

ISSUE BRIEF

Filling the Geriatric Gap: Is the Health System Prepared for an Aging Population?

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A discussion featuring

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Filling the Geriatric Gap

As the number of older Americans grows, so do concerns about whether the U.S. health system will be equipped to handle the multiple needs and demands of an aging population. Over the years, numerous federal studies and private-sector reports have concluded that the U.S. health system is lacking in practitioners who are trained to meet the special health care needs of older Americans. As the United States enters the 21st century and the ranks of the elderly begin to swell, pressures to address that problem have intensified.

Few question whether there is an adequate number of physicians, nurses, and other health professionals to deliver care to the elderly. The real problem lies in the fact that many of these providers, for a variety of reasons, lack the requisite skills and knowledge to recognize and appropriately treat the chronic health problems geriatric patients routinely bring into the waiting room. When an infant or young child is sick, parents rely on the knowledge of a pediatrician; experts say the same degree of specialization is warranted when an elderly person needs care.

Americans are living longer and healthier lives than ever before. But even with that improved health status, the increased longevity means a greater chance they will experience an aging-related problem such as incontinence, immobility, memory loss, or other chronic illness. Some experts worry that the geriatric training and practice gaps that now exist could hurt the quality of health care delivered to older Americans. While private foundations such as John A. Hartford, Robert Wood Johnson, Retirement Research, and Archstone have taken steps to address these problems, federal policymakers have yet to examine them in a comprehensive manner.

This Forum session will explore the field of geriatrics, the ways practitioners meet the health care needs of the elderly, training gaps, and the impact of Medicare payment policies on the delivery of health care to older Americans.

THE DEMOGRAPHIC REALITY

By the end of this century, nearly 40 million Americans will be age 65 and older. By 2011, some 77 million baby boomers born between 1946 and 1964 will begin to turn 65 and then join Medicare, putting more pressure on the system.¹ Between 2010 and

2030, nearly one in five Americans will be over the age of 65.²

Today, the 12 percent of the population over age 65 accounts for about one-third of the nation's \$1.1 trillion health care bill.³ The Bipartisan Commission on the Future of Medicare predicts that an even greater percentage will be age 65 and over by 2030, when care of the elderly may account for more than half of the nation's medical expenditures.⁴

Because it finances a majority of health care services used by older Americans, the federal government has a major role to play in shaping how this care is delivered. The \$225 billion and growing Medicare program pays about nearly half of the health care costs for the elderly; low-income elderly who are dually eligible for Medicaid account for about 16 percent of the Medicare population but about 30 percent of the program's expenditures.⁵ In addition, a significant number of the nation's 9.3 million elderly veterans are provided care in the Veterans Administration health system, which spends \$17 billion on medical care each year.⁶

Although the growing numbers of Americans 65 and older will put pressure on the system, coping with the rapidly increasing frail elderly population will present some of the greatest challenges. The number of persons age 85 and over is expected to expand nearly five-fold by 2050—from about 4 million today to 19 million.⁷

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The Veterans Administration estimates that the number of oldest-old veterans is expected to jump nearly 600 percent by 2010, to 1.3 million. Since they have the highest rates of disability, nursing home use, and multiple chronic problems, the oldest old will be at greatest risk for use of high cost health services.

In addition to age, the health system will have to gird for a more racially and ethnically diverse population of elderly patients and thus become more culturally sensitive. The numbers of ethnic minority older Americans are growing faster than the burgeoning elder population as a whole. By 2030, elders from groups classified as ethnic minority will comprise one-fourth of all older Americans, up from 14 percent in 1990. In California—the state with the largest number of older adults—41 percent of the over-65 population will be ethnic minority by 2020, up from 21.5 percent in 1990.⁸

Minority elderly tend to have higher rates of functional impairment, poverty, poor education, and malnutrition, as well as have more trouble navigating the health care system. To treat them effectively, experts believe, doctors and other practitioners will need to be sensitized to the way older minority patients view health care, taking into account such things as cultural beliefs, utilization patterns, views on dying, and in some cases responses to treatment.

The challenges of delivering high-quality, cost-effective care to a graying population are formidable, demanding examination of current policy and health system approaches. Although advances in medical science have shed much light on the aging process and the prevention and management of chronic illness, that knowledge has yet to be widely spread among the health care workforce.

WHY GERIATRICS IS UNIQUE

While it is highly likely that elderly patients will increasingly be cared for by a multidisciplinary team of providers, this issue brief will focus primarily on the role of the physician. Nevertheless, many of the issues raised can be applied to nurses, social workers, and other allied health professionals who treat older patients.

