

**Hartford Foundation-NAGEC
Strategic Planning Meeting
November 2, 2009**

Executive Summary

The Health Resources and Services Administration (HRSA) has a 20-year history of funding Geriatric Education Centers (GECs). These GECs have been the only group to provide interprofessional geriatric medical education in the United States designed to remediate the lack of competence in the care of older adults in the health care workforce (Institute of Medicine, 2008). The National Association of Geriatric Education Centers (NAGEC) and the John A. Hartford Foundation convened a strategic planning meeting with key leaders in the GEC network from around the country in order to generate ideas on how the GECs can enhance and improve their work. A pre-meeting survey* was distributed that captured preliminary suggestions in three broad topic areas: (1) developing partnerships; (2) conducting outcome evaluations; and (3) retooling for an aging America, which focused on expanding training to all health care providers, including paraprofessionals and informal caregivers and utilizing tools to facilitate this new, broader reach of the GECs. Participants were divided into three break-out sessions focused on each of these topics.

An overarching theme that was stressed throughout the meeting and in each break-out session was that geriatrics education be competency-based and well designed to give people the skills and knowledge they need to deliver better care within a particular discipline, working under specific scopes of practice, and within specific institutions. Well developed competencies must focus education and training on those skills that are relevant and feasible to teach and that can improve practice and achieve better outcomes for older Americans. Competencies in geriatric care within major health disciplines as well as basic interprofessional competencies have been developed and should be used to prioritize the training and learning of health care professionals.

One strategy for utilizing competencies to shape GEC activities is to develop evidence-based competency training that can be implemented by a wide range of health care workers. This should include innovative ways of organizing and delivering care through approaches such as the Patient-Centered Medical Home, and specific evidence-based models (e.g. Guided Care, IMPACT, Nurses Improving Care for Healthsystem Elders [NICHE], Hospital Elder Life Program, Care Management Plus, etc) that have been shown to produce superior health outcomes for diverse patient populations when administered correctly. There should be an assessment of the necessary competencies for health professionals to deliver care working in these innovative models.

Highlights from each of three break-out sessions follow.

Partnerships: The goals of partner development are to expand the audience of trainees, to leverage limited resources and funds to expand the reach of the training, and to continue to influence the delivery of more geriatric education in the future. Five types of new partnerships were suggested to expand current training. These were: (1) to add nontraditional groups, such as supervisors of direct care workers, to the current training sessions; (2) to tie competencies that have been developed by professional geriatric organizations (such as the American Geriatrics Society, Gerontological Society of America, Association for Gerontology in Higher Education, Hartford Foundation Geriatric Nursing and Social Work Initiatives, Association of American Medical Colleges, American Dietetic Association, American Occupational Therapy Association, etc.) to the curricula's learning objectives ; (3) to reach out to groups of practitioners that have not traditionally been targeted for geriatrics training through their professional and national quality improvement organizations (such as the American Academy of Family Physicians, CMS' contracted Quality Improvement Organizations, the American College of Physicians, and Home Health Agencies); (4) to reach out to practitioners attempting to provide enhanced care to patients through innovations such as Patient-Centered Medical Homes and other coordinated models of care; and (5) to provide training in non-traditional settings identified by community partners.

Outcome Evaluation: The goal of the GECs is to educate health professionals in the competencies needed to deliver improved health care to older adults which, in turn, should lead to better outcomes for this patient population. It was suggested that programs follow the principles of "competency-based education" using nationally established competencies in particular disciplines to prioritize offerings and raise the competency level of professionals already in the field. It was also suggested to put competencies on the NTACC website and direct people to it. To fairly assess the impact of GECs, they should be held accountable and evaluated based on the demonstration by learners of the acquisition of knowledge, skills and attitudes needed to achieve the stated competencies. It was stated that because GECs are dependent upon the cooperation of individual professionals and health care organizations to actually change practice and improve outcomes, their accomplishments also depend upon the successes and failures of the partners. It was also suggested that partnerships could be developed to assist in the effective implementation and evaluation of the training programs. And although challenging, certain partnerships (such as with health care systems), combined with additional resources and planning could lead to evaluation of the impact on health outcomes for older adults in certain defined areas.

