# Geriatric Medicine:
# A Clinical Imperative for an Aging Population



A Report from the American Geriatrics Society (AGS) and the Association of Directors of Geriatric Academic Programs (ADGAP)

# Executive Summary

- The nation's aging population is growing rapidly. The aging population is living longer, with fewer acute care based needs and more chronic care based needs. In general, our health care system meets chronic care needs in a limited and fragmented manner.

- Chronic care services are a hallmark of geriatric care. Geriatricians are physicians who are experts in caring for older persons; these primary care-oriented physicians are initially trained in family practice or internal medicine and complete at least one additional year of fellowship training in geriatrics.

- A subset of the nation's elderly population requires geriatric care. Approximately 15% of community dwelling Medicare beneficiaries need access to a geriatrician or geriatric services provided by a primary care physician.

- The first category of non-institutionalized Medicare beneficiaries is comprised of seniors with multiple, complex chronic conditions. In addition, residents of nursing homes and other congregate care facilities need access to quality, geriatric care.

- Over the past ten years, peer reviewed literature has strongly supported geriatric care models. These innovative care delivery systems include the use of geriatric assessment; ongoing care coordination, a physician-directed multidisciplinary team and a holistic approach to patient care that involves clinical, psychosocial and environmental follow-up.

- Despite the benefits of geriatric care, a shortage in the geriatric work force persists. Today, there are approximately 7,600 certified geriatricians in the nation, despite an estimated need of approximately 20,000 geriatricians. The lack of geriatricians impedes the delivery of chronic care to needy, elderly individuals.

- Financial disincentives pose the largest barrier to entry into the field. Geriatricians are almost entirely dependent on Medicare revenues. Given their patient caseload, low Medicare reimbursement levels are a major reason for inadequate recruitment into geriatrics.

- The Medicare bill included several new chronic care provisions, including a large-scale disease management pilot program. However, the new disease management program will not adequately address the needs of persons with multiple chronic conditions, nor will it address the financial disincentives within Medicare that have limited the supply of geriatricians.

- Different reforms are needed to increase interest in geriatrics, such as changes in the Medicare fee-for-service payment system, changes in the new disease management program, and changes in payment policy for federal training programs.

# Introduction

Our country is aging rapidly. In 1900, there were 3.1 million Americans age 65 and older, and, today, there are roughly 35.6 million aged persons.[1] By the end of the next decade, we will see an even more dramatic increase in the growth of the older population, a result of the post World War II "baby boom." By 2030, it is projected there will be about 71.5 million older persons, more than twice their number in 2000.[1]

People age 85 and older are the fastest growing segment of the entire population, with expected growth from 4 million people today to 20 million by 2050.[1] It is this group—the old, old—who consume the largest amount of Medicare resources. In fact, five percent of the Medicare population consumes 50 percent of the Medicare dollars.[1] Many of these "high consumers" are the frail elderly.

The implications of this "demographic imperative" are dramatic. We simply are not prepared for the burdens it will place on our health care and financing systems.

In addition, the nature of illness is changing due to longer life spans among our citizens as a result of public health measures and advances in medicine. Americans are not dying typically from acute diseases as they did in previous generations. Now chronic diseases such as diabetes and heart disease are the major cause of illness, disability, and death in this country, accounting currently for 75 percent of all deaths and 80 percent of all health resources used.[2] People live longer with disabling chronic conditions. On average, by age 75, older adults have between two to three chronic medical conditions and some have ten or twelve conditions.[3] Individuals with chronic illness have special health care needs, which involve greater care coordination and need for access to non-clinical support services.

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In addition to the special needs associated with chronic illness, older persons in general have unique characteristics that differentiate them from younger populations. But, the majority of physicians and health care practitioners caring for older patients have not been adequately trained in geriatrics. As a result, many practitioners may treat an 85-year old patient the same way they would a patient of 50 years—despite the remarkable differences between these patient populations. As a comparison, it has long been recognized that children's health care require a specialized knowledge base and no physician would treat a five-year old in the same manner as an adult patient.

It is time to give the field of geriatrics the recognition given to pediatrics.