The elderly most often see general internists and family physicians, most of whom provide adequate care to these patients. But the vast majority of physicians and health care practitioners with older patients have not been trained in geriatrics and the special needs of the elderly because it has until recently been a low priority for medical schools. As a result, practitioners

often treat a 70-year-old patient the same way they would a patient of 35. As the population ages and health needs become more complicated to treat, those gaps in training could cause problems.

Geriatricians are physicians who are expert in aging-related issues or gerontology. Most often they are primary-care based practitioners, board-certified in family practice, internal medicine, or psychiatry, who have completed additional years of fellowship training. Geriatricians have to pass a certifying exam and a recertifying exam every 10 years to assure competency.

Geriatric training can provide health care professionals with the skills and knowledge to recognize special characteristics of older patients and distinguish disease states from the normal physiological changes associated with aging. Additionally, geriatricians focus on maintaining and improving functional status, providing early intervention and continuity of care, examining co-morbidities, and fostering optimal outcomes.

Although a range of practitioners will be called on to deliver care to the majority of the elderly, many experts agree that a sufficiently large core of geriatricians or “aging specialists” will be needed to provide care for the 15 to 20 percent of the elderly who are the oldest and most frail. They also will be needed to advise and train the doctors, nurses, and other health care practitioners who have had little or no geriatric training but who treat large numbers of elderly patients.

Says one geriatric expert:

It's not that we have to train 100,000 geriatricians to take care of the soon to be 70 million people over 65, but rather we need to be sure that the physicians who are allowed to take care of the most challenging people in the population have the knowledge and skills to do it.

Looking beyond the Symptom

Acute problems are very often manifestations of a chronic disease process, such as arteriosclerosis or high blood pressure. But because older persons are burdened by more disease and physiologically incapable of fighting off many of those conditions, even the smallest change in health status can trigger a catastrophic event. Thus, while diagnosis and treatment of disease is still important, management of multiple chronic disorders has emerged as the main challenge in geriatrics.

For example, an 80-year-old woman who complains of a pain in the knee from a fall should be treated much differently than a 45-year-old woman with a similar

complaint. The geriatrician, for example, will practice the “incessant collection of evidence,” trying to ascertain the extent of the damage to the knee while also exploring why the elderly woman fell in the first place.⁹ Questions such as the following might help the physician in determining treatment: Is the woman being prescribed too many medications? If so, is she taking them? Is she taking other, over-the-counter medications that might make her unsteady on her feet or that are interacting adversely with the prescription medications? Does she live alone or in a senior housing complex where residents may exchange pills, or did she have any symptoms before the fall, such as dizziness, palpitations, chest pain, or shortness of breath?

Because of the lack of training and the time pressures of daily practice, many physicians are not aware of or ignore this evidence-collecting process, even though it may be crucial to diagnosing and treating their elderly patients. Another important step for practitioners treating elderly people is analyzing multiple problems and how they interact. For example, proper treatment of diabetes in the presence of heart failure and dementia is different from that of diabetes alone. Communications skills that allow providers to explain complicated conditions and treatments to persons who may also have visual, hearing, or cognitive impairment are also important, as is the willingness to involve the family.

Gaps in skills can easily result in physicians’ misdiagnosing, overlooking, or dismissing illnesses as the “normal” process of aging because they are not trained to recognize the different ways that diseases and drugs affect older patients. This has implications not only for the kind of care elderly patients receive but for health care spending as well. For example, older patients often react differently to prescription drugs than younger people. They also often take multiple drugs, ordered by multiple physicians in a fee-for-service arena, without any one physician coordinating use. However, confusion, lethargy, and falls are conditions frequently dismissed as “old age,” when they usually are signs of drug interactions or other underlying illnesses. According to a 1995 General Accounting Office study, inappropriate use of prescription drugs among the elderly resulted in hospitalizations costing about \$20 billion a year.¹⁰

Urinary incontinence is another problem that often goes undetected or is dismissed as a natural consequence of aging. Incontinence, which afflicts more than 20 million Americans, is embarrassing to many elderly who see it as a symbol of lost independence and control. Although urinary incontinence costs the U.S.

health system \$16 billion a year to manage, it is often treatable by exercises or medication.¹¹

Nutrition problems also often go undetected by physicians but, if managed correctly, can significantly affect expenditures for health care for the elderly. A frail senior who gets excellent medical care but cannot prepare meals independently is vulnerable to malnutrition and associated medical problems. The inability to prepare meals, which is linked to frailty and depression, often triggers admission to a nursing home at a cost of \$40,000 a year. Physicians with skills in geriatric care are trained to address the problem underlying the symptom, possibly heading off such a costly solution.

