

**"LIVING LONGER, LIVING STRONGER...." Testimony before the Senate Special Committee
on Aging
Official Forum
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Presented by
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Senator Reid and other members of this senate forum, I am Steven L. Phillips, Medical Director of Senior Dimensions Medicare-risk HMO out of Las Vegas, Nevada which is a HCFA designated Social Health Maintenance Organization 11 (SHM011). As a geriatrician who is actively involved in both the clinical and administrative roles of health care for older Americans I am truly honored to have this opportunity to address the Geriatric Imperative.

The American population is aging and with this comes new challenges regarding the nations ability to appropriately care for its elderly. At the beginning of the 20th century those over 65 accounted for 4% of the total population. They now account for 12% and are consuming 33% of all health-care dollars and by 2030 will represent 20% of all Americans and require nearly half of all health-care dollars. Needless to say America is in the midst of an unprecedented demographic shift due to people living longer and the promotion of Baby Boomers into their seventh and eighth decades of life. We have yet to realize the consequences of this transition within our society and the overall implications for various social institutions, families and individuals. From a healthcare perspective the prevention of disease and loss of ability to function in daily activities and provision of treatments to reduce the effects of disease upon medical, psychological, functional and social domains represents the Geriatric Imperative of the 21st century. Physicians and other healthcare professionals who understand the medical, psychological, functional and social aspects of aging will be better prepared to meet the current and future challenges facing our nation. The potential for harm and incurring unnecessary expense to an already strained health-care system is what can occur when a diagnosis is missed or unnecessary treatment or intervention rendered. The field of Geriatrics focuses on the whole person by dealing with multiple, complex and interrelated conditions that can ultimately result in functional decline and therefore the loss of independence. The World Health Organization stated over three decades ago that "Health in the elderly is best measured in terms of function" and that "the degree of fitness rather than the extent of pathology may be used as a measure of the amount of services the aged will require from the community." In other words the cost of health-care for an aging society can be viewed as being inversely proportional to functional status. The current health-care delivery model of organ-specific disease management does not begin to address the basic issues of functionality. Physicians and other health-care professionals must shift their focus towards the identification and restoration of function. How we as a nation care for this population is dependent upon the efforts of medical and other professional schools, academic training programs, national geriatric and gerontologic organizations, and health-care delivery organizations.

The role of medical and other professional schools is to increase the number of teachers in order to provide meaningful educational curriculum to their respective students and graduates for both primary-care and specialty practices. Reuben et al determined through a survey process that the current deficit of geriatrics faculty members was severe and would likely get worse unless substantial increases in geriatrics fellowship positions and mid-career training positions occurred. These deficits existed in medical and non-medical faculty positions across the board. The same scenario exists with physician equivalents and geriatricians required to provide for the growing elderly population between 2000 and 2030. Without adequate numbers of medical and non-medical faculty with expertise in the field of geriatrics the likelihood of meeting the projected manpower needs within clinical geriatrics is poor. The

proceedings of a conference on geriatrics curriculum development was published in 1994 in the American Journal of Medicine and identifies the core elements required at the undergraduate, graduate and post-graduate levels. The problems that exist now and into the future have been recognized with regards to the shortage of a geriatric workforce. The limiting factor is an adequate funding source to bring about the expansion of current programs and the reformation of the curriculum being taught at the undergraduate, graduate and post-graduate levels of most institutions for higher learning.

Within geriatrics and gerontology there are several national organizations working on solutions to the Geriatric Imperative. They are teaming up with governmental agencies, the pharmaceutical industry, managed care organizations and the health-care service industries. These organizations include the American Association for Geriatric Psychiatry, the American Federation for Aging Research, the American Geriatrics Society, the American Medical Directors Association, and the Gerontological Society of America. They are representative of those medical and non-medical service areas that by working in an interdisciplinary approach can provide for the medical, psychological, functional and social needs of the elderly. These organizations are committed to meeting the challenges of the 21st century and need to be applauded for their efforts. Though these organizations can not do it alone and require additional funding in order to expand their activities and build further links with academic and clinical institutions throughout the country.