Too often, illnesses in older people are misdiagnosed, overlooked or dismissed as the normal process of aging, simply because health care professionals are not trained to recognize how diseases and drugs affect older patients differently than younger patients. All of these situations potentially could translate into suffer-

ing by patients, concern from their caregivers and unnecessary costs to Medicare related to inappropriate hospitalizations, multiple visits to specialists who may order conflicting regimens of treatment and needless nursing home admissions. Special training is needed to prevent these outcomes. Geriatricians—physicians who specialize in the treatment of the frail elderly—are uniquely positioned to promote evidence-based, best practice for this vulnerable population.

A number of reports have been written on the need for increased geriatric training for physicians and other providers in order to meet the coming baby boom, beginning with the Institute of Medicine (IOM) in 1978.[4] Progress has been made, but as the IOM more recently noted, progress remains insufficient.[5]

The Medicare program has just undergone major reform: the addition of an outpatient prescription drug benefit and new disease management services. These are important changes designed to move this venerable program to the standards of the 21st century. At the same time, these changes do not fully address the needs of the frail elderly as they lack a physician-oriented chronic care delivery program for the frail elderly.

This report explores these and related issues at length by discussing:

- The history of geriatric medicine;
- The patients who need geriatric care;
- The benefits of geriatric care;
- Work force shortage issues related to geriatric care;
- The reasons for the geriatric shortage;
- Limitations in current Medicare reforms in this area; such as the difference between disease management and chronic care; and
- Proposed recommendations to improve the geriatric shortage.

# What Is Geriatrics?

Geriatrics is the branch of medicine that deals with the problems and diseases of older adults and aging. It is a relatively new field. Medical science has learned a lot about aging and age-related disease and how to prevent and manage such disease and associated chronic disability. Unfortunately, research and knowledge in geriatric medicine has not been transferred fully to the health care workforce, both because of the shortage of geriatricians, and the newness of the field.

What is a Geriatrician? Geriatricians are physicians who are experts in caring for older persons. They are primary care-oriented physicians who are initially trained in family practice or internal medicine and who are required to complete at least one additional year of fellowship training in geriatrics. Following their training, a geriatrician must pass an exam to be certified and then engage in continuous professional development, including passing a recertifying exam every ten years.

Geriatricians are physicians who are experts in caring for older persons.

Geriatric medicine training promotes specialized knowledge that focuses on quality care and safety for frail elderly persons. The following key features characterize geriatric care:

- Expertise in managing common conditions that affect older persons including dementia, falls, urinary incontinence, malnutrition, osteoporosis, sensory impairment, and depression;
- Understanding the interaction between aging and other conditions and diseases;
- Recognizing the effects of aging and other conditions on clinical health, physical and mental function and independence;
- Understanding the appropriate use of medications to avoid the potential hazards and unintended consequences of multiple medications;
- Coordinating care among other providers to help patients maintain functional independence and improve their overall quality of life;
- Evaluating and organizing health care and social services to preserve the independence and productivity of older persons; and
- Assisting families and other caregivers as they face decisions about declining capacity, independence, availability of support services, and end-of-life decision-making.

Using an interdisciplinary approach to medicine, geriatricians commonly work with a coordinated team of nurse practitioners, geriatric psychiatrists, medical and surgical specialists, physician assistants, pharmacists, social workers, physical and speech therapists and others. The geriatric team cares for the most complex and frail of the elderly population.

# Who Are the Patients that Need Geriatric Care?

Another common question is, "Do all patients need a geriatrician, just as most children regularly see a pediatrician?" The answer is no. Both work force realities and patient needs mean that a small portion of the Medicare population should access a geriatrician. Two discrete categories of beneficiaries need this access.

Approximately 15 percent of community dwelling Medicare beneficiaries need access to a geriatrician or geriatric services provided by a primary care physician.[6] In addition, residents of nursing homes and other congregate care facilities need access to quality, geriatric care.

The first category of non-institutionalized Medicare beneficiaries is comprised of seniors with multiple, complex chronic conditions. For these individuals, standard treatment for any one disease is not wholly appropriate given the complexity of interactions between their conditions and the aging process itself. The data suggests that frail elderly patients who are high utilizers of health care services lack adequate access to quality, geriatric care.

