties. Strategies include partnering with subspecialties for joint fellowships and joint junior faculty training and utilizing flexible funding models that adapt to the interests and availability of trainees. While “geriatricizing” has become a buzzword for this kind of effort, a senior leader offered a caution regarding the term and the mindset behind it. “People don’t respond well if you say, ‘we are going to geriatricize you.’ It sounds like a hostile takeover, so do it one by one, make the matches, don’t be too explicit. Joint fellowships are one great approach.” Another leader reported that his geriatrics program actively seeks out subspecialty fellows from different departments. While his program does receive some inquiries from potential subspecialty fellows who are interested in geriatrics, “They don’t necessarily come to us. Joint fellowships are more likely to come about from us being out there doing the integrating.”

#### Strategies

**Engage subspecialty leadership to gain access to trainees.** Consider strategies to build rapport regarding training with subspecialty leaders. Identify high-profile leaders who will support a collaborative program. Form an advisory board incorporating some of those subspecialty leaders.

**Offer more than money.** To attract fellows and “seal the deal,” geriatrics can offer other attractive resources. Duke University, for example, uses its focus on creating academic cross-specialty relationships in mentoring and career development as draws to their joint fellowship training program, which integrates geriatrics for fellows and junior faculty in the surgical and medical subspecialties. At Yale University, incentives include the opportunity to work with experts in human-subject research.

**Focus on a commitment to geriatrics, whether or not it comes first.** Keeping fellows engaged in academic geriatrics throughout their training and beyond should be the paramount goal, several leaders emphasized. “Most fellows spend more time in either geriatrics or another specialty,” Dr. Ken Schmader of Duke University said. Citing his colleague Dr. Harvey Cohen’s leadership in gero-oncology, Dr. Schmader observed that at Duke “some people who have trained in geriatrics and oncology have a primary appointment in oncology, but are active in geriatrics issues. Others, who joined our faculty, are more involved in geriatrics but with an oncology orientation.”

**Target specialties where interest is high.** Local culture matters, so determine which programs are best for joint training at your institution. On some campuses it may be more challenging to get some subspecialties focused on aging-related research, because there is much more money in other clinical disciplines, such as cardiology. One geriatrics program that had little success with cardiology made inroads with other subspecialties, such as rheumatology, infectious disease, hematology, oncology, and pulmonology.

***A recruitment message for potential subspecialty trainees.***

“Because trainees who participate in joint fellowships have a niche, they are appealing candidates for funding—they are well-trained and have access to double funding streams.”

Mary Tinetti, MD, Yale University

**Take advantage of board certification requirements.** Increasingly, subspecialty boards incorporate aging-related questions. The development of a curriculum in cardiology and geriatrics for fellows was a product of Duke’s mini-fellowship in geriatric cardiology. That curriculum responded to the need to address geriatrics questions on the cardiology board exams and was an opportunity to partner with a well-resourced group, the American College of Cardiology. (See section on *Mini-fellowships in Geriatrics* below.)

**Stay in touch after training ends.** Many geriatrics leaders emphasized the importance of staying in touch with geriatrics fellows who go on to additional subspecialty training in other disciplines. For example, Dr. Schmader continued to serve as senior mentor on an aging research project for a fellow who had completed a geriatrics fellowship and was returning to cardiology.

**Take a first step.** At the University of North Carolina, Dr. Jan Busby-Whitehead noted that her involvement with second- and third-year rheumatology fellows is not a true shared fellowship. Rather, the fellows receive some funding through the geriatrics CoE. “A rheumatology fellow doing aging research agrees to participate in education in the geriatrics program, but is not jointly boarded. This was a first step in opening relations with the Arthritis Center.”

***Close-ups***

**Drawing on excellence in research to build a joint fellowship program.** Bringing geriatrics to Yale University’s extremely talented medical subspecialists meant that the CoE “gained some of the best and the brightest and raised the prestige of aging-related research,” recalled Dr. Tinetti. One of the first strategies she and her colleagues used to jump-start the joint fellowship effort was to create an advisory committee made up of high-profile senior subspecialty faculty. Over time, this created visibility and helped to identify trainees for geriatrics. As time went on, “success beget success, faculty and trainees became aware of the joint fellowship approach, and subspecialists began to come to geriatrics unsolicited.” To recruit subspecialty fellows, “having money helped, but geriatrics also had an infrastructure for human research that did not exist elsewhere at Yale. This provided opportunities for joint fellows to develop an intellectually challenging niche within their specialty that offered unique directions for future research grants.”