Depression too is a widespread but under-recognized problem among the elderly that, if left untreated, can lead to serious dysfunction, disability, increased psychiatric and medical morbidity, and premature death from suicide. About 5 million elderly persons suffer from serious and persistent symptoms of depression, according to the Task Force on Aging Research Funding. Many elderly people deny or minimize depressive symptoms, and many health care professionals view depression as an inevitable part of getting old. Although more than 70 percent of elderly suicide victims have seen their primary care physician within a month of their death, they routinely are not treated or referred for treatment of their depression.¹²

Mainstreaming Geriatrics

Teaching practicing physicians as well as other health care practitioners about the principles of geriatrics—convincing them to undergo the cultural shift involved in moving from an acute to a preventative model of care and to look routinely beyond a symptom or disease manifestation—has implications both for seniors’ quality of life and for health care spending.

By age 75, elderly adults can expect to have two to three medical conditions. Disability in old age is linked with a poor quality of life, dependence on formal and informal care providers, and often substantial medical and long-term care costs. In addition, disabled persons are at additional risk of other adverse health outcomes, including deteriorating function, acute illness and injuries, falls, recurrent hospitalizations, and mortality. Successful prevention or delay of a disability could make a substantial difference in the health status and well-being of the elderly as well as in the care needs and costs of caring for this population.

This is particularly true for the frail elderly. The average annual health bill for persons over age 85 is

nearly six times greater than for persons age 19 to 64.¹³ This population also has less than half the income of persons age 65 to 75. And, while recent studies have shown that the percentages of older Americans with a chronic disabling condition is dropping, three in five frail elderly persons have a chronic problem, such as osteoporosis, arthritis, diabetes or heart disease, that could limit their independence.¹⁴

Proponents of geriatric training contend that having a health care workforce that knows how to manage chronic illnesses and steer patients away from expensive institutional settings could help keep a lid on health costs for the elderly—who, not surprisingly, have high utilization rates. People over age 65 already average nine physician visits a year, almost twice the rate for the general population. They also are hospitalized more than three times as often as the younger population, have longer hospital stays, and use twice as many prescription drugs.¹⁵ The Alliance for Aging Research has noted that the ability to delay the occurrence of hip fracture—which causes physical dependency but can be prevented through careful screening of an elderly person's home environment—would save some \$5 billion in health costs annually.

The Practice Realities

Some studies predict that at least 20,000 physicians with geriatric training are needed to care for the current population of elderly Americans. By 2030, some estimate that the United States will need about 36,000 physicians with geriatric training to manage the complex health and social needs of its rapidly aging population.¹⁶

Over the years, there has been a relative rise in the proportion of practicing geriatricians, but the numbers of such specialists who either see patients or teach medical students falls short of what many experts deem necessary. Today, there are about 9,000 certified geriatricians practicing in the United States,¹⁷ significantly up from 6,784 in 1994.¹⁸ But the pool is not expanding as fast as the population it serves and consequently is inadequate to meet rising patient and training demands. And the actual number of geriatricians may decline by the early part of the 21st century, just as the baby boomers start reaching Medicare eligibility, because many doctors now in practice will have retired and rules that made it relatively easy for generalists to become certified geriatricians have gotten tougher in recent years.

A Shortage of Geriatricians

There are several reasons why insufficient numbers of health professionals are being trained to meet the

health needs of the elderly. One stems from a shortage of geriatric faculty. According to “A National Agenda for Geriatric Education,” a series of white papers highlighting problems in geriatric care published in 1995 by the Health Resources and Services Administration, “inadequate numbers of faculty with knowledge and skills in geriatrics are being prepared,” despite federal and foundation support for fellowships in faculty training.

The shortage of geriatric academicians poses problems for mainstreaming geriatrics into daily medical practice. Faculty are needed to produce future leaders in geriatric education, research, and administration and to help with the education and training of generalists. The Association of American Medical Colleges (AAMC) testified in 1998 that 558 faculty members report geriatrics as their medical specialty in the nation's 125 allopathic medical schools.¹⁹ While that figure is a four-fold increase over 1991, most geriatric leaders believe the numbers still fall short of what is needed.