Twenty percent of the Medicare population has at least five chronic conditions, accounting for two thirds of total program spending.[2] These beneficiaries see on average 14 different/unique physicians in a year, have about thirty-seven office visits, and fill numerous prescriptions.[7] Fifty-five percent of these beneficiaries experience an inpatient hospital stay compared to five percent for those with one condition or nine percent for those with two conditions.[7] Finally, average annual prescriptions filled increased from 3.7 for all people studied with no chronic conditions to 49.2 for people with five or more chronic conditions.[7]

Individuals with five or more chronic conditions represent a large portion of a geriatrician's patient base. Geriatricians provide care coordination services to these patients based on their need for extensive family and patient telephone consultation, heavy pharmacological usage, and high need for transitional care as these patients move from different settings in the health care system.

Per capita spending and inappropriate utilization grows commensurate with a beneficiary's number of chronic conditions. For instance, beneficiaries with greater numbers of chronic conditions run considerably higher risk of hospitalizations for medical conditions that should have been treated on an outpatient basis before they got to a stage requiring hospitalization.[8] Access to quality, geriatric care could decrease inpatient utilization, thus decreasing costs to Medicare and improving beneficiary quality of life – all through the delivery of well coordinated clinical and social support services.

A vignette of a typical geriatric patient is provided below. All too often, these patients fall through the cracks of our health care system.

**An 87-year old woman is brought into a geriatrician's office by her daughter. The daughter is concerned about her mother's health, ability to drive and to live alone. Since her husband's death a few months ago, the patient has experienced a decline in her ability to care for herself. She has been behind in her bills, has been skipping meals, and recently had an automobile accident. She has been unsteady on her feet and reports having fallen several times over the last several months. Unwashed laundry in her home smells of urine. She sees several physicians for her arthritis, heart and lung diseases and takes several prescription medications from each physician. The daughter is unsure about whether her mother is actually filling the prescriptions or taking the medications. The daughter senses that, through better-coordinated care, her mother may be able to stay in her home and improve her physical health.**

The second category of geriatric patients is residents of long-term care facilities. These patients already receive some assessment and care coordination services, as mandated by federal law. While these services could be enhanced, in comparison to the outpatient setting these patients do benefit from the availability of assessment and care coordination services.

## The Benefits of Geriatric Care

Another important question for policy makers relates to the model of geriatric care. Are there proven benefits of geriatric care?

Over the past ten years, peer reviewed literature has strongly supported geriatric care systems. Some of these innovative care delivery models include: the use of geriatric assessment, ongoing care coordination, the use of a physician-directed multidisciplinary team and a holistic approach to patient care that involves clinical, psycho-social and environmental follow-up.[9,10]

Peer reviewed studies have demonstrated the following benefits of geriatric care:

- Preservation of physical function or slowing of decline;
- Dramatically increased patient and family satisfaction;
- Decreased time spent in an inpatient setting such as a hospital or nursing home;
- Improved social functioning in the community;
- Decreased rates of depression;
- Increased access to social support services; and
- Reduced disability.

These benefits are significant when delivered to the most complex and frail of the elderly population. Geriatric medicine promotes wellness and preventive care, with emphasis on care management and coordination that helps patients maintain functional independence in performing daily activities and improves their overall quality of life. As our nation ages and the baby boom population demands greater health care services, these benefits will be critical to maintaining productivity and an independent lifestyle.

## The Geriatric Training Gap – Is There a Shortage?

Today, there are approximately 7,600 certified geriatricians in the nation.[11] While estimates of potential needs for geriatricians vary, most experts agree that our nation faces a severe and worsening geriatric shortage, both in the area of clinical and academic geriatrics.

The Alliance for Aging Research estimated that another 14,000 geriatricians are currently needed to adequately care for the elderly population.[12] By 2030, they estimate the need to have 36,000 trained geriatricians.[12] A 1987 IOM study estimated the need for clinical geriatricians in 2000 to range from 9,000 to 29,000 depending on the mode of geriatric practice and other factors involving the quality of care delivered.[13] Based on both of these assumptions, the United States lags far behind in training an adequate supply of clinical geriatricians to care for the nation's frail elderly.