Yale trainees have stayed in academia and have focused on geriatrics research issues, generating an increased interest in aging within their specialty. Dr. Tinetti also cited a curriculum in pulmonary medicine and infectious disease that trainees developed and then used to train other scholars, which helped create a “critical mass” of academicians in infectious disease who focused on aging. Of the joint research and training approaches at Yale, Dr. Tinetti noted: “The biggest surprise is how well it has worked; it has brought geriatrics into the subspecialties in a way that has moved beyond the individual.” She emphasized that it is crucial to stay involved with trainees after the geriatrics funding ends so people stay focused on aging. “Otherwise the temptation is for people early in their careers to go after whatever money is out there.”

**A Flexible Awards Program.** At the University of Chicago, Dr. William Dale co-directs a flexible awards program with Marshall Chin, MD, a general internal medicine specialist. Open to junior and senior faculty in geriatrics and other disciplines, the program offers three pilot grants per year for research, innovative teaching, faculty development, or trainee opportunities. The program was developed because the geriatrics program is relatively small, with 12 faculty, several of whom are researchers. Geriatricians are required to partner with someone in another department or division; applicants from other departments are asked to find a geriatrics partner. “This made people look around and find someone they did not know with whom they could partner.” Dr. Dale noted that when someone really wants to work in long-term care, he and Dr. Chin strategize and “play off each other to find the right partner, as general internal medicine has more researchers than geriatrics.”

## 2. Mini-fellowships in Geriatrics

**The challenge: To develop continuing education in geriatrics that fits the career needs and scheduling issues of mid-career physicians**

### Summary

Mini-fellowships in geriatrics have the potential to reach a broad audience of physicians, including academic subspecialists and those in private practice, some of whom may have teaching responsibilities at community hospitals. A number of mini-fellowship models have emerged, ranging from year-long programs (integrated with trainees’ ongoing responsibilities) to courses lasting three to four days, sometimes with a follow-up program. The successful models have identified appropriate trainees, created an education model that fits their busy schedules, and incorporated curricula that can be readily translated by trainees into their own teaching and clinical practice. Since 2004, the Donald W. Reynolds Foundation has supported a consortium of four academic institutions (Duke, Mount Sinai, Johns Hopkins, and UCLA) to offer a mini-fellowship model (FD~AGE Physician Mini-Fellowships in Geriatrics) for physicians from around the country. While core geriatrics content is incorporated at all sites, each institution has individualized its teaching in terms of specialty or professional tracks, themes, or practice settings.

### Strategies

**Design a user-friendly training format.** Brief training—three- or four-day programs—is more adapted to the schedules of busy mid-career physicians.

**Offer more than didactic training.** Duke’s mini-fellowships incorporate “reverse site visits” by fellowship participants, which keep geriatricians and trainees connected and reinforce trainees’ education.

**Create a train-the-trainer program.** Duke offered mini-fellowships in oncology, cardiology, infectious diseases, and gastroenterology using a train-the-trainer model. The courses target two main groups: faculty from academic medical centers and physicians from community hospitals who may do some teaching and are interested in knowing more about taking care of older patients.

**Build on the need to master new geriatrics content in subspecialty board exams.** New aging-related content in subspecialty boards and maintenance of certification examinations means that faculty and other subspecialists will likely need additional education in geriatrics. At one institution, a leader reported that their mini-fellowships are attracting new subspecialists as a result of new requirements

and questions related to geriatric patients. For example, dermatology recently found that it would need to build competencies in geriatrics for boarding. While some subspecialists who are faced with such new requirements may pursue mini-fellowships for that purpose only, others are interested because they are caring for more elderly patients and their own parents.

**Offer continuing education that meets the institutions' as well as physicians' needs.** Institutions and departments may view continuing education in geriatrics for their faculty as important, and could be amenable to providing support, whether funding or release time for faculty to attend.

### Close-up

**From skepticism to success: A decade-old model for training non-geriatricians.** Boston University's Rebecca Silliman, MD, PhD, recalled, "Our faculty scholars program for clinician-educators initially met with some skepticism about training other specialists in geriatrics, but 10 years later, we have trained 60 physicians." Patricia Barry, MD, MPH, Dr. Silliman's predecessor, began the initiative to train non-geriatricians. The one-year training program (one half-day a week) for clinician-educators in primary care and medical/surgical specialties offers enhanced training in four areas: geriatrics content, evidence-based medicine, clinical teaching, and health care systems. It incorporates mentoring of faculty scholars, precepted clinical visits, a scholarly project, and didactic training.