The Alliance for Aging Research estimates that the United States has less than a quarter the number of geriatric academic physician scientists needed to train undergraduate students and residents. This shortage poses a problem since medical faculty often serve as role models or mentors who influence students' career choices. In May 1998 testimony before a congressional panel, the president of the AAMC said findings from surveys his organization has conducted make clear that, when it comes to choosing a specialty, medical students are highly swayed by their educational experiences.

After ignoring the problem for years, medical schools are more actively recruiting students into geriatrics, but the task remains difficult. About 16,000 students graduate from medical school each year, but, for a variety of reasons, only a fraction of those students are eager to specialize in geriatrics. One second-year medical student interviewed, the only one her in her class planning to go into geriatrics, said the attitude of her peers is “Why would you want to work with patients that never get better?” Her comment reflects the lack of exposure to other geriatricians in the academic environment.

Part of the problem is that undergraduate medical students still have very little systematic training in geriatrics. Only 10 percent of the nation's medical schools make geriatrics a separate required course.²⁰ Most medical schools require the teaching of geriatrics, but those programs generally incorporate the topic into a required course or offer it as an elective. Until 1998, for example medical students at the University of Pittsburgh's School

of Medicine were required only to have two days of geriatric training in four years of school.²¹ And when it is offered as an elective, most students are not rushing to sign up; less than 3 percent of today's medical students choose to take courses in geriatrics.²²

The situation is similar in graduate medical education (GME). While the number of residency training programs in internal medicine and family practice geriatrics has grown significantly in the past decade, many geriatric training positions still remain unfilled. In 1996, the latest year for which data are available, only 144 of 222 geriatric training positions offered were filled, according to the AAMC.

These statistics are not surprising. Like other primary care practitioners, geriatricians have not been financially or professionally rewarded for their work. Those pursuing a specialty in geriatrics have experienced low professional and public recognition, relatively low incomes, and long hours. Thus, the geriatrics field has struggled to attract the quality and quantity of physicians needed.²³

While salary limitations have an effect on attracting physicians to the field, medical school graduates emerge from training shouldering significant bills. Some in Congress have tried to address this problem. In 1997, for example, Sens. Harry Reid (D-Nev.), Charles Grassley (R-Iowa), and John Glenn (D-Ohio), introduced a bill (S.780) that would forgive \$20,000 of loan repayments for fellows in geriatric medicine. The bill died in the 105th Congress.

Geriatrics also has been slow to grow in academic medical centers. It is gaining recognition at a time when resources and opportunities in academia are declining, largely attributable to the fiscal pressures of managed care.

MEDICARE PAYMENT SHORTFALLS

Making the specialty more appealing would likely require significant reforms, particularly in the way Medicare pays for training and reimbursing care to geriatricians. Although legislation introduced in recent years would boost Medicare graduate medical education (GME) payments for geriatric medicine and psychiatry, thus far Congress and the administration appear reticent about instituting such sweeping reforms.

Unlike internists or family physicians—who depend on a variety of third-party payers for their revenues—geriatricians are almost entirely dependent on Medicare by virtue of their patient caseload. But low Medicare reimbursement for complex, prolonged evaluation and

management of conditions has been cited as one of the major barriers to drawing and retaining recruits into the geriatric field. The complaints parallel those made by primary care doctors about a payment system that rewards procedures instead of management.

The lack of a code for comprehensive geriatric assessment has made it difficult for geriatricians to be reimbursed fully for their services. A typical physician office is geared to see four to six patients an hour, assuming the physician treats only one symptom for each patient. A geriatrician gets paid less for spending time with families, counseling patients, and doing an evaluation to avoid hospitalization than for removing a number of small skin lesions or warts.

Visits and consultations, however, represent most of what geriatricians provide. Medicare's resource-based relative value scale system was meant to level the playing field so that payments for overvalued services would be reduced, while undervalued procedures would be more fairly compensated. But that has yet to occur; although the Medicare Payment Advisory Commission reports that payments for evaluation and management services have been steadily rising since 1991, surgical services are still reimbursed at a disproportionately higher rate. Because Medicare's physician payment policy is essentially still procedure-oriented (paying per procedure delivered), the program does not reimburse for the extra time and resources it takes to evaluate and manage older patients—most of whom present with multiple problems—during an office visit.

Medicare also does not reimburse for the cost of interdisciplinary teams of professionals necessary to deliver the spectrum of medical, psychological, and social services many elderly patients require. Thus, elderly patients are often hospitalized for conditions that could more appropriately be managed at home or in a nursing home.