Another party actively involved in the Geriatric Imperative are the managed care organizations. With an increasing number of elderly joining Medicare-risk health maintenance organizations (HMOs) there is a definite opportunity to improve the continuity of care and develop new approaches to service delivery for this defined population. As of May 1997 a total of 4.6 million persons were enrolled in risk contracts which represented an increase of 1 million in a single year. In April 1993 there were 118 health plans with Medicare risk contracts and by May 1997 there were a total of 280. Medicare-risk contracting allows for the creation of a global budget for Medicare services in contrast to the payment for individual services under traditional fee-for-service. A report by Kramer et al in 1992 categorized the most frequently encountered geriatric programs by the following six objectives: (1) identifying high risk patients, (2) assessing multi-problem patients, (3) treating multi-problem patients, (4) rehabilitating patients following acute events, (5) reducing medication problems, and (6) providing long-term care and home care. They identified many unique programs that included screening methods for new enrollees, approaches to comprehensive geriatric assessment, use of skilled nursing facilities for intensive rehabilitation and post-acute care, and drug profiling and review. The utilization of geriatric nurse specialists, advanced practitioners of nursing and social services were pervasive throughout many of these HMOs. They concluded that the geriatric initiatives observed were often not implemented throughout the entire HMO. Instead they involved several motivated staff with training and experience in geriatrics at one or more care centers. They suggested that this was the result of too few practitioners trained in geriatrics and a reluctance on the part of the HMO to allow system-wide deviation from the traditional fee-for-service based approach to care. The authors felt that in order to enhance geriatric care, we must carefully design demonstration programs, rigorously evaluate the benefits and costs of more integrated geriatric services, and refine programs based on evaluation findings. Just such a demonstration is occurring presently in the state of Nevada through the Health Plan of Nevada Senior Dimensions Medicare risk HMO. This demonstration is called the Social Health Maintenance Organization 11 (SHMO11). The SHMO 11 is a designated Health Care Financing Administration (HCFA) demonstration project that is funded through a risk adjusted payment mechanism. The intent of SHMO 11 is to address medical, psychological, functional, and social needs of seniors in a coordinated manner. There are three components within the SHMO 11 demonstration: Care Coordination; Extended Care Benefits; and a Geriatric Resource Team.

Care Coordination is based upon the elements of:

- -screening for risk;
- -assessment of those identified to be at-risk;
- -development of a plan of care based upon identified risks;
- -implementation of the plan of care;
- -monitoring the plan of care;
- -reassessment of the patient;
- -evaluation of the plan of care; and
- -reporting of the outcomes.

Each element is critical to the overall success of adequately addressing the medical, psychological, functional, and social needs of the senior population that is being served.

The Extended Care Benefits are designed specifically to augment the health plan's existing benefits and community based-services. They are made available through the Care Coordination process and are not an entitlement, rather they are determined by established criteria. These benefits include:

- -counseling for situational disorders;
- -nutritional services;
- -transportation;
- -personal care;
- -homemaker services;
- -adult day care;
- -in-home companion;
- -short-term institutional care;
- -short-term group home care;
- -maintenance therapy;
- -home safety; and
- -a personal emergency response system.

The rationale behind the use of these services is to reduce the burden of disease while maintaining the member's health in the safest and most independent environment possible.

The final component of the SHMO 11 demonstration project is the Geriatric Resource Team (GRT). The GRT is represented by multiple health care disciplines that assist in further clarification of the needs of high-risk member's. The GRT provides intervention recommendations and assists the primary care providers with reassessment and evaluation as needed. In addition to its clinical role the GRT serves as an educational resource for the entire health care delivery system. A core knowledge of geriatric expertise is often lacking with both traditional Medicare and Medicare Risk HMO delivery settings. For this reason the SHMO 11 demonstration incorporated the development of a GRT into the study design.

