

GERIATRICS IN LANCASTER COUNTY

Past, Present & Future

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“Example is leadership. Example is not the main thing in influencing others. It is the only thing.”

—Albert Schweitzer, M.D.
Gabon, West Central Africa

ABSTRACT

This article reviews the origins and development of the specialty of geriatrics in the United States, the history of geriatrics in Lancaster County, the establishment of a geriatrics fellowship within the Family Practice Division of the Lancaster General Health System, and its impact on the creation and rapid growth of the Division of Geriatrics at LGH. Finally, it offers a vision for the future of geriatrics in our community.

ORIGINS OF THE SPECIALTY OF GERIATRICS IN THE USA

Dr. Ignatz Leo Nascher, considered the father of the specialty of geriatrics in the USA, was born in Vienna in 1863, trained as a pharmacist in 1882, and immigrated to the United States in 1885. He received his medical degree from the New York University, and went on to write many articles and books related to geriatrics, most notably one in *The Medical Record of New York* in 1909 in which he introduced the word “geriatrics.”¹ He also made two assertions that defined most of his interests and research for the remainder of his life: 1) “Aging is a distinct period of life, a physiological entity as much so as the period of childhood;” and 2) Geriatrics should be a special branch of medicine like the specialty of pediatrics.

Dr. Nascher was clearly a visionary; at a time when some of his peers minimized the need for specialty training in the care of older adults, he spent most of his career legitimizing geriatrics as a specialty. Though he died in 1944, his influence and passion impacted the eventual recognition of the subspecialty of geriatrics later in the 20th century.

The American Geriatrics Society was organized on June 11, 1942, and held its first annual meeting in 1943 with Lucien Stark of Norfolk, Nebraska, as president. *The Journal of the American Geriatrics Society* was first published in 1953, but it wasn’t until 1968 that a Mount Sinai physician, Dr. Leslie Libow, started the first nationally recognized geriatrics fellowship at the City Hospital Center in Elmhurst Queens, now a major teaching affiliate of the Icahn School of Medicine at Mount Sinai in New York. Before providing leadership for the first geriatrics fellowship, Dr. Libow spent three years at the National Institutes of Health (NIH) studying healthy older volunteers.² This experience contributed significantly to his lifelong dedication to creating training opportunities for medical students and fellows in the slowly evolving specialty of geriatrics.

The National Institute on Aging (NIA) was established in 1974 by the Research on Aging Act, and in 1976 Congress authorized the first Geriatrics Research, Education, and Clinical Centers (GRECC). By supporting the establishment of fellowships in geriatric medicine and geriatric psychiatry, these centers provided much needed funding for the development of a faculty in geriatrics, leading to the opening of the first GRECC programs in 1976. The beneficiaries of this new and continuous funding stream for geriatrics research, education, and clinical centers have continued to play major roles in developing the field of geriatrics throughout the United States.³

Adding to the growing appreciation of the importance of training in geriatric care, a 1978 report by the Institute of Medicine (IOM) recognized the lack of qualified physicians to care for older adults in America.⁴ Even so, geriatrics did not gain recognition as a subspecialty until the mid to late 1980s. To gain a better historical perspective about that development, one needs to appreciate that era’s changing demographics in terms of age, and the rapid growth in medical pharmacology. The average

life expectancy in the United States at the beginning of the 20th century was only 47, yet by 1950 it was 68, and in 1980 it was 73. With the rise in life expectancy, there was an associated rise in the prevalence of many illnesses that occur mainly later in life, such as cancer, heart disease, diabetes, strokes, COPD, and memory loss.

Associated with the significant rise in life expectancy from 1950 to 1980, there was an exponential increase in the approval of new medications by the Food and Drug Administration (FDA). From 1930 to 1950, fewer than four medications were approved per year; from 1950 to the early 1980s, an average of 10 medications were approved annually; and since the 1980s between 20 and 55 new medications have been approved annually.⁵

With the rapid rise in the clinical use of multiple medications in the frail elderly population, it was not surprising that observant clinicians noted an increase in adverse drug events. A new medical word, *polypharmacy* (the use of five or more medications), was beginning to appear in the medical literature, applicable primarily to the older population. In summary, with the sharp increase in life expectancy, an increase in prevalence rates of multiple illnesses, the development of polypharmacy, and the decline in organ function with aging, many physicians began to appreciate the need to create the subspecialty of geriatrics.

