



THE EFFECTIVENESS OF A GERIATRICS CURRICULUM

Barrett, SV, Carlin, MM, Kadish, SJ, Pugnaire, MP, McGee, S
University of Massachusetts Medical School



Background

With support from the AAMC/John A. Hartford Foundation the University of Massachusetts Medical School developed a Geriatrics curriculum and faculty development that would be integrated across all four years. Beginning in Fall 2001, these were implemented over the next two academic years in both preclinical and clinical areas and are highlighted on the timeline above. Would implementation of this new Geriatrics curriculum and faculty development impact students' ratings of instruction time in Geriatrics?

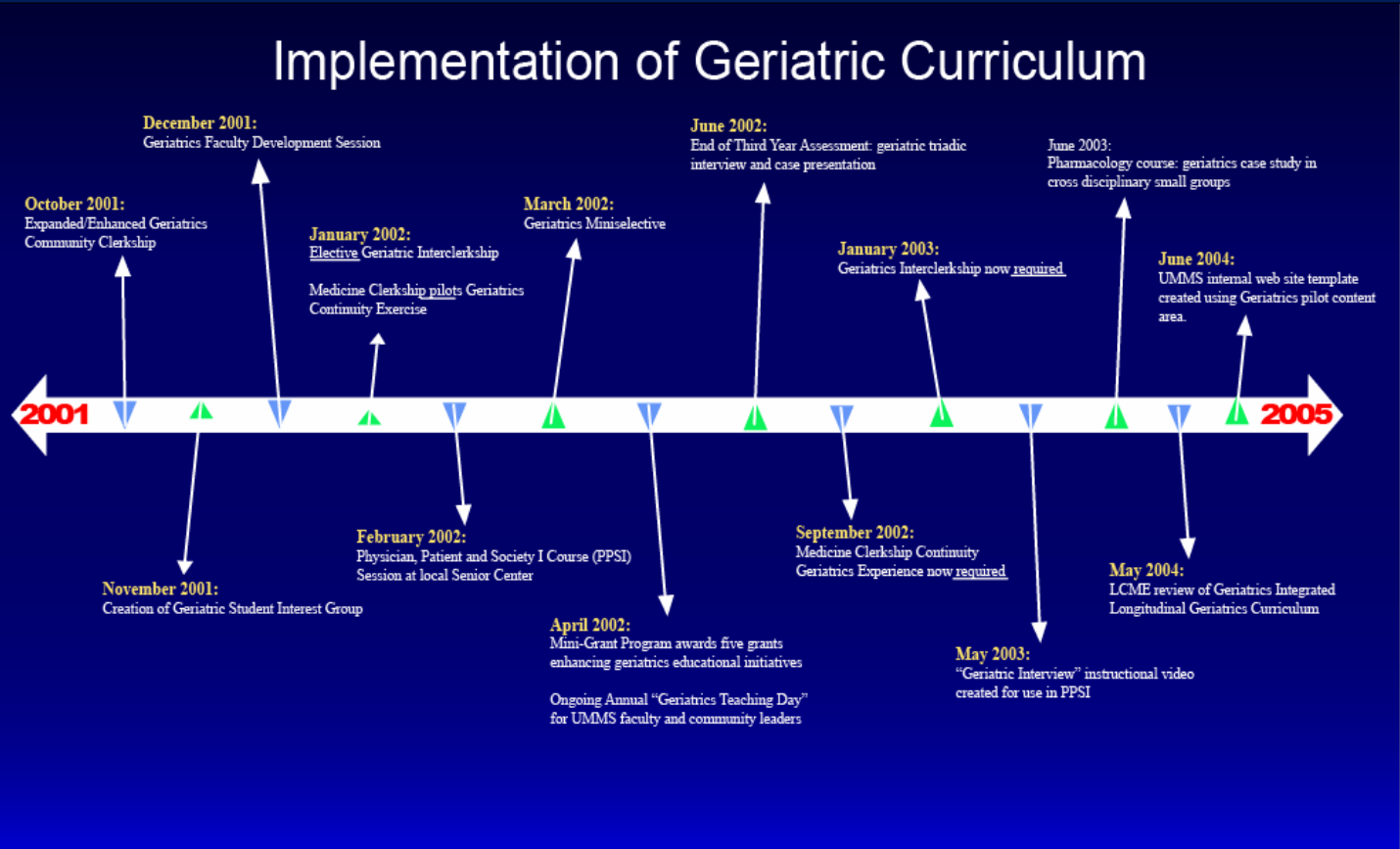


Table 1
Proportion of UMass Medical School Students who 'strongly agree' or 'agree' with the Geriatric/ Gerontology items on the 2001/ 2004 AAMC Graduation Questionnaire (GQ)