The program has its own part-time coordinator. Dr. Silliman reports that the program has met the needs of her institution as well as those of the physician trainees. "Thirty or so faculty scholar graduates are here at Boston Medical Center and many hold administrative, clinical, and educational leadership positions. The program is viewed institution-wide as providing very useful and practical faculty development. Participants see this as an opportunity to advance their careers, and also to learn how to provide better care for older adults. We also train advanced practice nurses and our geriatric medicine, psychiatry, dentistry, and oncology fellows." Dr. Silliman noted that "trainees don't anticipate how much they will learn from each other—this package has synergy." (See Resources below.)

### Resources

For more information about the FD~AGE Consortium Mini-fellowships, see:  
<http://knowledgemap2.mc.vanderbilt.edu/pogoe/node/456>

For more about the Duke mini-fellowships, see:  
<http://careinaging.duke.edu/facultydevelopment/fellowships/>

For more about the Johns Hopkins mini-fellowships, see: [http://www.hopkinsmedicine.org/geriatrics/education/Reynolds/dwr\\_jhu.html](http://www.hopkinsmedicine.org/geriatrics/education/Reynolds/dwr_jhu.html)

For more about the Mount Sinai School of Medicine mini-fellowships, see: [http://www.mssm.edu/geriatrics/education/mini\\_fellowship/index.shtml](http://www.mssm.edu/geriatrics/education/mini_fellowship/index.shtml)

For more about the UCLA mini-fellowships, see: [http://www.geronet.med.ucla.edu/centers/reynolds/mini\\_fellowship.htm](http://www.geronet.med.ucla.edu/centers/reynolds/mini_fellowship.htm)

For more information on Boston University Medical Center's faculty scholars program, see the companion publication to this report, *Approaches to Recruitment to Advanced Fellowship Training and Faculty Positions in Academic Geriatrics*, at: <http://www.geriatricsrecruitment.org/ManualTwo/FacultyScholars>

Also see the BMC geriatrics section's web site at:  
[http://www.bmc.org/geriatrics/educationFacultyPhysicians\\_CEGM\\_FacultyScholars.htm](http://www.bmc.org/geriatrics/educationFacultyPhysicians_CEGM_FacultyScholars.htm)

### 3. Training Hospitalists in the Care of Older Adults

**The challenge: To infuse hospital medicine with geriatrics knowledge and skills**

#### Summary

Hospital medicine is one of the fastest growing specialties. In 2007, there were 20,000 practicing hospitalists in the U.S. This was up from a few hundred in the mid-1990s. The Society for Hospital Medicine projects 30,000 hospitalists by 2010, many of whom will work for managed care organizations. Hospitalists are increasingly appearing as physicians-of-record for hospitalized frail older adults, and they often take an active role in elderly patients' care transitions. Given the dearth of board certified geriatricians, some leaders have developed teaching programs to increase the skills of hospitalists who care for older adults, including mini-fellowships (see Resources in the preceding section) and longer training. Longer teaching timeframes are particularly suited to academic medical centers with a critical mass of academic hospitalists. Two institutions that have support from the Donald W. Reynolds Foundation to train hospitalists are the University of California, San Francisco (UCSF), and Harvard Medical School, whose programs are described below. There are growing opportunities for hospitalists and geriatricians (and others) to partner on other hospital-related initiatives, such as improving care transitions for frail older people.

#### **Quick support for geriatrics training for hospitalists.**

"My only surprise is that I have not had to sell this program to anyone—trainees, hospitalists, the department of internal medicine. Everyone was on board."

Melissa Mattison, MD, Harvard Medical School and  
Beth Israel Deaconess Medical Center

#### Strategies

**Use a self-assessment and train-the-trainer approach to train academic hospitalists.** Encourage trainees to identify topics in which they need additional geriatrics education, and build their capacities as teachers. Incorporate core competencies related to the care of older patients into the curriculum.

**Consider a longer time frame for training hospitalists.** A longer time frame for teaching is particularly well-adapted to academic medical centers. It also supports opportunities for informal and case discussion, practice improvement with oversight, development of teaching skills, and confidence building. For example, UCSF's 40-hour Acute Care of the Elderly (ACE) program focuses on the care of hospitalized older adults and transitions in care. Led by two geriatrician hospitalists, this program offers "teaching and faculty development to learn geriatrics, improve teaching techniques, and develop geriatrics curriculum." All interested hospitalists at any of the UCSF-affiliated teaching hospitals are eligible to participate in this program.

**Use teaching materials and tools tailored for hospitalists.** (See Resources below.)

**Make it convenient for trainees.** Create a training format based on convenient times and hospital locations. Encourage informal as well as formal interactions. Don't forget lunch.

**Add value to in-house teaching.** Consider ways to provide free tuition for hospitalists to attend geriatrics continuing education programs, particularly those that address care for hospitalized older adults.

**Consider other collaborations.** One example is the cooperation between geriatrics and hospitalists in managing care transitions. (See Resources below.)