WHO SHOULD PROVIDE GERIATRIC CARE – INTERNAL MEDICINE OR FAMILY PRACTICE?

From the standpoint of the national professional organizations, the Congress of Delegates of the American Academy of Family Physicians (AAFP) first recognized the potential development of a new family medicine subspecialty in geriatrics in 1979, by establishing a task force to study the role of the family physician in dealing with the overall needs of the aging population. In 1980, the AAFP Congress of Delegates had an intense and divided debate about the place of geriatrics education in family medicine teaching programs, which resulted in the passage of a resolution that: “The AAFP conduct an active and aggressive public relations campaign to encourage the public to seek care for problems of aging from family physicians.” Additional resolutions were passed that stated: “The AAFP reaffirms its opposition to the creation of a primary specialty or subspecialty in geriatrics,” and further resolved

that: “The AAFP investigate methods of recognition for family physicians who take special training in problems of aging and care of the aged.” The final resolution stated “The AAFP promote the development of curricula in all family practice residencies to assure that future family physicians are competent in problems of aging and care of the aged.”⁶

Five years later, in 1985, the ABFM learned that the American Board of Internal Medicine (ABIM) had applied to the American Board of Medical Specialties (ABMS) for a Certificate of Added Qualification (CAQ) in Geriatrics. Despite the numerous resolutions passed by the AAFP’s Congress of Delegates in 1980 that opposed establishing a CAQ in geriatrics, Dr. Nicholas Pisacano, executive director of the ABFM, rushed its own geriatrics application to the ABMS in May 1985. The ABFM and ABIM eventually worked out their differences in the fall of 1986 by creating a joint ABFM-ABIM geriatrics agreement. Since that agreement, geriatrics fellowship programs (GFP) have been sponsored by internal medicine (IM) and family medicine (FM), and both accept physicians who have successfully completed residency training in IM or FP. The ABIM and ABFM eventually agreed to have the same board exam for IM and FP physicians who complete geriatrics fellowships.

By the spring of 1988 there were 74 requests to establish GFPs in the country, 55 by IM and 19 by FP, and there were already a number of existing GFPs in the United States by that time, when the ACGME established a required core curriculum for geriatrics fellowships. (As of July 2017, there were 107 IM geriatrics fellowships and 44 FM geriatrics fellowships.)

While the ACGME’s educational requirements for geriatrics fellowships are similar for both IM and FM, there are some training differences between IM and FM programs. Both require one year of training to become eligible for the board exam in geriatrics, but some of the IM tracks offer an additional one to two years of geriatrics training/research, which the ABIM considers important for fellows interested in academic and/or research careers in geriatrics.

Other differences between IM and FM training in geriatrics include the underlying objective of this additional training. The ABFM was, and still is, very clear that its purpose for GFP training is to develop physicians who plan to teach in family medicine residency programs, whereas IM aims to provide

additional training for those planning to be primary care providers in outpatient settings. The additional geriatrics training will better equip Internists to care for the complex frail older adults living in communities and institutional settings such as nursing homes and personal care facilities. Perhaps this philosophical difference may explain why there are more than twice as many GFPs in IM than in FM.

CREATION OF A GERIATRICS FELLOWSHIP PROGRAM AT LANCASTER GENERAL HEALTH

Dr. Nikitas Zervanos, the founder and director of the Lancaster General Family Medicine Residency Program (LGFMRP), was clearly the primary advocate and visionary who recognized the need to improve geriatrics training in the LGFMRP. In a memo to the family practice teaching staff on September 30, 1985, Dr. Zervanos acknowledged the aforementioned 1978 report by the Institute of Medicine about the lack of qualified physicians to care for older adults in America. As noted earlier, by that time the AAFP Board had already reversed course and approved a report recommending that the AAFP Congress of Delegates approve the creation of FP geriatrics fellowship programs, which they eventually did after a meeting in October 1985.

A sage once said, “institutions move slowly,” and that certainly was true regarding a GFP in the Lancaster community. Dr. Zervanos attended the 1985 FM meetings in Kansas City, and recalls returning with considerable enthusiasm for developing a GFP here. When he discussed this prospect with Paul Wedel, the president of Lancaster General Hospital, Mr. Wedel immediately saw the advantages to the community and LGH, particularly with the recent creation of an upscale retirement community at Willow Valley. Dr. Zervanos subsequently learned of a young, recently trained geriatrician who was interested in starting a geriatrics training program.