Office visits by geriatric patients comprise about 40 percent of the average internists' practice and about one quarter of all visits to family physicians.[19]

The supply of academic geriatricians is also insufficient. There are approximately 900 full time equivalent (FTE) academic geriatricians working in U.S. medical schools.[14] The Alliance for Aging Research estimates that 2,400 geriatric academicians are needed to perform various functions, such as integrating geriatrics into other specialties and across other health care settings, training new geriatric fellows, and translating new research into means of caring for older persons. Other studies had similar findings.[13] An IOM advisory panel recommended that at least nine academics trained in geriatrics sit in each medical school, but only 30 percent of medical schools have reached this target.[15]

As adequate numbers of geriatricians do not exist nationwide, geriatric faculty are needed to train other primary care and specialist physicians in the geriatric model of care. In this regard, program directors in family practice and internal medicine predict that 2,000 geriatric faculty are needed to train all medical residents, not just those in geriatric residency programs, in geriatric care principles.[5] A recent study suggests that shortages of geriatrics faculty in internal medicine and family practice residency programs still exist.[16]

While the number of physicians certified in geriatrics has increased over the past ten years, rates of growth are far behind projected need, due to inadequate numbers of individuals entering geriatrics and inadequate rates of recertification in geriatrics.

Given the number of geriatric fellowship slots in training programs, over 350 new geriatricians should enter practice each year. However, since 1999 geriatric fellowship training programs have graduated an average of 270 new geriatricians each year, and they operated at about 75 percent of enrollment capacity.[17] **(See Table I in Appendix regarding fellowship positions since academic year 1991-1992.)** Furthermore, re-certification rates average 50 percent; this is expected to decrease the total number of geriatricians over the next decade, despite growth in the number of geriatric training programs.[11,17] As geriatrics is a relatively new specialty, some geriatricians were initially certified without prior fellowship experience; these individuals have failed to recertify. This is contributing to an expected 27 percent decrease in the number of currently certified geriatricians from 1998 to 2004.[18]

The geriatric training gap is incongruous with the needs of our rapidly aging population or the reality of how all physicians actually spend their office time while in practice. The degree to which there is geriatrics training in physician specialties varies considerably. While just over 90 percent of all internal medicine residency programs include some geriatric curriculum, only 40 percent require geriatric medicine clinical training exceeding 25 half-days and about one-third of these programs require fewer than twelve half-days.[16] Family Practice residency programs require more training in geriatrics. Fifty five percent of family practice programs require more than 25 half days; nevertheless, 15 percent require less than six days of geriatrics training.[16] Of the many specialty and sub-specialty post-graduate training programs, only 27 of 91 non-pediatric programs, have any specific curriculum training requirements in geriatrics.[19] About 14,000 physicians in specialties other than family practice and internal medicine are certified each year, most of whom will have received no post-graduate experience in geriatric medicine as it relates to their field.[19]

Family Practice residency programs require more training in geriatrics.

The training gap is striking when considered in the context of the aging population. Office visits by geriatric patients comprise about 40 percent of the average internists' practice and about one quarter of all visits to family physicians.[19]

Data suggests that inadequate numbers of physicians are entering the geriatrics field. Additionally, non-geriatricians lack adequate training in geriatric principles. This is startling, considering the increasing longevity of Americans and prevalence of chronic conditions. The next section explores reasons for the work force shortage in geriatrics.

## Reasons for the Geriatrician Shortage

While interest in entering the field of geriatrics is slowly increasing, the number of geriatricians remains low and some training positions remain unfilled. In short, there remains a geriatric training gap. Despite the small but growing numbers of physicians selecting geriatrics as a career, practicing geriatricians reported unusually high job satisfaction in a recent study, even though satisfaction is marked by

the physicians practice environment and income, both of which have negatively influenced trainee desire to enter geriatrics.[20]

If there is a well-documented need for geriatricians and the job is satisfying, why aren't more physicians going into geriatrics?

The answer to this question is multi-faceted. Physician interest in a specialty or sub-specialty depends on various factors, such as patient demands for service, anticipated revenues, specialty interest developed through exposure during medical school, and preferences for where to train and to work.[21] In the case of geriatrics (despite the job satisfaction noted above), financial disincentives, which exacerbate large medical debt responsibilities, pose the largest barrier to entry into the field.