### *Close-up*

**Building inpatient excellence.** Hospitalist training is one of the components of Harvard Medical School's Advancement of Geriatrics Education (AGE) Project, which is directed by Dr. Lewis Lipsitz, with funding from the Donald W. Reynolds Foundation Aging and Quality of Life Program. Geriatrician Melissa Mattison, MD, an instructor in medicine at Harvard Medical School, leads the hospitalist component. Her practice and the hospitalist teaching program are based at Beth Israel Deaconess Medical Center, a Harvard teaching hospital. Using a "train-the-trainer" model, she teaches hospitalist scholars, who then become responsible for teaching residents and medical students. They volunteer to participate in the year-long program that centers around monthly discussions about geriatrics topics over lunch. Scholars select discussion topics based on a self-assessment of their educational needs. Dr. Mattison said that the chosen topics have been consistent over the three years, and reflect those areas where geriatricians would have anticipated a need for further education. Some of these topics are medication dosing, safety, and metabolism; delirium; and pain management.

Dr. Mattison also reviews with the scholars the Society of Hospital Medicine core competencies relevant to the care of older adults. Scholars also attend two days of a five-day continuing medical education (CME) course in geriatrics. These are the days that address care of hospitalized elderly patients. She has incorporated materials and assessment tools developed by the University of Chicago's CHAMP (Care of Hospitalized Aging Medical Patients) program. By the end of the third round of training, the Harvard program will have trained 20 faculty hospitalists. In 2009, the program will add a session for all 34 hospitalists at Beth Israel Deaconess as well as at other area hospitals.

Dr. Mattison noted several factors that reinforce participation: inviting past scholars to attend current sessions, including lunch in the hospitalist suite and free tuition for the CME training as well. The hospitalist suite is a nexus for ongoing informal discussions about cases and issues between Dr. Mattison and the hospitalist scholars. Holding training in the hospitalist suite has also allowed other hospitalists to see the program in action. The program has received support from the director of hospital medicine, the chair of medicine, and the chief of geriatric medicine. "Who wouldn't be supportive?" she asked. "Hospitalists are doing this on their own time, and the biggest expense is the two days of time when you need to get coverage for them while they attend the CME program—that and the free pizza."

### *Resources*

For information about geriatrics education for hospitalists, including teaching resources, see:  
<http://knowledgemap2.mc.vanderbilt.edu/pogoe//kmsearch/node/Hospitalists>

To download a special supplement to *The Hospitalist* on caring for the hospitalized elderly patient, see:  
[http://www.hospitalmedicine.org/AM/Template.cfm?Section=Search\\_Advanced\\_Search&section=Supplements&template=/CM/ContentDisplay.cfm&ContentFileID=1447](http://www.hospitalmedicine.org/AM/Template.cfm?Section=Search_Advanced_Search&section=Supplements&template=/CM/ContentDisplay.cfm&ContentFileID=1447)

For information about the University of Chicago's CHAMP mini-fellowship for practicing hospitalists, teaching materials including pocket cards, and assessment tools, see: <http://champ.bsd.uchicago.edu/CourseOverview.html>

For information about the Donald W. Reynolds Foundation support for geriatrics training for specialists, including two programs that target hospitalists (Harvard Medical School and the University of California, San Francisco), see: <http://www.dwreynolds.org/Programs/National/Aging/Cohort3.htm>

For information about the Society of Hospital Medicine's Project BOOST (Better Outcomes for Older Adults through Safe Transitions), see: [http://www.hospitalmedicine.org/AM/Template.cfm?Section=Search\\_Advanced\\_Search&section=Care\\_Transitions&template=/CM/ContentDisplay.cfm&ContentFileID=3879](http://www.hospitalmedicine.org/AM/Template.cfm?Section=Search_Advanced_Search&section=Care_Transitions&template=/CM/ContentDisplay.cfm&ContentFileID=3879)

To download the *Care Transitions for Older Adults Implementation Guide*, see: [http://www.hospitalmedicine.org/AM/Template.cfm?Section=Search\\_Advanced\\_Search&template=/CM/HTMLDisplay.cfm&ContentID=17221](http://www.hospitalmedicine.org/AM/Template.cfm?Section=Search_Advanced_Search&template=/CM/HTMLDisplay.cfm&ContentID=17221)

## CHAPTER IV: SELECTED PROFILES OF COE DIRECTORS AND THE PROGRAMS THEY LEAD

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*The following three programs were selected because of their different programmatic resources, institutional environments, and approaches to managing academic geriatrics growth and development. Each profile reflects a common drive to extend and integrate programmatic, professional, and institutional strengths. Some of the approaches described here may stimulate others to consider program development and management in new ways.*

**1. Boston University Medical Center Hartford Center of Excellence in Geriatrics; Rebecca Silliman, MD, PhD, Director.** Dr. Silliman is also Professor of Medicine and Public Health; and Chief, Section of Geriatrics.