Unfortunately, many members of the Lancaster General medical staff expressed strong resistance to the idea of a GFP. Though Paul Wedel saw this as a golden opportunity, he reluctantly had to back off developing a GFP due to lack of support from the medical community, and Dr. Zervanos’ dream was put on hold for 16 years.

It wasn’t until 1999 that the medical staff finally agreed to the creation of a GFP, after which the Lancaster General Hospital board approved the staff’s recommendation. It was determined

that the GFP would be under the direction of the Family Practice Department (FPD). Dr. Scott Paist, a faculty member of the FPD, successfully completed the ACGME application requirements, and the ACGME approved the establishment of a GFP at LGH in 2000. Dr. Paist had earned his CAQ in geriatrics without taking a geriatrics fellowship through a “grandfather clause,” which provided a limited opportunity for experienced, non-fellowship trained physicians to sit for the geriatrics boards.

DEVELOPMENT AND STAFFING OF THE LG GERIATRIC FELLOWSHIP PROGRAM (LGGFP)

This article’s author joined Dr. Paist in 2001. After graduating in the first class of the LGFMRP in 1973, I was a co-founder of the Norlanco Family Health Center in the Mount Joy/Elizabethtown area. I earned a CAQ in the subspecialty of geriatrics after completing a geriatrics fellowship at the Philadelphia Geriatrics Center in 1988-89, and was the geriatrics fellowship director (GFD) from 2002 until the end of 2005.

In its first year (2001), the newly created geriatrics fellowship was fortunate to attract two exceptional fellows: Dr. Dale Hursh, an experienced family physician and a past graduate of LGFPRP, and Dr. Debra Kylander, a 2001 graduate of LGFMRP. Both set high standards of excellence in the program. Dr. Hursh joined the geriatrics practice upon completing his fellowship in 2002, and in 2017 became director of the geriatrics practice in the Lancaster General Health System.

Between 2006 and 2015, the success of the Lancaster General Geriatrics Fellowship Program (LGGFP) can be attributed to the effective leadership of Dr. Matthew Beelen, a graduate of the LGFMRP and of Lancaster General’s one-year Faculty Development Fellowship (FDF), which made him a perfect fit to take over the leadership of the GFP when he passed his geriatrics boards. (When he had completed his FDF year in 2003, there wasn’t a full-time faculty position open in the FP Residency. Since he had expressed interest in geriatrics while doing his FDF, Dr. Bruce Pokorney, the Lancaster General medical staff director, astutely encouraged Dr. Beelen to apply to the GFP. He concurrently filled a half-time teaching position in the Department of FM, and completed his geriatrics fellowship over a two-year period from 2003 to 2005 as a 0.5 FTE fellow.)

In 2015, Dr. Christi Stewart, a graduate of the LGFMRP in 2006, a graduate of the LGGFP in 2007, and a graduate of the Lancaster Palliative Care Fellowship in 2008, agreed to serve as the GFD for two years prior to moving to Virginia. Dr. Scott Delong, a graduate of the LGFMP in 2007 and LGGFP in 2008, has been the GFD since the fall of 2017.

DESIGN OF THE LGGFP

Since the beginning of the LGGFP, the fellows' educational experience has involved three main tracks: an inpatient hospital geriatrics service, an outpatient service, and nursing home care service. The GFP purposely maintained a limited inpatient census due to staffing and educational priorities. The admissions came from the resident population in the nursing homes staffed by the fellows and geriatrics faculty, and from the geriatrics office practice. In addition to these three major tracks, the fellows' other rotations included geriatrics psychiatry, hospice care, geriatrics rehabilitation (physical, occupational, and speech therapies), neurology, cardiology, Office of Aging, Adult Protective Services, Home Health Program, and the Incontinence Clinic.

