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I am Dr. John Murphy, Associate Professor, Residency Director and Director of the Division of Geriatrics, in the Brown University Department of Family Medicine. I am a geriatrician. Within the Brown University School of Medicine, at Memorial Hospital of Rhode Island, and nationally, a major focus of my professional career is on educating physicians in the care of older persons. In this capacity, I serve as a member of the Education Committee of the American Geriatrics Society. I appreciate the opportunity to participate in this forum today on behalf of the American Geriatrics Society.

I applaud the Senate Special Committee on Aging for holding this forum highlighting the national shortage of geriatric-trained health professionals. As a 1995 Department of Health and Human Services' report concluded, the need for adequately trained health care providers to identify and manage older persons' health care needs is urgent.

My testimony today will:

- Describe how our country's health care workforce is ill equipped to care for the aging of the baby boomers;
- Detail the key reasons for the shortage of geriatricians;
- Provide examples of current initiatives of the American Geriatrics Society to address this problem; and
- Suggest recommendations to increase the numbers of geriatric trained health care professionals in order to improve the quality of health care services provided to our Medicare beneficiaries.

THE PROBLEM: The U.S. health care workforce is ill equipped to care for the aging of the baby boomers.

Our country is aging rapidly. In 1900, there were 3.1 million Americans age 65 and older, and at the close of this century, there are roughly 35 million people. By the end of the next decade, we will see an even more dramatic increase in the growth of the older population, as a result of the post World War 11 "baby boom". By 2030, it is projected that one out of every five Americans will be over age 65. People age 85 and older is the fastest growing segment of the elderly, with expected growth from 4 million people today to 19 million by 2050. The implications of this "demographic imperative" are dramatic and we are not prepared.

In addition to longer life spans, the nature of illnesses are changing. Americans are not dying from the same diseases they did in previous generations. Chronic conditions are now the major cause of illness, disability and death in this country, accounting for 75 percent of all deaths today. People are now living longer with disabling chronic conditions, primarily as a result of medical advances, surgical interventions and pharmaceuticals. On average, by age 75, older adults have between 2 to 3 chronic medical conditions.

Aging is a significant women's issue. On average, women live 7 years longer than men and have more chronic illness and disability. Moreover, women occupy over 70 percent of nursing home beds in this

country.

Geriatrics is a relatively new field. Medical science has learned a lot about aging and how to prevent and manage disease and chronic illness. Unfortunately, this geriatric research and knowledge is not being spread through the health care workforce.

Geriatric medicine promotes wellness and preventive care, with emphasis on care management and coordination that help patients maintain functional independence and improve their overall quality of life. With an interdisciplinary approach to medicine, geriatricians work with a coordinated team of nurses, geriatric psychiatrists, physician assistants, pharmacists and others. Geriatricians strive to balance the use of expensive high-tech interventions with the potential harm these procedures can cause in older persons with multiple chronic illnesses.

I would like to share with you my reason for becoming a geriatrician. My medical education as a family physician was very strong. Yet, when first practicing as a junior faculty family physician, I found that I consistently ran into difficulty when caring for very frail older patients, unlike my experience in caring for other age groups. I was not alone in this experience, but very few colleagues were willing or able to seek the remedy that I chose. Most just shied away from the care of frail older patients. I decided to take a leave of absence from my faculty position and pursue fellowship training in Geriatrics

In my fellowship, I learned skills that had a dramatic impact on my ability to care for frail older adults, and this enhanced effectiveness also led to a sense of fulfillment, a feeling that was previously missing.

Older persons have unique characteristics that differentiate them from younger populations. Thus, special training is needed to identify them from younger populations. 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. This can translate into needless suffering and unnecessary costs to Medicare from inappropriate hospitalizations, multiple visits to specialists who may order conflicting regimens of treatment and needless nursing home admissions.

Three important and related problems need to be solved if we are going to deal effectively with the aging of our country:

1. Shortage of geriatricians -- physicians who specialize in caring for older adults: Geriatricians are physicians who are first board certified in family practice internal medicine or psychiatry, and then complete additional years of fellowship training in geriatrics. Geriatricians must pass a special certifying exam upon completion of training and pass a recertification exam every ten years thereafter.