Nor does Medicare adjust for the age or medical complexity of geriatric patients in its reimbursement system. As a result, geriatricians have had relatively lower incomes compared to other physicians because they tend to specialize in care of the frail, chronically ill elderly, who usually are sicker and require more health care resources.

The disincentives in reimbursement extend beyond practicing doctors. Physicians-in-training, who quickly see that procedural and acute care skills are more valued by payers, are unwilling to specialize in a field that requires time-consuming efforts that basically go unpaid. For training institutions, the costs and rewards

of training geriatricians do not favorably compare to fees received for preparing residents in surgery, for example.

To better manage frail, chronically ill patients, many recommend that Medicare be refined to recognize the social as well as medical components of elderly health care. The fragmented Medicare fee-for-service system impedes physicians from delivering a set of comprehensive services to elderly patients, particularly the frail and chronically ill. But those who have been trying to get Medicare to pay extra for case management services say it has been an uphill battle. Because it fears that providers will game the system, the Health Care Financing Administration (HCFA) has been reluctant to have Medicare cover this service. HCFA officials argue that case management is difficult to monitor, hard to target, and is easily abused. The agency also is not convinced that evidence exists to show that case management and coordination can reduce costs.

The agency, however, is interested in offering a way to both alter practice patterns and improve efforts to increase patient compliance with medication, diet, and activity regimens. Consequently, it is in the process of developing a demonstration to test effective ways to coordinate care delivered to seniors with chronic illnesses enrolled in traditional Medicare. Given the higher average monthly fee-for-service costs for persons with one or more chronic conditions, HCFA says the goal of the project is to “improve the quality of items and services provided to targeted individuals” as well as “reduce expenditures under Medicare” for these services.

Medicare GME Policy

Medicare policy regarding training is another area that some have identified as warranting reform. Medicare spends slightly more than \$7 billion a year to support graduate medical education. But that money has historically flowed to teaching hospitals only. As a result, doctors who provide a large proportion of both primary and specialty care to chronically ill, elderly persons receive most of their geriatrics training in acute-care settings. This has inhibited physicians-in-training from being exposed to the kinds of patients and conditions seen in the community-based sites where they might practice and where the vast majority of geriatric care is delivered.

This training gap means that physician trainees are not seeing geriatricians in a variety of leadership roles. Through its support of medical education, Medicare is seen as a potentially important lever to promote exposing medical students and residents to non-acute clinical training sites where geriatricians practice. These include

nursing homes, adult day care centers, ambulatory clinic-based geriatric evaluation units, geropsychiatry units, physician offices, and hospices.

Congress has taken some small steps to move Medicare in this direction. The Balanced Budget Act (BBA) of 1997 includes a provision that would for the first time authorize HCFA to direct Medicare GME payments to nonhospital providers. The goal of the measure is to spur more training in community-based sites by redirecting GME dollars from teaching hospitals. The effect on geriatric training is unclear, however. For now, HCFA is proposing to pay directly only for residents who train in rural health clinics, federally qualified health centers, and Medicare+Choice plans—sites that were specified by Congress. The proposed regulations do not allow nursing homes and hospices (where many geriatricians practice) to get direct Medicare GME payments, however.

Another Medicare policy that some think Congress should address deals with a BBA provision that places a cap on the number of GME slots supported by Medicare. Medical educators and the geriatrics profession have urged Congress to amend the training restriction to exclude geriatrics fellows. There is a reluctance, however, to make exceptions like this since it could open the floodgates, leading other specialties to seek exemptions. Congress apparently believes that decisions on residency slots are best left to the teaching institutions. Nevertheless, anecdotally, some physician leaders have indicated that the cap already is limiting geriatric training slots in teaching hospitals, exacerbating the shortage situation.

For those concerned about the shortage, however, the effect of overall reduced Medicare support for GME may be an even bigger worry. Many believe cuts in GME payments will further weaken the geriatrics field. Future cuts to GME, they say, will limit access to skills that are necessary to provide good geriatric care.

The Bipartisan Commission on the Future of Medicare will be looking at many of these areas as part of their report to Congress and the administration, which is due out in March of 1999. The commission is now looking at ways to reform Medicare GME policy, including suggesting that the dollars be targeted differently.

Title VII's Contribution

Although reforming Medicare is viewed by many as key to spurring more interest in geriatrics, Congress has used other less generous vehicles to fill training and practice gaps. Title VII of the Public Health Service Act includes several provisions designed to boost geriatric

training. Through Title VII, Congress spends \$9 million each year to fund geriatric education centers (GECs) and geriatric training programs (GTPs), which offer opportunities for a variety of health care professionals to develop skills for caring for older Americans. But this represents only about 3 percent of the \$304 million budget for all Title VII programs.