Retooling for an aging America: Two categories of opportunities were identified in this section: (1) training additional health care workers; and (2) incorporating underutilized or new types of training delivery. Several additional categories of health care workers were identified including the following in geriatric/gerontological training: staff at community-based organizations, direct care workers, and especially primary care providers in community-based practices. The suggested modes of providing training included: increasing the number and kinds of curricula developed for distance learning, using new platforms for web-based access, tapping repositories of interprofessional and discipline-specific competencies, developing "mega" GECs to provide expertise in developing and

reviewing materials in commonly taught areas such as mental health, physical inactivity, or chronic disease management (so that GECs can avoid reinventing what others have done), and providing easily accessible materials to ensure that learners demonstrate the competency requirements necessary for licensure/certification/accreditation standards.

Suggestions to HRSA for possible next steps included:

1. Increasing the focus on consensus-based interprofessional competencies and evidence-based practices (including innovative models of care) as fundamental principles of GEC training.
2. Setting realistic expectations regarding outcome evaluation of GEC's within current budget limitations and training models.
3. Encouraging GECs to increase their partnerships with other federal agencies and a broader range of private programs in order to achieve program synergies and possibly make evaluation tasks more manageable.

Suggestions to the Hartford Foundation for possible next steps included:

1. Convening an interdisciplinary consensus conference to develop a national set of behaviorally-based discipline-specific competencies, potentially linked to the multidisciplinary competencies identified by the American Geriatrics Society Multidisciplinary Competencies Committee.
2. Brokering connections to existing geriatrics education and training programs and experts.
3. Sharing the availability of GEC educational and training offerings to health care organizations interested in improving quality of care.

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Introduction

With the aim of expanding the impact of the national network of Geriatric Education Centers (GECs) on geriatrics health care training, the National Association of Geriatric Education Centers (NAGEC) and the John A. Hartford Foundation convened a strategic planning meeting with key leaders in the GEC network from around the country. Before arriving at the meeting, attendees reviewed the 2008 Institute of Medicine Report “Retooling for an Aging America: Building the Health Care Workforce.” At the meeting participants discussed the past and current educational experiences of GECs, the work of the National Training and Coordination Collaborative (NTACC) contract to aid the GECs in evaluating the effectiveness of their educational programs, and the broader trends in health professions education that are being adopted by educators.

Discussion was divided into three major issues: partnerships, evaluation, and retooling for an aging America. Across all of these issues, planning was focused on how the GEC network can increase the number of health care professionals trained in geriatrics in order to deliver quality health care to older people in the U.S. It reflected the Hartford Foundation and NAGEC’s common commitment to ensure that older adults receive high-quality care with special emphasis on those from low-income, rural, and minority populations.

Scarce dollars make it imperative for GECs to move their agenda forward as efficiently as possible to meet the expanding need. It is therefore vital to take advantage

of non-financial resources, develop new synergistic relationships to carry out new ideas and plans, and establish collaborative entities for the enhancement of mutual missions.

This report is an overview of the meeting and the strategies discussed in the three broad issue areas, which are outlined in this report as Partnerships, Outcome Evaluation, and Expanding the Reach: New Tools, New Technologies, and Additional Professions. Additionally, because of the overarching importance of tying GECs' work to demonstrated competencies, the subject became an integral part of every section, and is presented here as the first item.

“Competency Drives Education”: Competency Training

The Institute of Medicine's (IOM) report *Retooling for an Aging America*, states that currently most health care workers receive very little geriatric training and are therefore not prepared to deliver the best possible care to older patients. Older adults constitute 13% of the U.S. population and yet constitute 50% of hospital occupancy, 70% of home care agency cases, and 90% of nursing home residents. Older adults with multiple chronic conditions drive some 80% of Medicare spending and yet the quality of care they receive is poor. Twenty percent of Medicare beneficiaries discharged from hospitals are readmitted within 30 days at great expense to the Medicare Trust Fund and causing dislocation and distress for the patients and their families. Outpatient quality of care for geriatric conditions such as falls, incontinence, and dementia is substantially worse than the overall quality of health care in the U.S., meeting only 33% of quality of care indicators as opposed to 55% of indicators for the general population. Nursing home care remains mired in a cycle of employing low-wage, low-skill workers with rapid staff turnover and high rates of dissatisfaction for residents and families.