Today, there are less than 9,000 certified geriatricians in the United States. This number is expected to drop by the year 2000, just as the baby boomer generation begins to reach Medicare eligibility. Many high level Federal panels, including the Institute of Medicine and HHS have documented this severe shortage and have called for significant increases in geriatricians.

Of the approximately 98,000 medical residency and fellowship positions supported by Medicare in 1998, only 324 were in geriatric medicine and geriatric psychiatry.

An increased number of trained geriatricians are critically needed as:

- **Academic Geriatricians:** Increases in geriatricians in medical schools are essential to train

primary care, specialist physicians, and other professionals to diagnose and treat problems common in older persons. They are also needed to lead clinical research activities in developing cures and treatments for the diseases that affect this population. Unfortunately, the situation for geriatricians in academic settings is getting worse. Geriatricians are being required to use a greater percentage of their time to generate clinical income to support their positions, which translates into less time for their teaching

- **Clinicians:** Geriatricians are needed as consultants to primary care physicians and as direct primary care providers to the most frail, chronically ill Medicare beneficiaries. Trained geriatricians can be more effective primary care providers for frail older persons, who have complex chronic health care problems. For these patients, geriatricians are often able to manage their care in the least resource intensive settings, obviating the need for more costly hospitalizations and nursing home placements.

Geriatric psychiatrists are needed to identify and manage the complex interactions of psychiatric disorders, the aging process, medical illness, and disability, as well as the psychological, social, cultural, economic and environmental factors that are relevant to the proper assessment and treatment of elderly patients. Of the 32 million Americans age 65 and over, an estimated 4 million suffer from dementing disorders such as Alzheimers' disease and nearly 5 million suffer from serious and persistent symptoms of depression.

2. Lack of training in schools for all professionals: All health care professionals doctors, nurses, and others - need adequate training in geriatrics. As the country ages, almost all health care professionals, except pediatricians, will be caring for growing numbers of older people.

However, medical schools and other professional schools have just recently begun to teach geriatrics, but current training is inadequate to prepare the country to care for the exploding numbers of older people. This lack of training has been documented by many studies, including those done by the Institute of Medicine and HHS.

For example, in academic year 1994-1995, only 10 percent of all U.S. medical schools required their students to complete a separate required course in geriatrics. Most other schools either offered geriatrics as an elective or included it as a small segment of another required course. When offered as an elective, most students are not taking geriatric courses.

A recent General Accounting Office (GAO) report underscores this problem. A key area of geriatrics training is palliative and end-of-life care. This GAO found that training was inadequate, with only about one-half of medical schools and residency programs educating students about end-of-life care.

3. Lack of training for current practicing professionals: The vast majority of current practicing physicians and other health care professionals have never had geriatrics training. Since there is a long pipeline before current students will be practicing, the country must train current practicing professionals in geriatrics to care for the growing numbers of older people.

Some examples of how illnesses of older people are misdiagnosed or dismissed as "normal" aging are:

- **Drug reactions:** Older patients can react differently to prescription drugs than younger people, and often take multiple drugs, ordered by multiple physicians, without any physician coordinating this use. A 1995 GAO study, commissioned by Senator Wyden, documented these problems and cited an FDA estimate that inappropriate drug use resulted in hospitalizations costing about \$20

billion annually.

- **Urinary incontinence:** Because it can trigger a series of other health care problems, incontinence is a leading cause of nursing home admissions in this country. However, this problem is usually treatable by exercises or medication. Unfortunately, this problem often goes undetected or is not treated properly.

Key Reason for Shortage of Geriatricians: Poor Medicare Reimbursement

A key reason for the lack of physician interest in a geriatrics career is financial.

Geriatricians are almost entirely dependent on Medicare revenues, because of their patient caseload. The Institute of Medicine report identified low Medicare reimbursement levels as a major reason for inadequate recruitment into geriatrics.