***In a nutshell:* The CoE at this private university with modest funding incorporates an integrated clinical model, collaborative research, and interdisciplinary training with a focus on training educators.**

**Integrated and indispensable.** “We try to make ourselves indispensable to everybody. In addition to the patients we serve, we are also available to university faculty and staff—and their parents! That is part of being indispensable,” Dr. Silliman said. Compared with larger state schools, this private institution has modest resources. The CoE is notable for several reasons, according to Dr. Silliman. “Boston University Medical Center is the safety-net hospital for Boston. There are only a handful of CoEs whose main hospitals are safety-net hospitals. We run a tight and integrated care system that feeds the hospital. In turn, we are efficient in our admissions and discharges. We are good citizens, we have some of the best teachers in the institution, and we help the entire institution as much as possible.” The CoE is also well known for its home visiting program for frail older adults and other clinical services. The section of geriatrics faculty includes 16 physicians, 12 advanced practice nurses, and a social worker.

**A mixture of funding streams.** “Our funding approach is to have multiple strategies, and try and do them all well. We embarked on a new clinical program focusing on dually eligible patients, and clinical revenues have grown substantially. We receive a fair amount of money from the hospital, with whom we have been historically related through our home care program, which dates from 1875.” (The hospital, rather than the medical school, receives the overhead payments from section grants.) “We have revenue streams that support our administrative director, two secretaries, and a part-time administrative staff person. Educational grants support our fellowship program and a long-standing required fourth-year clerkship is supported by the School of Medicine. Hospital funds flow through the department of medicine to support clinical work. Our research grants support our research enterprises, and that is it. We get a modest amount of indirect dollars back and I use that to support a grants manager, and a portion of our fiscal administrator’s salary. The program receives little in the way of individual donations or bequests, as few patients served by this hospital are wealthy.”

**Sound administration blended with learning about leadership.** “We are not robust in terms of administrative support, but we have a great administrative director and are fortunate to have a fiscal manager who has been here since the 1980s and knows everything and everybody,” Dr. Silliman explained. “Many physicians have been promoted to managerial positions because of their research—not because of their abilities as leaders. Most are not born leaders, and most have to learn. I recommend participating in a program such as the Hartford Geriatrics Leadership Development Program. I learned a lot from this program.”

**Collaboration with a competitive edge.** Dr. Silliman and her team participated in the Hartford-RAND Interdisciplinary Geriatric Health Care Research Center that helped lay the groundwork for their

Pepper Center grant and a new initiative for interdisciplinary clinical research and teaching activities. Dr. Silliman said that Boston Medical Center (BMC) has a strong mission and message of collaboration that ‘comes down from on high,’ because we are a safety-net hospital.” She emphasized, “Geriatrics has always been collaborative and interdisciplinary. We work strategically with multiple disciplines, which is better than going it alone. Whether it is through fellows working with other sections, or senior researchers, that is how I believe we make progress in research, and it helps BMC to be competitive.” To get the Pepper Center funded, “we took advantage of all the resources we had here to make it work by putting different people’s priorities together.” While this process does not work all the time, Dr. Silliman recommends building “on the strengths you have, recognizing that sometimes collaboration is more about the individual than the discipline.” (See p. 45 for further information on BMC’s decade-long program infusing geriatrics into other specialties.)

**Mentoring as a priority.** Dr. Silliman enriches her geriatrics mentoring by also mentoring outside of geriatrics. She mentors for a K-30 program for junior faculty, and for BMC’s Center of Excellence in Women’s Health, including an NIH-funded K-12 initiative, *Building Interdisciplinary Research Careers in Women’s Health* (she is a co-PI with Karen Freund, MD). About five years ago, Dr. Silliman decided to stop doing clinical care. “I have clinicians who work with me, who do clinical care as well or better than me, but they can’t do what I do. You make time for the things that are important to you.”

**2. Emory University/University of Alabama at Birmingham (UAB) Southeast Center of Excellence in Geriatric Medicine and Training (SCEGM); Richard Allman, MD, Co-Director.** Dr. Allman is also Director of the Birmingham/Atlanta VA GRECC; Director of the Center for Aging and the Division of Gerontology, Geriatrics, and Palliative Care; the Deep South Resource Center for Minority Aging Research; and Parrish Endowed Professor of Medicine at UAB.