Geriatricians are almost entirely dependent on Medicare revenues, given their patient caseload. The IOM and MedPAC identified low Medicare reimbursement levels as a major reason for inadequate recruitment into geriatrics.[5,22] Geriatricians are financially disadvantaged relative to other physicians in the health care system, making geriatrics less attractive. The financial bias in the system favoring specialists and sub-specialists over primary care physicians is well recognized. Because of the complexity of care needed and the time required to deliver quality care, Medicare payment policies currently provides a disincentive for physicians to enter the field of geriatrics and to carry a full caseload of Medicare beneficiaries who are frail and chronically ill.

Geriatricians are almost entirely dependent on Medicare revenues, given their patient caseload.

***First,*** the physician payment system does not cover the cornerstone of geriatric care—assessments and the coordination and management of care—except in limited circumstances. Care management includes services such as telephone consultations with family members, medication management, and patient self-management services. Geriatricians spend considerably more time performing care management services than other providers.

***Second***, the Medicare physician reimbursement system bases payment levels on the time and effort required to see an "average" patient, and assumes that a physician's caseload will average out with patients who require longer to be seen and patients who require shorter times to be seen over a given time period. However, the caseload of a geriatrician will not "average" out. Geriatricians specialize in the care of frail, chronically ill older patients; the average age of the patient caseload is often over age 80.

Inadequate reimbursement ignores an important factor in treating medically complex and/or chronically ill patients; caring for these patients is fundamentally different than caring for the typical Medicare patient. All aspects of evaluation and management of patients are made more time consuming and difficult by these differences. History taking is more time consuming because of sensory, communication, and cognitive impairments and the frequent need to obtain additional

information from sources beyond the patient. Physicals are more time consuming because of mobility restrictions. Supplemental exams are required to care for the frail elderly including initial and subsequent assessments of hearing, vision, and mental status. Medical decision-making is more complex and more time consuming because of the interaction of multiple chronic illnesses and multiple medications. Care coordination needs are greater because the care must typically be coordinated with not only the patient but also caregivers. Indeed, many activities require significant non-face-to-face time—meaning pre- and post-service time outside of the office visit. Until these factors are acknowledged by the fee schedule, geriatric practices will not flourish nor will the geriatrician shortage end.

***Third,*** certain practice settings where geriatricians typically work may appear unattractive to trainees. For instance, many geriatricians spend all or part of their practice in a nursing home setting. This environment, with increased and typically not reimbursed telephone responsibilities, increasingly high malpractice premiums, complex patients with multiple co-morbidities, and historically low reimbursement, fails to attract many practicing physicians.

The limitations in Medicare reimbursement strongly influence geriatrician supply. Anecdotal evidence suggests that a sizable number of geriatricians cannot maintain a private practice without some level of subsidization to help sustain the practice, ranging from seeing non-Medicare patients to nursing home medical director responsibilities or other mechanisms. Clearly, until the reimbursement challenges are resolved, many trainees will not seek out geriatrics as a career option.

## Medicare Reform and the Geriatric Patient: How Does Disease Management Differ from Geriatric Care?

The Medicare program has recently undergone major reforms, such as the addition of outpatient prescription drug coverage and disease management. Will these new changes address the problems faced by frail older persons and the physicians who treat them?

Little is being done to change the nature of the system from acute episode care to sustained chronic care. The Medicare bill included several new chronic care provisions, including a new study on chronic care, a small scale physician-oriented demonstration program, and a larger scale disease management pilot program. However, as this section notes, the new disease management program may not adequately address the needs of persons with multiple chronic conditions.

The new disease management pilot program establishes chronic care improvement organizations (CCIOs) under the Medicare fee-for-service program. CCIOs, which may include disease management organizations, health insurers and integrated delivery systems, will be required to improve clinical quality and beneficiary satisfaction and achieve spending targets in Medicare for beneficiaries with

certain chronic conditions. CCIOs will be held at full risk for their role in helping beneficiaries manage health through decision-support tools and the development of a clinical database to track beneficiary health.

Why aren't disease management programs sufficient to transform the system of care for frail older persons?