Another important fellowship rotation is the Alzheimer's Memory Center (AMC), which continues to serve numerous families whose loved ones are likely experiencing early signs of memory loss even though their primary care providers have not yet diagnosed it. (Patients with known dementia who need assistance with symptom management or overall care planning are also seen at the AMC.) The AMC assessments include a comprehensive history with a family member and patient (when appropriate), a physical exam by a geriatrician, and cognitive testing by a neuropsychologist. At the completion of the assessment, an interdisciplinary team reviews the findings and makes appropriate recommendations to the residents and family members before leaving the office. The effectiveness and success of this program has been appreciated by hundreds of families in the Lancaster community and surrounding counties. The local Alzheimer's Association recognizes the Lancaster AMC as the best available resource in South Central Pennsylvania for families and primary care physicians who are dealing with the possibility of cognitive impairment in older adults, and would like a more definitive diagnosis with specific recommendations.

The types of rotations the geriatrics fellows experience reflects the need for specialized geriatrics

education in the care of older frail adults who experience multiple co-morbid medical problems and are frequently receiving multiple medications. The term "geriatrics syndrome" is frequently used to describe a group of common geriatrics problems such as urinary incontinence, high risk for falls, hearing impairment, visual impairment, gait disorders, memory loss, dizziness, unintentional weight loss, and frailty.

EVOLUTION OF THE LGGFP

The LGGFP continuously evolves to improve the quality of the geriatrics educational experience. Initially, the inpatient geriatrics hospital service was considered very important for the fellows' training, but due to time constraints and the need to expand geriatrics training experiences in other areas, it was eventually replaced with a new geriatrics consultative service. The hospital consulting experience was found to be more practical and educational. It taught the fellows how to perform an effective geriatrics consultation in the hospital setting, and it served as a teaching tool that equipped other physicians to care for frail hospitalized older adults with multiple co-morbid problems. These consultations also taught other physicians how to manage multiple medications in a frail older population prone to adverse drug interactions, and how to have meaningful conversations with frail adults/health care agents regarding goals of care during a hospital stay.

Twenty-eight fellows successfully completed our geriatrics training program from 2001 to 2017, of whom 18 were graduates of the LGFPRP. All graduates who took their geriatrics Boards (100%) passed on their first attempt. By comparison, the average first-time pass rate for all the geriatrics fellowship programs in the country, whether IM or FP, was 85% during the years of 2013 to 2017.⁷

Notably, the average geriatrics board score (560) for LG graduates was the highest average for all programs in Pennsylvania during that interval, including the programs at the University of Pittsburgh and the University of Pennsylvania, which were established more than 10 years before the Lancaster General Fellowship Program.⁸ The 100% first-time pass rate and high board scores for LGGFP demonstrate a high level of geriatrics excellence in comparison with other programs. Contributing factors to this performance include:

1. The LGGFP attracts highly motivated FP residents from the LGFPRP.

2. The LGFPRP itself attracts excellent medical school graduates from the entire United States, due to its high historical ranking by reputation among FP training programs.⁹

3. The LGGFP has a diverse and integrated geriatrics educational experience, which provides exposure beyond just the usual hospital and outpatient office practice settings.

GROWTH OF THE GERIATRICS PROGRAM IN THE LANCASTER COMMUNITY

While the initial development of the Lancaster General Geriatrics Program was built around the requirements of the ACGME, it quickly became apparent that citizens of Lancaster were looking for providers who were interested in and trained for the specialty of geriatrics. When asked why they wanted to see a geriatrician, patients or health care powers of attorney (HCPOA) often responded: “I don’t know why I need to see so many different physicians and why I need to take so many medications.” These concerns were frequently valid; it was common for geriatricians to observe many frail older adults seeing three to five specialists and taking more than 10 to 15 prescription medications. Since many of these individuals were frail and had less than 24 months to live, many of their health care agents were more interested in discussing goals of care, available palliative care, and community resources such as adult day programs, home aids, respite care, and qualifications to enter a personal care or nursing home facility.

Concurrent with the growing demand for geriatrics-trained primary care physicians, local nursing homes were inviting the fellowship-trained geriatricians to care for their residents. With the growing demand for geriatricians, the geriatrics program grew rapidly by attracting many of the recent Lancaster Geriatrics Fellowship graduates to the faculty, as well as employing nurse practitioners who had special interest and experience in caring for frail older adults. Consequently, the geriatrics program experienced exponential growth, expanding from 1.5 FTE providers in 2001 to 31 providers in 2017 (16 physicians and 15 CRNPs).