GECs are affiliated with educational institutions, hospitals, nursing homes, community-based centers for the aged, state agencies, and veterans hospitals and are designed to provide short-term faculty training, curriculum or educational resource development, and technical assistance and outreach to practitioners in the community. Some GECs, like the one at the George Washington University, form consortia with other medical institutions in their community to leverage their collective knowledge and resources and to have a broader impact on the community and practitioners that deliver care. Despite their shoestring budgets, these entities have gone beyond simply training health professionals to facilitating community partnerships. The Greater Washington DC Area Geriatric Education Center Consortium, for example, is trying to set up an institute to improve the training and knowledge base of home care workers, who are increasingly caring for sicker elderly patients and need a better understanding of how to be part of the health care team.

Lawmakers also have attempted to boost the number of geriatricians who can teach others about the field. In 1998, Congress enacted the Health Professions Education Partnership Act of 1998 (S.1754), which would allow the Secretary of the Department of Health and Human Services to provide up to \$1 million in grants to physicians and dentists who plan to teach geriatric medicine, psychiatry, and dentistry. The law requires the secretary to establish a program to provide geriatric “academic career awards” to junior faculty members in order to promote careers in academic geriatrics. Junior faculty recipients would get about \$50,000 apiece a year for five years to help them do nothing but teach geriatrics. Recipients would be required to provide training in clinical geriatrics, including the training of interdisciplinary teams of health care professionals.

The goal of the measure is to protect teaching time and relieve academic geriatricians from the pressure of having to see patients to generate clinical revenues that supplement their salaries. By helping geriatric faculty focus on teaching and research, Congress hopes to produce mentors and role models who would eventually become directors of departments of medicine, help sensitize medical institutions to the utility of geriatrics

practice, and inspire students to enter the field or acquire gerontological skills.

THE VA'S ROLE

The Department of Veterans Affairs has played a major role in developing the geriatrics field for more than 20 years. While 13 percent of the total U.S. population is 65 years of age or older, slightly more than one-third of the nation's 25 million veterans are in that age range, according to the VA. By 2020, 51 percent of the veteran population will be 65 years and older. With the veteran population aging more quickly than the population as a whole, the VA health system decided early on to implement strategies to address such changes. These include the establishment of a Geriatric Research Education and Clinical Centers program in 1975 and development of the VA's Geriatric Medicine Fellowship program in 1978. Both have been supported and expanded over the past two decades.

The training of health care students and professionals in geriatrics and gerontology has been a priority for the VA. Of the more than 100,000 health profession students who get clinical training experiences in VA facilities each year, many get their geriatric experiences by rotating through the VA's geriatrics and extended care clinical programs. The VA had one of the first physician fellowship programs in geriatric medicine and it has the largest single program of geriatric fellowship-trained physicians in the United States, graduating 275 physicians between 1978 and 1992. The number of resident positions in the VA's advanced geriatric training program continues to grow each year, increasing from 41 in 1991 to 92 to 160 in 1998. Nearly half of all the graduates from the VA's advanced geriatric medicine training program hold academic appointments and have become educators of future geriatricians.²⁴

THE IMPACT OF MANAGED CARE

With its emphasis on wellness, prevention, and team delivery, managed care is helping to integrate geriatrics into mainstream practice. HMOs and other managed care systems are ultimately designed to integrate a variety of health care services and promote population-based strategies. Geriatrics appeals to managed care organizations, which argue they want to promote care management while simultaneously equipping practicing physicians, nurses, social workers and others on the health care team with the skills to better treat the elderly. Many plans have physicians on staff who understand how to care for

the elderly and have put geriatricians in leadership roles to better define systems of care.

Under a capitated rate, Medicare HMOs have the opportunity to develop systems for the chronically ill that include routine assessments, geriatric expertise, interdisciplinary delivery, preventive and educational interventions, psychosocial support, and regular follow-up care. Under a fixed rate, health plans and medical groups have the flexibility and incentive to spend Medicare dollars on both medical and social services provided by a multi-disciplinary team of practitioners, including basic nutrition, vision and hearing aids, or transportation. Geriatric experts say that this strategy should guide future reform of Medicare, adding that "selected" nonmedical services, such as social work or transportation, are inextricably linked with successful medical outcomes.