Ted Johnson, MD, MPH, has served as the SCEGM Co-Director based at Emory University since March 2008. Dr. Johnson is Associate Director and Atlanta Site Director, Birmingham/Atlanta VA GRECC and Interim Director, Division of Geriatric Medicine and Gerontology at Emory University. (Note: In Spring 2008, former SCEGM Co-Director, Dr. Joseph Ouslander, moved from Emory University, where he also directed the Center for Health in Aging, to the Charles E. Schmidt College of Biomedical Science at Florida Atlantic University where he is Professor of Clinical Biomedical Science and Associate Dean for Geriatric Programs).

**In a nutshell: Based on a unique collaboration between Emory University (Atlanta) and the University of Alabama (Birmingham), the SCEGM marked its 10th anniversary in 2008.**

**Finding Partners.** “When Dr. Joseph Ouslander moved to Emory University, he contacted the Hartford Foundation about collaborating with UAB. We had also contacted Hartford and they expressed an interest in doing something in the Southeast,” Dr. Allman said. The resulting SCEGM has served as a model and foundation for other joint ventures, which have included a two-site GRECC within the VA. Dr. Allman also directs the UAB Center for Aging, which is linked to the SCEGM, the GRECC, and two NIA-funded Centers—the Deep South Resource Center for Minority Aging Research and the Roybal Center on Applied Gerontology.

**Synergy through collaboration and a little competition.** “Emory and UAB have a common vision, shared responsibilities, and ownership for the CoE,” says Dr. Allman. “In establishing the joint CoE, Dr. Ouslander and I had an equal voice with the interdisciplinary steering committee. Each site brought unique expertise to the table. We also had synergistic goals and common scientific interests that we thought could be strengthened through collaborating.” Dr. Allman can also raise the expectations of what his own university or health system can do for geriatrics by using Emory’s or the VA’s investments as examples. This helped facilitate palliative care at UAB.

**Sharing resources, balancing benefits.** However, Dr. Allman said, “making sure everyone benefits can be a challenge. Sometimes it will appear that one institution or individual is benefiting more than another. When sharing ideas, there can be intellectual property issues. Although at times we are competing for fellowship applicants or funding, we support each other and remain committed to our collaboration over the long haul. We share curricula, exchange information about applicants, and maintain an ongoing dialogue. Sometimes mistakes are made and we discuss those.”

**Commitment to communication.** Dr. Allman emphasizes that communication is a key to their joint success. “Establishing the collaboration was challenging. We set aside the time for frequent communication to accomplish all the upfront work. We continue to make communication a priority by holding face-to-face meetings every three months, and, in between, by using monthly video- or teleconferencing. We also have joint staff meetings with the GRECC, which has enriched the research strengths of the overall program, as well as provided additional educational resources and support for videoconferences.”

**The advantage of distance.** As a two-site program, they have turned the challenge of the physical distance between sites into an advantage. “We are close enough to make commuting possible but there is an advantage to not being too close. We rent two vans for senior and junior faculty and utilize the two-and-a-half-hour drives between Birmingham and Atlanta for planning and mentoring. This is very precious time in the van.” Informal gatherings incorporate a pre-meeting social get together, sometimes held at faculty homes.

**Support for fellows and junior faculty via collaborative recruitment, mentoring, and review.**

The two medical schools recruit fellows jointly using a common SCEGM form. Candidates are asked if they are applying to Emory, Alabama, or both. They share interviews within a day of each other so the candidate only has to make one trip to the region. “If we want to offer a position, we let our partner know and coordinate that.”

“If a junior faculty member at one institution applies for support from the SCEGM (for salary support, pilot research funding, or funding for an educational or quality improvement project depending on whether they are in the research or clinician-educator track), content experts from the other institution review the proposal. When someone writes a proposal, they get a friendly peer review,” Dr. Allman observed.

Joint mentoring is another advantage. Dr. Allman cited a UAB geriatric medicine fellow with an interest in long-term care administration who benefited from mentoring from Dr. Ouslander (“an expert in that area”). This fellow later went to Emory for a year of advanced training in long-term care administration. An Emory fellow traveled to UAB for four two-week training experiences in palliative care over a one-year timeframe. “There are face-to-face mentor meetings with the content mentor at the other site. We highlight presentations by junior and senior faculty at quarterly SCEGM meetings. Junior faculty benefit greatly from receiving peer review and mentoring from faculty at another medical center. By responding to reviews from experts external to one’s own institution, fellows and junior faculty learn how to deal with critiques of their work that are part of getting proposals funded and papers published,” Dr. Allman said.