To satisfy the growing demand for geriatricians, over the past several years the LGH geriatrics leadership decided to move strategically from having geriatricians serve as primary care physicians to being geriatrics consultants. This change created the opportunity for geriatricians to see more complex frail older adults, while at the same time using consultations as

an educational tool for the referring primary care physicians. This strategic change is also consistent with the response of the American Geriatrics Society (AGS) to the shortage of trained geriatricians in America. The AGS recommends that geriatricians should focus primarily on caring for frail older adults who frequently have multiple diagnoses, polypharmacy, multiple specialist providers, and numerous geriatrics syndromes.

Significant factors in the success of the fellowship program and growth in the number of geriatrics-trained providers were the vision and leadership within the geriatrics program, coupled with strong support from the Lancaster General administration, which recognized the growing demand for geriatricians in the Lancaster community. Over the past 17 years LGH has been very supportive by employing more geriatricians and nurse practitioners.

Another factor that contributed to a rising demand for geriatrics provider services related to an exponential rise in medical costs that was especially marked in the nursing home eligible population. The Center for Medicaid and Medicare Services (CMS) observed a rising number of hospitalizations and re-hospitalizations coming from nursing homes, which the Medicare system inadvertently promoted with its policies. If a nursing home patient was admitted to the hospital (or re-admitted) and had a three-night stay, the resident qualified for Medicare Part A rehabilitation services upon returning to the nursing home. This meant that the nursing home received a higher per diem rate for rehab, and the resident did not incur any expenses under Medicare Part A for up to 20 days of rehabilitation. Eventually, CMS recognized these perverse financial incentives in 2012 by financially penalizing hospitals that had higher than expected readmission rates.

Because of the financial penalties for hospitals, the Lancaster General System began collecting admission and readmission data from nursing homes to the hospital. The data demonstrated that geriatricians consistently had much lower admission and readmission rates when compared with non-geriatrician peers. When trying to control run-away medical costs among large populations, medical systems are beginning to recognize the importance of employing trained geriatricians to care for frail older adults.

These same low admission and readmission rates have also been experienced by United Health Care Insurance/OPTUM, a managed care program specifically designed to care for dually eligible Medicare

and Medicaid residents in nursing homes. Reducing avoidable admissions and readmissions to hospitals lowers cost significantly. These OPTUM savings not only cover the salaries of the nurse practitioners caring for OPTUM-insured nursing home residents, but also reimburses the nursing homes for additional care required during acute changes in the resident's condition.

In the Lancaster community there is high demand for trained geriatricians in settings such as emergency rooms, hospitals, nursing homes, personnel care homes, and homes in the communities, and there aren't nearly enough geriatrics-trained providers to fill these needs. As an alternative, the Division of Geriatrics is committed to creating additional educational opportunities for primary care providers who are interested in expanding their knowledge in caring for the frail elderly population in Lancaster County.

During the rapid growth of the Lancaster General Health Geriatrics Program, an overall director of the geriatrics program was needed, so beginning in 2002, your author served as both the geriatrics fellowship director and the geriatrics program director. These two positions were separated in January 2006 when Dr. Matthew Beelen was appointed director of the geriatrics fellowship program while I continued to serve as the geriatrics program director until January 2010 when I stepped down. Dr. Leon Kraybill, a graduate of the LGFMRP and LGGFP in 2004, was subsequently appointed as the geriatrics program director from 2010 to January 2015.

Dr. Kristen Nebel, also a LGFMRP graduate in 2006 and a LGGFP graduate in 2007, served as the geriatrics program director from 2015 to 2017. As noted earlier, since 2017 Dr. Dale Hursh, a graduate of the LGFMRP and of the first class of the LGGFP in 2002, was appointed as the geriatrics program director in 2017. In 2014 the Division of Geriatrics was established with Dr. Kraybill as the first director.

Finally, early in the development of the outpatient geriatrics practices much of the geriatricians' time was spent working with families whose loved ones were experiencing memory loss that could be mild, moderate, or severe, and there was a need for a caregiver support group. This group was started in 2006 by Pamela Brubaker RN, MSW (the author's spouse), together with Shelby Swartly, who continues to provide exceptional leadership and support to family caregivers who have loved ones experiencing dementia.

While there were a number of leadership changes

in this rapidly growing specialty, the leadership physicians provided effective guidance that met the needs of the organization. Since all leaders but one, were trained in the LGFPRP and LGGFP, the leaders were familiar with the local medical institutional culture, and were able to assume leadership effectively without experiencing a major learning curve. Even though there are pros and cons to appointing leaders from within, this practice is becoming the norm among several large health care institutions where an understanding of the local institutional culture and work environment matters.