Already a number of managed care plans with experience treating the chronically ill understand that nonmedical services need to be linked with medical care. Many of these plans provide transportation services, work with patients and their families to make sure seniors' homes are safe to protect against falls, and provide relief to informal caregivers.

Early findings of a care management program run by Group Health Cooperative of Puget Sound and PacificCare reveal that targeted health promotion and illness management interventions by geriatric nurse practitioners resulted in fewer hospitalizations and increased activity. Kaiser Permanente in San Diego also has a program in which seniors with special health and medical needs are identified and referred to receive case managed, coordinated care services. The plan also has recently begun proactive screening to identify the frailest of its members so it can develop case management strategies for these patients.

The federal government's PACE project is an example of a managed care model that cares for an exclusively frail elderly population. The "Program of All Inclusive Care for the Elderly," or PACE, pays providers a capitated rate and advocates a multidisciplinary approach to treatment that meets both medical and social needs. Begun as a demonstration in 1990, PACE was a replication of On-Lok, an expensive, day-care model that began in San Francisco in the 1980s and that most experts say could not be replicated by managed care plans. Nonetheless, PACE is now being tested at 14 sites around the United States and, in 1997, Congress enacted legislation that gave permanent status to the project, allowing programs to exist without a federal waiver.

PACE serves a population that is hard to treat. In order to participate, patients must be eligible for nursing home care. The average age of a PACE enrollee is about 80; they average five to six diagnoses and are usually on 10 to 12 medications. About 90 percent of PACE enrollees are dually eligible for Medicaid and Medicare.

PACE's goal is to keep frail elderly patients in the community for as long as possible, so they can function outside of expensive nursing homes. Based on an adult day-care model, PACE provides a range of services that Medicare would not necessarily cover, including prescription drugs, transportation services, and even home modifications to prevent falls. Essentially, the program covers what is needed within reason to keep a patient at home. It also features a coordinated team to provide services. Patients come to a specific location to receive medical, nutritional, therapy, or social work services. They also can see a specialist or primary care doctor at this site. But the jury is still out on whether it can serve as a model for managed care because it is highly localized and covers a small population of patients.

HCFA has started a routine system for identifying Medicare+Choice enrollees who are at high risk for adverse health outcomes. As of January 1999 HCFA will begin requiring all Medicare+Choice plans to conduct high-risk screening on new enrollees within 90 days of enrollment. This screening process is seen as an important tool for better geriatric care and can be applied easily by all physicians. The tool is a way to get physicians to recognize geriatric syndromes in frail elderly and set up a system of care for those patients. From the plan's perspective, the health risk assessment tool is a way to focus on identifying those elderly patients who are eligible for disease management and preventive health programs that can reduce the use of expensive hospital and nursing home care. These patients can then be handled by a case manager (usually a nurse), who coordinates the patient's health and social needs.

Geriatricians say instituting an assessment and case management program can help the physician do a better job. "There are specialized needs of the geriatric patient that the average physician does not have time to deal with but if they do not deal with them it leads to bad outcomes," says one physician. "Case managers serve as a resource for developing and implementing the team approach to patients."

A number of plans, for example, have designated physicians who want to serve the frail elderly and team them with nurse practitioners (N.P.s) having backgrounds

in geriatrics to provide ongoing primary care and to meet with the family. United Healthcare's EverCare program relies on geriatric nurse practitioners as case managers who make regular visits to patients in nursing homes to detect problems that may go unnoticed by the nursing home staff. By working with EverCare physicians and other practitioners, N.P.s, who in many states are authorized to prescribe medicine, can handle problems in the nursing home instead of transporting the patients to expensive emergency rooms or hospitals. Kaiser Permanente in San Diego has a similar program that provides primary care to nursing home residents and patients in subacute settings. The plan has a group of physicians who work in the community, rather than in the office, caring for elderly patients in skilled nursing facilities and making visits to hospice patients.

Other plans have set up group clinics for elderly with chronic illness. At the Kaiser Permanente plan in Colorado, this effort has produced enhanced patient satisfaction, lower use of nonprimary care services, and higher member retention rates.

Many health plans also have set up pharmacy programs, asking elderly members to bring in their medications and prescriptions for review. This so-called "brown bag" review helps plan doctors assess whether the medications conflict with each other, have expired, or, in the case of a covered benefit, are being filled. This kind of program can change physician behavior; according to one managed care plan, 45 percent of doctors said that, as a result of the medical review, they changed their patients' prescriptions and about 25 percent took patients off all unnecessary medications.