Disease management covers many different activities influencing individual health status and the use of health care services. Typically, disease management programs treat patients with specific, clearly defined diseases, such as diabetes, asthma, congestive heart failure or chronic obstructive pulmonary disease where the evidence is clear and management strategies are straightforward. Disease management focuses on patient education and evidence-based self-management strategies as tools to improve care. Disease management relies on improved disease outcomes to improve health and reduce disease-specific health care utilization. Patients who are the best candidates for disease management programs are those who have the motivation and cognitive skills to appreciate their role in illness management and implement self-management strategies.

Geriatric care is another term for coordinated care or care management. Care coordination programs generally enroll patients with multiple chronic conditions. The combination of conditions puts the patients at high risk of medical and social complications that requires specific interventions tailored to the specific needs of each enrollee. These interventions include an array of services, such as telephone coordination with other physicians, extensive family caregiver support, referrals for social supports, and high levels of medication management.

While disease management is appropriate for certain Medicare beneficiaries with a single chronic condition, such as diabetes, asthma or hypertension, it fails to address key issues for patients that have multiple chronic illnesses and/or dementia. (**See Table II in Appendix**) This issue is further explored below.

***First,*** disease management is not typically appropriate for persons with more than one chronic condition. Imagine putting a patient with diabetes, hypertension, dementia, asthma, and COPD into a disease management program for each of these conditions. Most of the people who are most costly to Medicare have multiple conditions and the care for these people cannot be segmented into different disease management programs. In fact, many of these individuals with one or more chronic conditions also have Alzheimer's disease or another dementia. Disease management focusing on diabetes without taking dementia into account wouldn't be successful. While some disease management companies suggest that they have taken a new holistic approach to patient care, this evidence remains anecdotal.

***Second,*** when used for patients with multiple co-morbidities, disease management can disrupt a patient's critical relationship with a primary care physician. Some disease management programs utilize specialists that focus only on specific interventions tailored to one condition. The nature of chronic illness requires a comprehensive, care coordination-based approach that utilizes a variety of inter-

ventions. Disease management programs that lack a physician component do little to coordinate the care of older persons with multiple illnesses and little to mitigate the safety hazards of fragmented, redundant care delivered by multiple providers.

***Third,*** a major component of disease management involves self-management and patient education. These simply do not work for persons with Alzheimer's disease or a related dementia. Diabetes self-management often involves patient education, or patient self-management, which is inappropriate for a beneficiary with Alzheimer's disease or related dementia. Likewise, disease management for asthma and hypertension depends on patient compliance with treatment recommendations; this would not be effective for persons with Alzheimer's disease or related dementia. In comparison, care coordination models rely on engaging family and caregivers and maximizing their involvement.

***Fourth,*** disease management does not always address functional issues that are common in old age or the complications that arise from multiple chronic illnesses.

***Fifth,*** treatment guidelines provide little guidance when multiple chronic illnesses co-exist. Therapeutic decisions are less straightforward, making treatment decisions less amenable to algorithmic self-management protocols.

Finally, disease management programs place little importance on using social support services, a major component of a care coordination approach, which relies on a holistic model of patient care.

Additional physician participation and attention to the needs of multiple chronic conditions and especially dementia could improve project outcomes, but the model remains different from the approach of a new fee-for-service care coordination benefit.

The final section of this report suggests steps that could be taken to address the limitations in the new disease management program as well as in the health care system in general.

# Solutions

As the IOM and other organizations have noted over the past three decades, the nation will benefit from an increased supply of geriatricians. In addition to certified geriatricians, there is a need for increased geriatric training and awareness in other physician specialties and other health professions. To achieve these goals, policy makers should consider the following recommendations to create an appropriate market and incentives to generate more appropriately trained professionals:

**1. Traditional Medicare Payments:** As stated above, limitations in Medicare fee-for-service payments present a major barrier into entering geriatrics and providing high quality care to patients. Congress could make two changes to address this issue. First, Medicare should cover geriatric assessment and care coordi-

nation services. Second, Medicare should develop and implement a risk adjuster to account for the time and complexity involved with treating a frail elderly patient where a physician's practice has a high number of these patients. Revamping the fee schedule may help attract physicians and other appropriate non-physician professionals to a career in geriatrics.