Yet, even today, few health professions trainees have more than a few hours in specialized training in the care of older adults, despite the clear evidence that caring for 85-year-olds is different from caring for 55-year-olds. Most of those currently practicing have had even less training. It is imperative that geriatrics education be competency-based and well designed to give people the knowledge and skills they need to deliver better care within a particular discipline, working under specific scopes of practice, and within specific institutions. Well-developed competencies must focus education and training on those skills that are relevant and feasible to teach and that can improve practice and achieve better outcomes for older Americans. Similarly, attention to the realities of work environments, institutional commitments, and available time and resources is also essential to ensure that newly achieved practice skills can actually be implemented. The current GEC training enterprise needs to keep its focus on enabling practice change and quality improvement, which is the final determinant of improved patient outcomes.

Initial sets of consensus competencies in geriatric care within major health disciplines as well as basic interprofessional competencies have been developed. These competencies, rather than faculty interest or topical mandates proposed without evidence of relevance to health outcomes of older adults, should be used to prioritize the training and learning of health care professionals. They must “enhance the geriatric competence of the entire workforce, increase the recruitment and retention of geriatric specialists and caregivers, and improve the way care is delivered,” (IOM Report Brief, 4/08, p. 1).

Strategies for Using Competencies to Shape GEC Activities:

1. Develop evidence-based behaviorally-assessable competency training that can be implemented by a wide range of health care workers delivering care to older adults in a variety of care settings. These include innovative ways of organizing and delivering care through approaches such as the Patient-Centered Medical Home, and specific evidence-based models (e.g., Guided Care, IMPACT, Nurses Improving Care for Healthsystem Elders [NICHE], Hospital Elder Life Program, Care Management Plus, etc), which have been shown to produce superior health outcomes for diverse patient populations when administered correctly.
2. Create curricular resources for evidence-based practice especially around these models and bring that training to a broad range of health professionals and paraprofessionals;
3. Identify a basic level of expected competency for paraprofessional direct-care workers and family caregivers;
4. Upgrade professional staff competencies and develop evaluation procedures that demonstrate that relevant competencies have been achieved;
5. Provide access to geriatrics training materials for professionals and institutions to meet increasing demands by licensure/certification/accreditation bodies;
6. Convene an interdisciplinary consensus conference to develop a national set of behaviorally-based discipline-specific competencies that would be used as a framework for GEC training; potentially link these to the multidisciplinary competencies identified by the American Geriatrics Society Multidisciplinary Competencies Committee;

7. Inculcate skills of interprofessional teamwork, which include communication, role sharing, and delegation to enable health care professionals to work efficiently; and
8. Prepare for future demands for higher levels of geriatrics competency as part of professional licensure and certification. Similarly, be prepared to help health care delivery organizations and individual professionals to increase their geriatric skills when health care reform innovations such as Patient-Centered Medical Homes, Accountable Care Organizations, and Pay-for-Performance become accepted modes of practice.

Developing Capacity to Teach Competencies:

1. Partner with existing faculty development programs (e.g. Council on Social Work Education's GeroEd Center, the American Association of Colleges of Nursing's Geriatric Nursing Education Consortium, The Donald W. Reynolds Foundation-funded Faculty Development–Advancing Geriatric Education program (FD-AGE), and the American Geriatrics Society/John A Hartford Foundation's Geriatrics for Specialty Residents initiative, etc.) to develop interprofessional geriatrics curricula;
2. Develop training for geriatric clinician educators in multiple disciplines through the existing Geriatric Academic Career Awards, other HRSA programs, and proposed expansions of geriatric clinician educator programs to other disciplines; and
3. Develop training for non-geriatric faculty in multiple health professions in specifically focused mini-fellowships of short duration.

Easily accessible training and assessment materials that currently exist and can be accessed to enhance interprofessional training programs include but are not limited to:

1. American Board of Internal Medicine (ABIM) Practice Improvement Module and practice assessment program (www.abim.org/moc/earning-points.aspx);
2. Portal of Geriatric Online Education (POGOe), which provides one-stop shopping for high-quality geriatric education material (www.pogoe.org); and
3. A potential model for on-line training materials in the future includes a virtual clerkship, using the Health Resource and Services Administration (HRSA)'s Computer-assisted Learning in Pediatrics Program (CLIPP) http://www.med-u.org/virtual_patient_cases/clip as a model for geriatrics.