The Blue Cross and Blue Shield Association and its 55 plans believe they, too, have a role in helping to integrate geriatrics into primary care practice. In 1997, the national association, along with the American Geriatrics Society (AGS), started the National Blue Initiative for Quality Senior Care. Neeraj Kanwal, M.D., Anthem Blue Cross and Blue Shield's executive medical director for senior markets, says many of the primary care physicians his plan worked with acknowledged their lack of skill in caring for elderly patients and were willing to accept help to become better at geriatrics.

Working with AGS, the Blues plans put together resources designed to help physicians in their day-to-day practice with senior patients. The program provides physicians with practical tools to use in practice, such as workbooks, charting aids, guidelines, and pocket reminder guides. Doctors also earn continuing medical education credits.

Kanwal says the goal is to change the medical rubric of primary care physicians, moving them away from "episodic" care to focusing on managing their elderly patient's health and social needs. The group has produced a self-study curriculum that summarizes key components of practicing clinical geriatrics and offers guidelines on specific conditions, such as geriatric psychiatry, malnutrition, dementia, falls, pain management, and urinary incontinence.

So far, Anthem, which provides Medicare HMO coverage to 61,000 beneficiaries, has distributed information to 2,000 physicians in Connecticut, Kentucky, Ohio, and Indiana. Kanwal says that because his plan is voluntary it does not know how many doctors are using it or whether it has led physicians to modify how they practice. While they intend to survey physicians in the next year to assess the utility of this effort, Kanwal admits that changing physician behavior is difficult.

As the number of older Americans continues to grow, policymakers, health plans, and providers have increasingly become aware of the special needs of caring for this population. This Forum session will bring together a panel of experts to discuss the status of geriatric care today as well as Medicare incentives and disincentives for training health care professionals and for providing comprehensive, all-inclusive care to the elderly.

THE FORUM SESSION

Christine K. Cassel, M.D., M.A.C.P., chairman of the Department of Geriatrics and Adult Development of Mount Sinai Medical Center, will open the session with a discussion of the benefits of geriatric medicine, academic training issues, and how Medicare payment policies impact the delivery of health care to older Americans. Dr. Cassel is a leading expert in geriatric medicine and has published numerous books including *Geriatric Medicine* (first published in 1984 and now in its third edition). Prior to her current position at Mount Sinai, Dr. Cassel served for ten years as Chief of Internal Medicine at the University of Chicago, where she was professor of Medicine and Public Policy Studies, director of the Center on Aging, Health, and Society, and director of the Center for Health Policy Research, among other positions.

Richard D. Della Penna, M.D., physician-in-charge for Continuing Care Services, Home Health, and Hospice for the San Diego Kaiser Permanente Medical Group, will discuss his experience delivering geriatric care in a managed care environment. In addition, Dr.

Della Penna serves as the principal investigator for the Hartford Foundation's project on Implementing Geriatric Interdisciplinary Team Training for Practicing Professionals. Dr. Della Penna also serves as the regional elder care coordinator for the Southern California Permanente Medical Group and on Kaiser Permanente's national Interregional Committee on Aging.

Finally, **Mathy Mezey, Ed.D.**, director of the John A. Hartford Foundation Institute for the Advancement of Geriatric Nursing Practice at New York University (NYU), will discuss the role of nurses in improving care received by older adults. Prior to her position at NYU, Dr. Mezey was a professor at the University of Pennsylvania School of Nursing, where she directed the geriatric nurse practitioner program and was director of the Robert Wood Johnson Foundation Teaching Nursing Home Program, a program to link schools of nursing and nursing homes.

The discussion will focus on the following policy questions:

- How should Medicare be revised to better promote care management services for chronically ill beneficiaries, in both a fee-for-service and a managed care environment?
- What are the prospects of refining the fee schedule to attract physicians and other professionals to careers in geriatrics? What are the legislative and financial hurdles ahead?
- Should the federal government provide incentives for medical schools and professional schools to incorporate geriatrics into training programs? Does the private sector have a role?
- Should there be more incentives for current practicing professionals to take geriatrics continuing medical education? Can the government via Medicare provide those kinds of incentives?
- What has been the impact of some of HCFA's demonstrations (for example, PACE and On-Lok) that are designed to promote interdisciplinary care for chronically ill patients?
- Are these cost-effective or are they too expensive to institute nationally? Are they relevant models in today's health care environment?
- What evidence is there that geriatrics skills really produce better outcomes? Should the Institute of Medicine or appropriate entity examine this issue to influence policy in this area?
- What can the private sector do to better integrate geriatrics practice?

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