**2. Medical Education Loan Forgiveness:** Data on the number of course offerings in geriatrics suggest that medical students are unaware of geriatrics and lack adequate incentives to enter the field. Furthermore, physicians who have an interest in pursuing geriatric fellowships are often discouraged because of their large education debt and the relatively low compensation after training. The Public Health Service and/or the National Institutes of Health could provide loan forgiveness to individuals who get a CAQ in geriatrics. This strategy has been used in other work force shortage areas in the past.

**3. Graduate Medical Education Changes:** Medicare graduate medical education (GME) is the primary financing system for physician training programs. In the past, Congress has used the GME program to create incentives to train increased numbers of geriatricians. Under the current law, hospitals receive limited Medicare GME funds for physician trainees. The 1997 Balanced Budget Act instituted a per-hospital overall cap on the number of GME slots that will be supported by the Medicare program. Policy makers should provide for further limited changes in this area by authorizing a limited waiver in the per hospital cap for geriatric trainees.

**4. Provide adequate funding for Title VII geriatrics programs:** Title VII of the Public Health Service Act provides three types of geriatric health professions programs: geriatric academic development awards, geriatric education centers, and awards to geriatric training programs. These programs address shortages in academic geriatrics. In recent years, Congress has increased funding for this program. Congress should continue these important increases.

**5. Maintain and expand the Title VII programs:** The geriatric health professions programs are up for Congressional reauthorization this year. The geriatric health professions programs have received tremendous commendations from current recipients for their efforts to increase the number of junior faculty in geriatrics and help multi-disciplinary geriatrics training programs grow. Congress should increase the authorization levels and expand these programs in other ways.

**6. Institute incentives for medical schools, as well as professional schools, to incorporate geriatrics into training programs:** As stated earlier in the report, many medical schools do not offer appropriate levels of geriatrics' focused curriculum, despite efforts by the Association of American Medical Colleges and others to increase geriatrics' curriculum. All health care professional schools, at all levels, should be incentivized to incorporate and highlight geriatrics into their curriculum.

7. **Medicare Chronic Illness Care Programs:** Under the new CCIO program, part of what could make one who is submitting a proposal successful is demonstrating that their care management team and staff have undergone some level of geriatric-specific training as it relates to the progression of disease for those conditions which the vendor proposes to manage. In addition, CMS could require each bidder to demonstrate a certain percentage of physician involvement in their CCIO. Another smaller demonstration authorizes a physician-based pay for performance model. Congress should further explore the value of the pay for performance model in improving patient care and adequately reimbursing physicians for information technology and other related care management expenses.

8. **Medicare and/or Medicaid Certified Nursing Homes:** Many geriatricians serve as nursing home medical directors. However, due to limited supply, some nursing home medical directors lack geriatrics training. As the primary payors for nursing home care, Medicare and Medicaid could use their purchasing power to create change over time. CMS could modify conditions of participation so that a certain percentage of staff would have to have completed some type of geriatric training. The industry would be provided time to comply with new training requirements.

# Conclusion

It is a policy imperative to facilitate development of a health care workforce that can address the needs of a growing elderly population. The demographics and concomitant concern over financing Medicare in the future makes the need for action a top priority. Movement toward change will take steady and long-term leadership that has to begin now. It will take a focused effort from policy makers to see that proper incentives are in place for geriatric care providers. These incentives must be sufficient to meet current and expected need.