A recent article in the American College of Physicians Observer illustrated that geriatrics is one of the only specialties where a physician will spend additional years in medical school, only to reduce his or her earnings potential.

The Medicare fee-for-service system acts as a serious disincentive for physicians to provide quality care for Medicare beneficiaries, especially those who are frail and chronically ill:

- The physician payment system does not provide coverage for coordination and management of care, except in very limited circumstances, and does not support an interdisciplinary team of health care professionals. While the Medicare physician payment system provides reimbursement for hundreds of costly procedures, this system fails to pay for the scope of assessment and case management services provided by geriatricians and an interdisciplinary team of professionals that enhance care to patients. **I maintain this is the real problem in recruiting physicians to geriatrics.** The reimbursement system makes it difficult to provide effective care and few health care professionals can find fulfillment in doing a lousy job.
- Another issue is that the Medicare physician reimbursement system bases payment levels on an "average" patient, and assumes that a physician's caseload will average out 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, where the average age of the patient caseload is often over age 80. This is true not only for geriatricians, but for all primary care physicians who want to focus on caring for older Medicare beneficiaries.

In addition, we believe many more candidates would apply, despite the future financial implications, if they did not have such large, immediate loan payback obligations associated with financing their medical education.

Because of these problems, it is difficult for patients to find geriatricians in private practices in many areas of the country, including such unlikely places with large older populations as southern Florida. It is much more common for geriatricians to be employed by hospitals, nursing homes, HMOs and other institutional settings, which, recognize the cost-effective approach of geriatricians.

Current Initiatives of the American Geriatrics Society

The American Geriatrics Society (AGS) - the organization of over 6,000 geriatricians and other health care professionals specially trained in the management of care for older patients - has developed and implemented special programs to address the concerns of professionals and the public on aging issues. A key objective is to provide educational materials for current practicing health care professionals and students about the special health care needs of older patients. Some of these projects include:

- **AGS Clinical Practice Guideline: The Management of Chronic Pain in Older Persons** was just released this month. This new guideline seeks to dispel the myth that pain is a normal part of aging. Pain in older adults is underrecognized and undertreated. It is estimated that one out of every four older adults suffers from chronic pain. These first-ever guidelines seek to educate health care professionals and the public on how to recognize, assess, and treat pain in older Americans.
- **The Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine** is the Society's ground-breaking continuing education program for primary care providers. This detailed self-assessment program on the medical care of older adults has helped to define the knowledge base of geriatrics.
- **The AGS' Complete Guide to Aging & Health** is the Society's reference guide for the public on aging and health.
- **Hartford Geriatrics Training Initiatives**, funded by the John A. Hartford Foundation, advocate improved geriatric care in all medical and surgical specialties, as well as to practicing primary care physicians. The Initiatives reach out and make the principles of geriatric medicine accessible across disciplines and throughout the training and continuing education continuum.
- **The National Blue Initiative for Quality Senior Care**, begun in 1997 is a partnership between the AGS and the Blue Cross Blue Shield Association to develop and conduct educational programs for primary care physicians participating in BCBSA member plans with the purpose of promoting high quality care for older adults. Dr. Kanwal from Anthem Blue Cross and Blue Shield will be describing this program in more detail.
- **Geriatrics at Your Fingertips** is a new pocket-sized reference guide to clinical geriatrics which provides up-to-date, practical information on the evaluation and management of diseases and disorders that most commonly affect older persons.

Recommendations to increase the numbers of geriatric trained health care professionals

Clearly, the need to train all health care professionals - students and current practicing professionals - about the special needs of older adults and the need to encourage increased numbers of geriatricians should be a major priority of the Federal Government.

Through Medicare and Medicaid, the Federal Government is financing the vast majority of health care services to older Americans. The lack of appropriately trained health care providers translates into costly and unnecessary Medicare and Medicaid spending and poor quality of life for older people.

We urge Congress to consider adopting the following recommendations:

1. Revise the current Medicare physician payment system to promote care management services

for chronically ill beneficiaries. While enrollment in Medicare managed care plans is expected to increase significantly, many older Americans who are frail or chronically ill are likely to choose to remain in the traditional fee-for-service program for the foreseeable future.