**Collaboration as a foundation for future efforts.** Along with serving as a model for the joint GRECC, the SCEGM serves as a model for a collaborative five-year P30 grant received in 2007 from the National Institute on Aging (NIA) to establish a multi-institutional Deep South Resource Center for Minority Aging Research. One of only six in the country, Center partners include the UAB Morehouse School of Medicine, Tuskegee University, and the University of Alabama at Tuscaloosa. The SCEGM has also become a regional resource. It supported the initiation of Mercer College of Medicine’s own geriatrics

program. It also offers conferences and a regional resident award event for internal and family medicine residents to learn about careers in geriatrics. “A third of our fellows have come from this recruiting event.” (For more information on this event see the companion publication to this report, *Approaches to Recruiting Premedical and Medical Students and Residents to Careers in Geriatric Medicine*, at: <http://www.geriatricsrecruitment.org/ManualOne/ResidentAwardSummit>)

**Recommendations for others contemplating a two-site program.** Dr. Allman urges others to approach such a collaboration as a long-term commitment, with an emphasis on regular, ongoing communication. “You need to have leadership at both places, a common vision, and regular face-to-face communication. Things will not always go smoothly, and you will work through this. Also, it helps to identify mutual or complementary interests so you can take advantage of strengths at both institutions, such as our joint efforts in palliative care.”

“We know some colleagues who have a harder time collaborating, and sometimes there are personal or institutional problems. Others may not pursue joint CoEs because they don’t think it will work. But, people are really surprised that it does. We find this is one of the most professionally rewarding things we have ever done. We discussed whether we would be separate centers if we had the opportunity. We concluded that we are better together than apart. I want to look good to the other director. And that can trickle down as various faculty move around, because everyone knows everyone else. Both institutions take great pride in the collaboration, and it is consistent with the NIH Roadmap for Interdisciplinary Research.”

**3. Indiana University School of Medicine Hartford Center of Excellence in Geriatric Medicine and Training; Christopher M. Callahan, MD.** Dr. Callahan is Cornelius and Yvonne Pettinga Professor and Director of the Indiana University Center for Aging Research. (The Indiana University Hartford Center of Excellence in Geriatric Medicine and Training is directed by Steven R. Counsell, MD.)

***In a nutshell:* At this state university, an important goal has been the building of a research shop in collaboration with the Center of Excellence in Geriatric Medicine.**

**Build a new program collaboratively.** “The most gratifying thing for us is that we built this program in an urban public hospital starting from zero research in geriatrics,” Dr. Callahan said. “We represent the research arm of the larger geriatrics program and are embedded within the Regenstrief Institute. We collaborate with other programs that contribute to the critical mass of researchers.” Two thirds of the Center for Aging Research’s funding comes from extramural sources, such as the NIH and the Hartford Foundation, and 10 to 15 percent from endowed chairs and local philanthropy.

**Get through the early years.** “You pass through developmental stages when you are trying to get these centers off the ground. They have a 50 percent mortality rate in the first five years, but if you survive the first five years you have a better chance of surviving long-term,” Dr. Callahan said.

**Assemble a critical mass of researchers.** “No one makes it on their own anymore. You can’t have a research shop with only one or two people, and you don’t reach a critical mass until you have four or five physician investigators and four or five staff. However, you can usually only start with half of that, so there is a premium on recruiting a few key people in the early stages.”

**Recruit strategically.** “Candidates need a push and a pull—something they are not getting where they are. You have to lure them with something they want, fill in the missing piece for them,” Dr. Callahan explained. Among his own bargaining chips are “an unusual primary care laboratory served by electronic medical records and a reasonable amount of financial resources so we can recruit by offering packages to expand people’s scope of research. Sometimes people are looking for a brand new place to

build, or junior people feel crowded where they are.” He urges looking towards the universities that are “net exporters of researchers, because there are not enough spots.” “Reach out to their leadership who can encourage people to come and look at your research center because you are up and coming,” he said. He cautions, however, against spending an excess amount of time recruiting.

**Stay focused.** In the early years, “Faculty can get distracted into other academic missions. It can be hard to ascertain whether it’s the university or the program that has distracted them. Perhaps they are not enjoying the research enterprise. There are a lot of competing opportunities that are equally compelling. You will see institutions announce that they are going to devote a significant amount of time to research, but when you look back, they have not, and instead have focused on clinical duties.”

**Seed the program with pilot projects before initial funding runs out.** “The capacity to have piloted things has become more critical to a successful grant application. With start-up funds from the university, we received substantial funding from the Regenstrief Institute for infrastructure, administrative support, shared staff, and pilot research grants. Pilot research projects can be critical to a successful grant application over time. As you are revising a grant, it can be more competitive because you can show progress through the piloted project.”