Example of Competency Training

“Keeping Granny Safe: A Consensus on Minimal Geriatrics Competencies for Graduating Medical Students.” Roseanne M. Leipzig, Lisa Granville, Deborah Simpson, M. Brownell Anderson, Karen Sauvigne, Ranier P. Soriano, Academic Medicine: May 2009 - Volume 84 - Issue 5 - pp 604-610

In the absence of geriatrics-specific competency-based performance standards for medical students, and with the aim of ensuring that all physicians demonstrate competency in geriatrics, national consensus was created for essential geriatric competencies that should be demonstrated before internship. These 26 competencies are organized within eight content domains: Medication Management; Self-Care Capacity; Falls, Balance and Gait Disorders; Hospital Care for Elders; Cognitive and Behavioral Disorders; Atypical Presentation of Disease; Health Care Planning and Promotion; and Palliative Care.

Partnerships for Effective Implementation

Partnerships need to be developed to expand the audience of trainees and to influence the development and dissemination of more interprofessional geriatric education. Each GEC develops partnerships based on the needs and unique circumstances in the areas they serve. Given the reductions in monies for GECs over the last several years, many of the more successful partnerships have been those that provide financial resources or leverage other sources of funds. Equally important are those partnerships that provide access to unique trainees and/or to in-depth program evaluation.

Strategies to Expand the Effective Reach of GECs:

1. Continue to identify new partners who can provide access to additional health care professionals such as hospitals, long-term care facilities, health care organizations with a continuum of care, colleges and universities, health care professional organizations, state licensing and inspection boards, quality improvement organizations, community-based organizations, and state health departments;
2. Expand the definition of the health care workforce to include everyone involved in a patient's care, including health care professionals of all disciplines, direct care workers, informal caregivers, and the patients themselves;
3. Reach out to new consortium partners in order to expand geographically (e.g., rural, statewide, regional, etc.);
4. Develop financial partnerships (e.g., with foundations and health systems) and funding at the practice-change level, contracting with institutions that wish to initiate large-scale systems change;

5. Develop resource partnerships (e.g. POGOe, Geriatric Social Work Initiative of the Hartford Foundation) in order to promote training materials that currently exist;
6. Expand available programming through inter-GEC collaborations (e.g., GEPR, curriculum development, distance learning);
7. Actively seek partnerships with underserved communities in order to maximize the development of performance tools to enhance traditional training for nontraditional groups, such as informal/formal caregivers, staff of agencies that work with direct care workers, etc.;
8. Partner with professional organizations that have already developed competencies, e.g., the American Geriatrics Society, the Gerontological Society of America, etc.;
9. Carry out health promotion and prevention training at sites where the patients receive services, e.g., within the context of medical homes, coordinated models of care, and when health coaches are used, in order to ensure that curricula that are delivered can be directly applied without large influxes of money and resources;
10. Reach out to groups of practitioners and organizations engaged in quality improvement, including but not limited to the American Academy of Family Physicians, CMS's contracted Quality Improvement Organizations, the American College of Physicians, home health agencies, hospitals, and long-term care providers;
11. Reach out to clinicians in non-traditional settings that provide services for older people (rather than directly serving older people), such as pediatric clinics where

- grandparents accompany children to their appointments;
12. Engage partners that can assist with marketing and publicity of all GECs, e.g., through the American Homes and Services Association, American Hospital Association, Alliance of Community Health Plans, etc.;
 13. Find partners to provide technical assistance and support to allow GECs to maximize partnerships with their collaborating organizations and to obtain revenue generating contracts where possible.

Example of Affiliations and Partnerships

The following outlines an array of affiliations and partnerships of California's three GECs. This is an example of successful utilization of extensive partnership funding streams that extend the GECs' mission.

- a. UCLA and U.S. Department of Veterans Affairs partnerships: Training programs and medical fellowships
- b. Partnering with Delivery Systems: Team care participation – a work in progress
- c. Reynolds Centers of Excellence
- d. Minority Aging Research Center: funded by the National Institute on Aging
- e. Academic Geriatric Resource Center (AGRC): Provides internal funding at all University of California centers
- f. Partnering with Public Health or Physician Programs
- g. California Social Work Education Center, Aging Initiative: Collaboration of the 17 schools of social work in CA and the 58 counties, originally funded by the Archstone Foundation
- h. Elder Abuse Initiative: Funded by Archstone to conduct systems analysis in 17 CA counties
- i. Team San Diego Aging and Independence Services: Aimed at providers and offers student opportunities
- j. Cal State Fullerton: Provides on-line certificate programs
- k. Cal State System: The major mover in providing nurses and social workers for the state
- l. California Council on Geriatrics and Gerontology (CCGG): Statewide professional organization; Executive office established inside UCLA; organization appointed to advise legislature on aging education
- m. California Association of Long Term Care: Quality improvement in long-term care

Outcome Evaluation

Evaluation is a huge challenge for the GEC program and is threatening to become the tail that wags the programmatic “dog,” requiring minimally that the following information be reported:

1. core measures;
2. diversity distribution; and
3. training outcomes at the primary, secondary, and tertiary levels, meaning (1) demonstration by learners of the acquisition of knowledge, skills, and attitudes, (2) changes in practice/care delivery, and (3) changes in health outcomes of beneficiaries.