THE FUTURE OF GERIATRICS IN THE LANCASTER COMMUNITY

A recent important management decision that will help to define the future of Geriatrics locally is the creation of a fulltime position for a director of post-acute care/population health. Phyllis Wojtusik, R.N., has spent the last 18 years giving leadership to the successful creation and management of Lancaster General's fellowship program, including the development of effective working relationships with many of the nursing homes in Lancaster County.

In her new role, Phyllis developed special working relationships with nine local nursing homes that committed to improving the transitions and rehabilitation of older residents who require institutional post-acute care. She first developed and implemented standards of care for rehabilitation after hospitalization for hip fractures, pneumonia, and congestive heart failure, and observed significant reductions in the lengths of rehabilitation stays at all nine nursing homes, with significant reductions in 30-day hospital readmission rates at most of them.

The effectiveness of Mrs. Wojtusik's work with these nine nursing homes drew the attention of Dr. Joseph Ouslander, professor and senior associate dean for geriatrics programs at the Florida Atlantic University, and executive director of the esteemed *Journal of American Geriatrics*. By collaborating with Dr. Ouslander in the implementation of his Interact Tool,¹⁰ there will be future opportunities to publish Lancaster's exceptional rehabilitation outcomes for post-acute and long-term care.

With the continued support of the LGHealth management team, the future of Lancaster's geriatrics program is very promising. Collection of outcomes data for frail older adults will provide new opportunities to continue with cutting edge interventions that improve the quality and cost of care, and customer satisfaction in the Lancaster Community.

Phyllis Wojtusik, R.N., sees numerous future opportunities for the LGHealth Geriatrics Program, including using telemedicine for frail older adults in nursing homes, personal care homes, and in the community, especially during weekends and overnight. Another high priority is development of standard protocols for chronic medical conditions such as diabetes, COPD, and osteoarthritis. The work of the geriatricians and CRNPs/PAs has caused a significant decline in ER visits and hospitalizations, which makes it attractive to consider creating an insurance specific health plan (ISHP) within institutional long-term care (LTC) settings, similar to the Optum managed care plan of United Health Care. Creating a local insurance product would keep the financial benefits of good management locally, and provide opportunities to share the savings with the LTC facilities and the managing health care system.

Another future opportunity is the creation of a strong geriatrics presence in the ER, where many complex frail older adults are seen and admitted to the hospital without any conversation with the patients and/or their health care agents regarding goals of care.

Finally, there continues to be an expanding need for educational resources that are readily available to families and institutional staff in personal care homes and nursing homes who care for older adults with moderate to severe memory loss associated with behavioral problems. Providing appropriate care for this population requires a strong interdisciplinary team approach and continuous education for staff and families. While professionals who care for residents with memory loss and behavioral problems no longer use physical restraints, chemical restraints continue to be utilized frequently. As

a community we should be able to do better, by providing multiple educational resources for professionals and family caregivers who deal with these residents.¹⁰

All of these opportunities fit within the increasing emphasis on population health. The expansion of Lancaster General's Geriatrics Program to meet the needs of the growing population of older adults, especially during the last six to 24 months of life, will improve customer satisfaction and quality of care, and lower its cost.

One of the best kept secrets in the Lancaster community is the number and quality of geriatrics physicians and CRNPs who are passionate about expanding and improving the care of the elderly residents in our community. One effective method that Penn Medicine Lancaster General Health's management team could use to improve geriatrics services is the creation of an Institute for Geriatrics Care. Like other medical institutes, the Institute for Geriatrics Care could consolidate multiple health care services for the elderly into a cohesive and centrally located geriatrics care center. This program could include the Office of Aging and Adult Protective Services, Legal Aid Services, memory disorder assessments, and therapy services such as physical, occupational, speech and cognitive assessments and treatments. Together, these and other outpatient services could dramatically improve geriatrics care and resident satisfaction in the Lancaster community. An Institute for Geriatrics Care could share outcomes data with other geriatrics institutions. This concept would be consistent with the goals of the Center for Medicaid and Medicare Services and the Institute of Medicine to encourage innovative geriatric care.

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