Presently there are a total of six (6) Medicare HMOs that have been selected by HCFA to participate in the SHMO 11 demonstration. Due to the complexity of this program only one (1) of the selected participants is operational at this time. That HMO is Health Plan of Nevada and has truly placed the state of Nevada squarely in the forefront of senior health care in the United States. The SHMO 11 demonstration is available through Senior Dimensions Extended Care (SDEC). SDEC became operational on November 1, 1996 in Las Vegas, Nevada and began to be offered in the Reno/Sparks area on April 1, 1998. Over the next several years, Care Coordination, Extended Care Benefits and a Geriatric Resource Team or their equivalents are likely to become a standard of practice within all Medicare-risk HMOs. This demonstration has allowed for the creation of a true continuum of care directed and coordinated through an interdisciplinary approach that ensures the appropriate utilization of resources based principally upon the needs of the members served. At the end of our first eighteen

months, we have been successful in maintaining 85 percent of our at risk members for nursing home placement in a less restrictive environment.

The SHMO 11 demonstration is supporting the development of an integrated delivery system that is based upon enhancing the role of primary care physicians. As pointed out by Edward H. Wagner, MID, MPH, "we are at a crossroads and the integrated primary care model has the ability to reach all older adults, not just a targeted subset, while maintaining patients' crucial relationships with their doctors as well as continuity of care." Until recently there has been no motivation nor adequate knowledge for HMOs to change their delivery model in order to more appropriately meet the needs of an older and more functionally impaired patient population. The reality of market competition and ever increasing costs has finally provided the motivation for change. The successful HMOs will develop clinical glide paths, organized primary care teams with adequate information and management support with ready access to geriatric expertise. The critical factors include the willingness of an HMO to change, primary care physicians committed to a better way of caring for their elderly patients and a core group of geriatricians to develop and assist in the implementation of change.

The HMO Workgroup on Care Management, convened under the auspices of the Robert Wood Johnson Foundation's national program, "Chronic Care Initiatives in HMO's," recently published their recommendations on the type of services that should realistically be available to older adults who are enrolled in an HMO with a Medicare risk contract. These recommendations are based upon the goals of geriatric care: to promote health, independence, and optimal functioning, to prevent avoidable decline in health status, and to enhance quality of life. The essential characteristics that all HMO's with Medicare risk contracts need to provide and ultimately be held accountable for include:

1. Has a systematic program for identifying enrollees at high risk for adverse health outcomes.
2. Makes available a geriatric case management program that proactively serves high-risk enrollees in all settings-including clinic, home, and institution-in order to promote functional independence, prevent functional decline, enhance quality of life, and ensure the appropriate use of health services.
3. Makes geriatric expertise available for designing and administering geriatric programs and for consultation with primary care physicians, case managers and other providers.
4. Facilitates geriatric education and training for case managers, primary care physicians, and other health professionals.
5. Makes available programs to educate frail or chronically ill enrollees and their caregivers in self-care.
6. Has mechanisms to identify and coordinate services to meet enrollees' social needs.
7. Makes available wellness programs designed to promote successful aging and healthy living.
8. Makes data available to providers through a management information system.

Measures ongoing performance of selected geriatric care processes and outcomes as part of continuous quality improvement.

Recommendations for Geriatric Policy:

- 1 . Emphasize geriatric training at the undergraduate, graduate and post-graduate levels in all future

Federal and State initiatives.

2. Schools of Medicine, Nursing and other Allied Health Care Professionals will develop curricula that foster an understanding and willingness to work within the field of geriatrics.
3. Institute requirements that all health care professionals have a specified number of CME, CEU or other equivalent continuing education credits which pertain to the field of geriatrics.
4. Eliminate impediments (lack of adequate funding, fragmented system of care) that inhibit health care professionals and organizations/institutions from delivering the most appropriate care based upon an individual's needs and personal desires.
5. Create a demonstration program that fosters the partnering of the multiple components of geriatric health-care into a model program that incorporates all of the discrete parts into a united project with a common goal of maximizing the care of those they serve.
6. Current standards for Medicare risk HMO's must be revised to reflect the needs of frail, chronically ill patients to assure quality care and to guard against incentives to deny appropriate care.
7. Quality standards must be prescribed in federal law, with more detailed requirements provided in regulations to act as indicators of possible problems and the reporting of these standards are monitored on a timely basis.