Because GECs are so dependent upon the cooperation of individual professionals and health care organizations to actually change practice and improve outcomes, their accomplishments also depend upon the successes and failures of their partners. GECs can make a difference by teaching geriatric competencies and should be held accountable for that. Evaluation should be based on the trainees’ demonstration of the knowledge and skills needed to achieve the stated competencies. GECs should not be held accountable to prove that this educational training has had a direct effect on the quality of patient care without a significant influx of resources.

Strategies to successfully navigate the intricacies of outcome evaluation:

1. Carefully selecting partnerships (or collaborators) who can assist with higher level evaluations;

2. Ensuring that the facility/institutional leadership agrees with the GEC about the culture change that is being promoted;
3. Working with the strength of an agency, that is, what they can do best (including staff, tools, etc.);
4. Identifying three to five areas of training needs and improving their outcomes;
5. Encouraging collaborating agencies to develop evidence-based programs that are tied to education initiatives;
6. Linking educational interventions and outcomes to improve reporting of changes;
7. Developing consortium partners that can facilitate outcome measurements of the training programs;
8. Connecting to health reform (Pay-for-Performance incentives, Accountable Care Organizations, Medical Homes, etc.); and
9. Utilizing health care professional research experts to help with evaluation.

NTACC: The National Training and Coordination Collaborative (NTACC) provides GEC evaluation consultation to improve reporting to HRSA. NTACC can help document practice changes. It tries to anticipate what GECs are going to need and works to provide methods to help attain the required information. It has the ability to move quickly during a grant's application process development and to works with groups of GECs around outcomes.

Mapping evidence-based programming practice change: Successful mapping requires (1) effective programming; (2) good reporting; (3) connecting to Centers for

Medicare & Medicaid Services; and (4) Pay-for-Performance in hospitals (Quality Improvement Organization Support Center – QIOSC).

Cross-GEC partnerships for critical mass on a topic: Developing collaborative projects across multiple GECs provides an economy of scale. By co-producing a standardized curriculum on a single topic, GEC educators have access to: (1) multiple needs assessments (or perhaps to a single needs assessment developed by multiple GECs); (2) a panel of content experts who can vet the content; and (3) assistance with dissemination models. Finally, NTACC can assist with evaluation across multiple sites, making it more likely that patient care can actually be measured.

For most health care workers, geriatrics teaching curricula are more effective in the presence of geriatrics clinical training. GECs must get employers to integrate didactic and clinical experiences into many training programs in order to better incorporate inter-professional competency development. For reporting purposes, training and education should continue to be linked to outcomes. NTACC can help the GECs to develop new evaluation strategies to better document changes that are being achieved by programs.

How can GECs be responsive to institutions?

How can GECs get up to standard for the next era?

How can GECs retain relevance?

***Retooling for an Aging America: Expanding the Reach –
New Tools, New Technologies, Additional Professions***

GECs are mandated to train physicians and at least three other disciplines. Current reimbursement formulas do not encourage the various health professions to participate in an interprofessional model of health care delivery, even though it provides the best care for geriatric patients. Therefore, GECs need to provide interprofessional training throughout the training pipeline and utilize the right setting with training that includes all team members. GECs must also develop/obtain knowledge of products related to new health reform structures (e.g. Accountable Care Organizations, Patient-Centered Medical Homes, etc.) and be early disseminators of any evidence-based studies on the effectiveness of those products.

Strategies:

1. Development of specialized “mega” GECs for dissemination of curricular materials and other resources;
2. Utilization of new platforms for web-based access;
3. Creating Geriatric Academic Career Awards (GACAs) for multiple health professionals;
4. Extending GEC program funding to five years;
5. Developing training programs for supervisors and staff of the agencies that train and supervise the direct care workers (because GECs cannot train direct care workers); and
6. Developing mission-based budgeting (this is more an issue for medical schools where education is often considered an unfunded byproduct of clinical care/research).