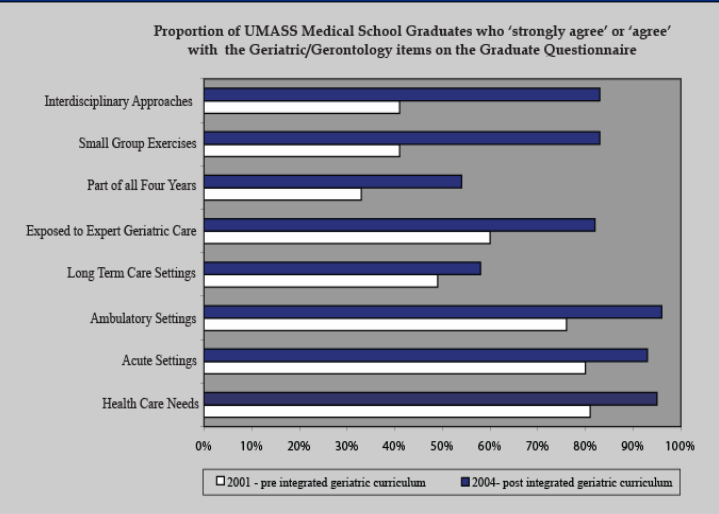
	Pre integrated geriatrics curriculum GQ 2001 (n=74)	Post integrated geriatrics curriculum GQ 2004 (n=93)	Significant change in proportion (p<.05)
Interdisciplinary approaches were used to increase my knowledge of geriatrics	41 %	83 %	YES
Small group exercises were used to increase my knowledge of geriatrics	41 %	83 %	YES
Geriatric/gerontology was part of all four years of my medical education	33 %	54 %	YES
I was exposed to expert geriatric care by the attending faculty of my medical program	60 %	82 %	YES
I am well prepared to care for older adult patients in long-term health care settings	49 %	58 %	NO
I am well prepared to care for older adult patients in ambulatory settings	76 %	96 %	YES
I am well prepared to care for older adult patients in acute settings	80 %	93 %	YES
I learned about the health care needs of healthy older adults during my medical training	81 %	95 %	YES

(Scale: 5 point Likert Scale)

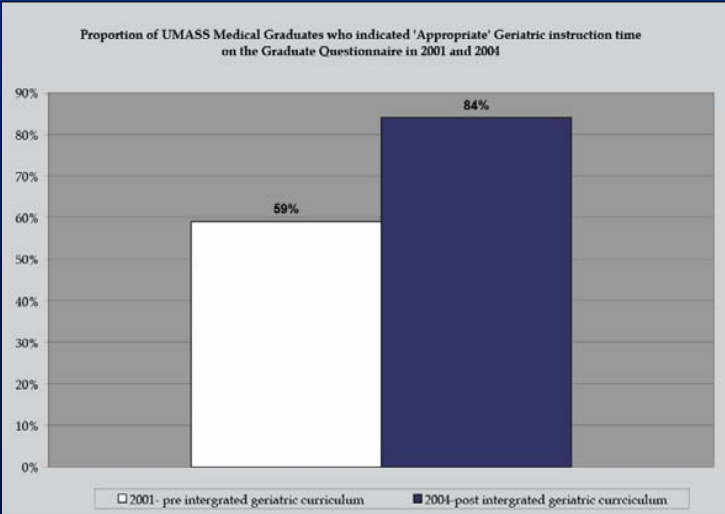
Methods

The new curriculum was examined by comparing AAMC Graduation Questionnaire responses for geriatrics items [Class of 2001 (no new curriculum) versus Class of 2004 (full curriculum)] using two bi-variate analyses. The first comparison was performed by examining the difference of the percent of 'strongly agree and agree' ratings (combined) between the two cohorts using an approximation to the binomial distribution. In the first analysis (Table 1; Graph 1) the null hypothesis was, "There is no difference in the proportion of students in each cohort indicating a 'strongly agree or agree' to each of the eight geriatric/gerontology items. The second analysis (Graph 2) looked at the difference of the percent of students who indicated that the geriatric instruction time was "adequate" between the two cohorts (scale: inadequate, adequate, excessive). The null hypothesis in the second bivariate analysis was, "There is no difference in the proportion of students in each cohort indicating a 'appropriate' to the amount of geriatric instruction time".

Graph 1



Graph 2



Results

Of the eight geriatrics/gerontology items, seven ratings increased significantly (p < .05) in GQ2004 (n=93) versus GQ2001 (n=74) (Table 1). In areas of teaching method (small group and Interdisciplinary approach) the percent strongly agree/agree doubled from 41% to 83%. Ratings in five items increased by 15-20%, and one item (care in long term health settings) increased by 9% (ns). The data in GY2002 and GY2003 showed incremental gains as the curriculum was rolled out. Ratings of instruction time in Geriatrics also increased significantly from GY2001 to GY2004 (p<.05) (Graph 2).

Conclusion

The incremental implementation of a new geriatrics curriculum coincided with a significant increase in student satisfaction with their geriatrics educational program, as measured by the AAMC GQ. This finding supports the educational value of longitudinally integrated curricula as measured by tracking of student satisfaction over time.