**Create endowed chairs.** A challenge for the second five-year period of supporting a research center is establishing endowed chairs in order to bring in more senior leadership. “The endowed chairs were a safety net that allowed us to put together packages to attract new faculty,” Dr. Callahan explained. Geriatrics has three newly endowed chairs (one held by Dr. Callahan; one held by Dr. Counsell, who directs the Indiana University geriatrics program and CoE; and a third that was used to recruit a senior researcher.)

**Avoid “expensive” money.** “When someone gives you \$50,000 and in return expects an additional \$500,000 from philanthropy and intramural resources, it’s costing you more than you’re getting. Sometimes you may have to pursue a grant that is ‘off theme’ or somewhat outside your faculty’s area of expertise, but this can become expensive money—it costs you more, lowers morale, and shakes you from your focus. You and the funder can become unhappy,” Dr. Callahan said.

**Learn to say no!** Maintaining focus is crucial as a research shop matures. “The more successful you are, the more you have to say no in order to stay focused on your research themes and areas of expertise. You may disappoint some people, but it may be necessary to say no to some enticing opportunities—a grant or partnership—in order to maintain your focus,” he said.

**Resist premature leadership.** For academic leadership, “the most critical thing is scientific credibility [publications and funding]. You don’t even get into the chair or dean’s office until you have that.” However, “a unique risk in academic geriatrics is that people are prematurely promoted to leadership positions because the pool is so small. You will be around the table with other people in the medical center with a longer track record of accomplishment. You can get by for a short period of time if you don’t yet have the experience, but eventually they will pull out your CV.”

**When seeking support, adapt to “different worlds.”** “While the division chief, associate dean for research, and department chair are all looking at the same metric, the metric changes when you go out in the community. No one is concerned about publications. They want to know about the health of the community, your impact on the local economy, and stories about lives you have saved. In the community, the culture, body language, the way they debate, what they mean when they say ‘we are committed,’ and the timeframes are all different. I can use a word in the medical center and go into industry and the word means something different.” Unlike academia, “industry will be going in a new direction tomorrow.” Of traveling between two worlds he said, “That makes it exciting.”

**Employ a low cost strategy: enjoyment.** Dr. Callahan talks with pride about “a research center where people are enjoying themselves. It is very palpable to visitors and people you are recruiting. You have to put energy into creating an enjoyable place to work. It does not happen by accident and may be the only thing that helps with retention. Anyone can offer people more money, but having a shop where people are enjoying themselves does not cost a lot of money.” Leaders need to “pay attention and get rid of hassle factors. We are proud of faculty development and have taken a very broad approach to developing leaders—people who are balanced and enjoyable to work with. It is good for us, produces the kind of environment we want to work in, and has turned out to be a recruiting tool. After all, we are competing with institutions in a more desirable place. We can’t sell an ocean-front location.”

### **The John A. Hartford Foundation**

[www.jhartfound.org](http://www.jhartfound.org)

The John A. Hartford Foundation of New York City is a private philanthropy established in 1929 by John A. Hartford. Mr. Hartford and his brother, George L. Hartford, both former chief executives of the Great Atlantic and Pacific Tea Company, left the bulk of their estates to the Foundation upon their deaths in the 1950s. The Foundation is a committed champion of health care training, research and service system innovations that will ensure the well-being and vitality of older adults. Its overall goal is to increase the nation's capacity to provide effective, affordable care to its rapidly increasing older population. Today, the Foundation is America's leading philanthropy with a sustained interest in aging and health. Through its grantmaking, the Foundation seeks to enhance and expand the training of doctors, nurses, social workers and other health professionals who care for older adults, and to promote innovations in the integration and delivery of services for all older people.

### **The Hartford Centers of Excellence In Geriatric Medicine and Training**

A cornerstone of The John A. Hartford Foundation's medicine programming is the Centers of Excellence in Geriatric Medicine and Training initiative, created to address the critical shortage of geriatric medicine and geriatric psychiatry faculty members in the nation's medical schools. Operating since 1988, and currently at 28 institutions across the country, this program has produced hundreds of geriatrically knowledgeable scientists, teachers and clinicians. It has also helped create a higher level of recognition and appreciation of the discipline throughout medical centers, universities, and affiliated clinical service settings.

### **The American Federation for Aging Research**

[www.afar.org](http://www.afar.org)

The American Federation for Aging Research (AFAR) is a leading not-for-profit organization supporting biomedical aging research. Since its founding in 1981, AFAR has provided more than \$113 million to nearly 2,500 new investigators and students conducting cutting-edge biomedical research on the aging process and age-related diseases. The important work AFAR supports leads to a better understanding of aging processes and to improvements in the health of all Americans as they age.

American Federation for  Research

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