Strategies for training direct care workers: Providing career ladders/lattices for direct care providers (e.g. housekeeper advancement to aide; aide to LPN, etc.) not only promotes commitment to developing competency but also promotes career options.

Strategies for geriatric career trainees: Several barriers exist to health care providers who wish to receive more interprofessional geriatrics training. They include the lack of financial incentives, a charismatic role model on faculty, and a supportive environment that encourages commitment to quality geriatric care once the trainee has returned to practice. The right environment for training is important, and marketing GEC programs as new and exciting entities can create a “buzz” along with a new focus of GECs as proactive leaders in program development. Partnering with the Hartford Foundation’s initiatives that develop faculty training programs such as the Hartford Centers of Excellence in Geriatric Medicine, Centers of Geriatric Nursing Excellence, and the Social Work Faculty Scholars Program helps to leverage limited resources. Other strategies include utilizing community-based organizations to identify “pockets” of providers; developing needed train-the-trainer programs; creating a change-agent model that promotes “ambassadors for change,” getting key administrators to invest in the changes, and utilizing distance learning repositories.

Barriers to training professional staff who are already practicing primary care include: (1) Discomfort with geriatrics (ageism); (2) lack of knowledge about the special needs of the elderly; (3) finding the “right” setting for training, and (4) the belief that “we already care for older adults (and, therefore, don’t need to learn anything new).”

Strategies for increases in geriatrics funding:

1. Constituent lobbying is needed to advance legislation beyond the current restrictive supplemental appropriations to existing bills and provide maintenance of funding without growth;
2. Funding for NAGEC for lobbying/ advocacy;
3. Some success has been reported in geriatrics certification for professions listed in bills as “other”, e.g. dietitians, nutritionists, psychologists, dentists, physical therapists; and
4. Obtain advanced practice nursing agreement to include geriatrics training in all aspects of training.

Recommendations

To increase the reach and impact of GECs, they need to expand their partnerships with a wide variety of collaborators such as:

- Other HRSA programs, e.g., Title VIII nursing programs, Federally Qualified Health Centers, Training Center Grantees, and Geriatric Academic Career Awardees;
- Wider federal training and quality improvement initiatives in care of older adults through the CMS, the Department of Veterans Affairs, Quality Improvement Organizations, etc.;
- Health delivery systems engaged in quality improvement and staff training programs;

- Private philanthropy-funded quality improvement and training initiatives such as The Atlantic Philanthropies' CHAMP (Curricula for Homecare Advances in Management and Practice) program, the Donald W. Reynolds Foundation's medicine and nursing training centers, and the John A. Hartford Foundation's Geriatric Nursing Education Consortium, Chief Resident In-Training Program, and Geriatric Social Work Initiative; and
- Other GECs.

The current system of “parallel play” and lack of coordination among efforts, reduces impact and makes sharing best practices extremely difficult. Without partnerships, GECs are underfunded and under-supported to accomplish the very important mission of improving the capability of health care professionals to care for older adults.

Partnerships are also essential to move beyond a focus on teaching and learning to the improvement of health care quality that will benefit American citizens. The process of changing the ingrained practices of established health professionals is complex and demanding. Most continuing education efforts that limit themselves to educational interventions are ineffective. Interventions that combine education with micro-systems redesign, changes in management practices, and measurement of appropriate outcomes, have been shown to achieve substantial quality improvements and improved health outcomes.

With more substantial partnerships and the collaboration of available health professions faculty interested in education and quality improvement in geriatric care, the

ambitious evaluation agenda posed for the GECs becomes more possible. Without these partnerships, the current evaluation framework that includes assessment of patient level health outcomes as well as learner acquisition of knowledge, skills, and attitudes is unrealistic in the current level of funding.

GECs have mandates, limitations and requirements that are not sensible in the current environment and need to be addressed when reauthorizing legislation is prepared.

*A Pre-Meeting Survey resulted in responses that were grouped into the three categories. The survey questions were:

- What new partnerships would assist the GECs in meeting its goals?
- What resources and/or partnerships would assist the GECs in more effectively measuring the impact of their training programs, particularly at the patient/systems level?
- List approaches (e.g., distance learning, collaborations) that would assist the GEC network in expanding its reach.
- In what ways can the GECs implement the recommendations to enhance geriatrics competence found on page S-10 of the IOM report *Retooling for an Aging America*.