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# Appendix

**Table I**
Geriatric Medicine Fellowship Programs
(Internal Medicine and Family Practice)

| Academic Year | Programs | Total # of Positions Available (All Years of Training) | Fellows (All Years of Training) & % of All Available Positions | 1st Year Fellows & % of All Fellows | Fellows 2nd Year & Beyond & % of All Fellows | IMGs(All Years of Training) | 1st Year Positions Available | 1st Year Fellows & % of Filled First Year Positions | Fellows Completing Program |
|---|---|---|---|---|---|---|---|---|---|
| 1991-1992 | 92 | 317 | 198 (62.5%) | -- | -- | 64 (32.3%) | -- | - | -- |
| 1992-1993 | 97 | 341 | 215 (63.0%) | -- | -- | 88 (40.9%) | -- | -- | 117 |
| 1993-1994 | 98 | 409 | 225 (55.0%) | -- | -- | 111 (49.3%) | 163 | -- | 118 |
| 1994-1995 | 99 | 406 | 220 (54.2%) | -- | -- | 115 (52.3%) | 192 | -- | 117 |
| 1995-1996 | 99 | 433 | 223 (51.5%) | 117 (52.5%) | 106 (47.5%) | 132 (59.2%) | 206 | 117 (56.8%) | 101 |
| 1996-1997 | 103 | 437 | 242 (55.4%) | 144 (59.5%) | 98 (40.5%) | 145 (59.9%) | 222 | 144 (64.9%) | 129 |
| 1997-1998 | 107 | 472 | 305 (64.6%) | 205 (67.2%) | 100 (32.8%) | 170 (55.7%) | 226 | 205 (90.7%) | 181 |
| 1998-1999 | 112 | 502 | 335 (66.7%) | 239 (71.3%) | 96 (28.7%) | 209 (62.4%) | 262 | 239 (91.2%) | 222 |
| 1999-2000 | 114 | 529 | 368 (69.6%) | 269 (73.1%) | 99 (26.9%) | 218 (59.2%) | 307 | 269 (87.6%) | 294 |
| 2000-2001 | 119 | 504 | 321 (63.7%) | 247 (76.9%) | 74 (23.1%) | 187 (58.3%) | 337 | 247 (73.3%) | 276 |
| 2001-2002 | 120 | 461 | 338 (73.3%) | 259 (76.6%) | 79 (23.4%) | 187 (55.3%) | 373 | 259 (69.4%) | 295 |
| 2002-2003 | 127 | 461 | 368 (79.8%) | 292 (79.3%) | 76 (20.7%) | 190 (51.6%) | 394 | 292 (74.1%) | -- |
| 2003-2004 | -- | -- | -- | -- | -- | -- | 430 | -- | -- |

**Source:** AMA and AAMC Data from National GME Census, JAMA 1992-2003
Note: 1998 was the first year candidates could sit for the Board with one year of training.

**Table II**
**Differences Between Disease Management and Case (or Care) Management**

| Characteristic | Disease Management | Case (Care) Management |
|---|---|---|
| | | |
| **Patient Population** | **People diagnosed with a specific disease** | **People at high risk for costly, adverse medical events and poor health outcomes.** |
| | | |
| **Methods for Identifying Patients** | **Data on the presence of a particular diagnosis; prescription for certain drugs used to treat a disease; referrals by physicians who treat many patients with that disease** | **Mailed questionnaires; data on use of hospital and emergency room services; referrals by physicians using criteria to identify "high risk" patients** |
| | | |
| **Patient Education** | **Standardized curriculum and educational materials for a specific disease** | **No standardization of curriculum or education materials; highly individualized** |
| | | |
| **Reliance on Evidence-Based Treatment Guidelines** | **High** | **Low** |
| | | |
| **Reliance on Protocols and Standardization** | **High** | **Low** |
| | | |
| **Importance of Using Social Support Services** | **Low** | **High** |
| | | |
| **Importance of Engaging Family and Caregivers** | **Low** | **High** |
| | | |
| **Reliance on Care Coordination** | **Medium** | **High** |

**Source:** Testimony of Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate, Special Committee on Aging, Sept. 19, 2002.

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The American Geriatrics Society is a nationwide, not-for-profit association of geriatric health care professionals dedicated to improving the health, independence, and quality of life for all older people. The AGS promotes high quality, comprehensive, and accessible care for America's older population, including those who are chronically ill and disabled. The organization provides leadership to health care professionals, policy makers, and the public by developing, implementing, and advocating programs in patient care, research, professional and public education, and public policy.

The Association of Directors of Geriatric Academic Programs was formed in the early 1990s to provide a forum for academic geriatric medicine divisions and program directors. Its purpose is to foster the enhancement of patient care, research, and teaching programs in geriatrics medicine within medical schools and their associated clinical programs. ADGAP is affiliated with the American Geriatrics Society in New York City and shares offices and staff with the AGS.

The Empire State Building, 350 Fifth Avenue, Suite 801, New York, New York 10118, (212) 308-1414, www.americangeriatrics.org