Therefore, the traditional fee-for-service Medicare program must be revamped to provide incentives to better manage care for frail, chronically ill patients. These patients need coordination and management services and care by an interdisciplinary team. These services will not only improve the quality of care, but will reduce unnecessary Medicare spending on duplicative and potentially harmful services. Medicare payment policies should reimburse for coordination and management services and interdisciplinary teams, and make special payments for professionals who spend extra time with frail, older patients. Refining the fee schedule will also be key to attracting physicians and other professionals to a career in geriatrics.

2. Institute loan repayments for fellows in geriatric medicine. S. 780 introduced one year ago by Senators Reid, Grassley and Glenn would forgive \$20,000 of educational debt incurred by medical students for geriatric fellows. Physicians who have an interest in pursuing geriatric fellowships are often discouraged because of their large educational debt.

3. Increase Medicare graduate medical education (GME) payments for fellows in geriatric medicine. S. 779 introduced one year ago by Senators Reid, Grassley and Glenn would provide increased GME payments to provide incentives to teaching institutions to promote the availability of fellowships and recruit geriatric fellows.

4. Institute a new program for geriatric academicians: S. 1754, the health professions reauthorization bill, approved by the Senate Labor and Human Resources Committee last month, would create a faculty development program for geriatrics health professionals. Specifically, it would provide salary support for junior faculty who will learn teaching methods and implement these in health professions schools. Senator Reed of this Committee, from my home state of Rhode Island, was instrumental in obtaining this provision.

5. Provide adequate funding support for Title VII geriatric programs: It is essential that adequate appropriations be provided for geriatric education centers, geriatric faculty training programs, and for primary care training programs which emphasize geriatric curriculum.

6. Provide an exception to the overall graduate medical education cap for geriatricians: The 1997 Balanced Budget Act instituted an overall cap on the number of graduate medical education slots that will be supported by the Medicare program. This provision should be amended to exclude geriatric fellows. In addition, the cap should be revised to include in the base those primary care residents who were training in outpatient and long term care settings when the base year was established.

7. Provide payment for GME to non hospital providers: The 1997 Balanced Budget Act authorized GME payments to non-hospital providers. HCFA has just issued a proposed rule to implement this provision that would not reimburse nursing homes, and hospice for training. It is critical that residents and fellows are trained in these settings in order to provide high quality care to Medicare beneficiaries.

8. Institute incentives for medical schools, as well as all professional schools, to incorporate geriatrics into training programs: All health care professional schools, at all levels, must immediately incorporate and highlight geriatrics, including palliative and end-of-life care issues, into their curriculum.

9. Institute incentives for current practicing professionals to take geriatrics continuing medical education: Medicare policies should be revised to provide incentives for all health care professionals to have some level of geriatric continuing medical education credits, including end-of-life care and palliative care training.

10. Conduct innovative demonstrations that promote high quality interdisciplinary care, such as MediCaring: HCFA should conduct new demonstration programs to promote better models of coordination for chronically ill patients. Improving quality of care and functional status should be a key element of these demonstrations. A high priority should be placed on conducting models that would improve end-of-life care, such as MediCaring. The goal of MediCaring would be reduce unnecessary, high cost, acute care services at the end of life, thereby leaving more financial opportunity for coordination, continuity and comfort.

11. Assure new evaluation and management documentation guidelines are workable for geriatricians: New Medicare documentation guidelines would place an extraordinary burden on geriatricians and have unintended consequences for frail, older persons with chronic illnesses. While these guidelines are now being revised, Congress should assure that any revisions reflect the types and complexity of services provided by geriatricians. Moreover, these guidelines should be pilot tested, prior to implementation, at a representative sample of geriatric practices.

We would like to work with this Committee, the Medicare Commission, and others to obtain these important changes. The challenge will be looking beyond the Medicare system to reform the way we approach medical care for older Americans in general. Failure to act in this area is likely to result in billions of Medicare and Medicaid dollars being spent for ineffective services, as well as, poorer quality.