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Donald A. Jurivich, D.O
Beth and George Vitoux Associate Professor of Medicine
Chief, Section of Geriatric Medicine
University of Illinois at Chicago College of Medicine

Executive Summary

Among many agendas for elderly, the 2005 White House Conference on Aging would wisely focus on the future role and support of Geriatric Medicine in this nation. An appeal is made here for the WHCOA to understand and vigorously build our nation's medical workforce in Geriatric Medicine. Interdisciplinary in nature, a primary force in Geriatric Medicine is the Geriatrician. These physicians specifically train in the recognition and treatment of disease in old age as well as frailty. To meet the increasing needs of the aging population, geriatricians and their healthcare team members need new mechanisms to advance their numbers and ability to handle the population explosion of senior Americans.

Refinement of existing and introduction of new programs on aging are proposed. These suggestions fall into Education, Research, Clinical Services and Administrative categories. Current congressional efforts, such as the Geriatric and Chronic Care Management Act (S. 2593 and HR. 4689), are key steps in addressing the future of Geriatric health care. Additional legislative steps are needed at the State and Federal levels. These steps include: malpractice reform, increased incentives for the practice of geriatric medicine, and funding of interdisciplinary geriatric healthcare teams. Better partnerships are needed between State government and their Universities, thus each state in the Union should be expected to support their university campuses with Centers on Aging that comprehensively address education, research and clinical services for their aging citizens. The Department of Veterans Affairs should be charged with further standardization of veteran health care benefits in geriatric medicine as well as bolster research and education in all VA facilities rather than just a few centers.

In short, the WHCOA can greatly enhance the practice of Geriatric Medicine in this country by improving Geriatrician support in two ways. Firstly, Medicare can be changed to provide the tools of geriatric practice, namely, an interdisciplinary team. Secondly, it can change reimbursement schedules for geriatricians to make this a medical specialty of choice. By taking these steps, we can expect much needed growth in a field that is uniquely committed to solving problems of the aging population.

Introduction

As a physician dedicated to understanding the infirmities of old age and seeking ways to lessen physical, cognitive, and psychosocial disabilities of senior citizens, I wish to present the Policy Committee with ideas for meeting upcoming challenges of our aging population. I present these ideas as an academic physician who provides direct clinical care of elderly, educates the next generation of physicians, and investigates how age affects basic responses to physiological stress. In addition to speaking on clinical research and education, I wish to recommend ways to enhance State and Federal programs for the advancement of healthy aging.

Background

Geriatric medicine, a distinct discipline in internal medicine and family practice, developed in this nation as a response to the population explosion of aging seniors and the ever increasing amount of age – related disabilities. T. S. Eliot once wrote in *Gerontion*, "I have lost my sight, smell, hearing, taste and touch. How should I use them for your closer contact ?" The poet's lines echo a sense of disability associated with age as well as a sense of hope for preservation of our functional abilities in late life. Strides in health care continue to push our average life expectancy, yet we have not made as significant progress in dealing with chronic conditions and frailty at the end of our life-spans. While acute and catastrophic illnesses continue to afflict us, the emerging health paradigms necessarily need to focus on multiple chronic conditions in our elderly. To meet our future challenges, the Federal government must modify existing programs and implement new ones that will aggressively meet the health care needs of our aging society.

Training and Sustaining Geriatricians

Optimally, this nation should have one geriatrician for every 500 frail elderly. We fall well short of this goal for many reasons. The practice of Geriatric Medicine is difficult because current physician reimbursement is not commensurate with incredibly complex and lengthy patient encounters. Furthermore, geriatricians have not been given the proper tools for their practice, namely, interdisciplinary healthcare teams. Both of these problems are further confounded by medical malpractice insurance rates that increasingly consume resources better utilized for senior health services. Thus, the future training and maintenance of geriatricians in this nation depends on Federal leadership in meeting the professional needs of this exceptionally dedicated group of physicians. To do so, the following recommendations are suggested:

a) Enhance Medicare reimbursement for physicians with fellowship training in Geriatric Medicine. For example, allocate 100 rather than 85 % of Medicare allowable charges for professional services or support adequate reimbursement with extended geriatric visit codes.
b) Charge CMS with developing and funding reimbursement codes that adequately fund care of *frail* elderly.

c) Create comprehensive geriatric assessment and chronic disease management as a Medicare benefit (e.g., pass the Geriatric and Chronic Care Management Act (S. 2593 and HR. 4689).
d) Develop a national strategy for solving the malpractice crisis.
e) Provide incentives for Geriatric Medicine. For example, provide Federal coverage of Medical Liability costs for fellowship-trained Geriatricians comparable to the federal program for VA staff physicians.
f) Modify Medicare Part A or Graduate Medical Education to provide hospital-based medical directorships in Geriatric Medicine and fund inter-disciplinary health care teams.
g) Support 2nd and 3rd year geriatric fellowship training with special emphasis on research on innovative models of healthcare for elderly.
h) Increase the total number of geriatricians through a variety of mechanisms, including increased number of residency slots, increased GME funding to hospitals that develop geriatric residency slots, loan forgiveness programs, increased State 20 waiver programs for foreign medical graduates as well as designating "manpower shortage areas" where less than 1 geriatrician exists per 1000 frail elderly.

Geriatric Team Healthcare

Geriatric medicine entails interdisciplinary work. Thus, adequately trained professionals in geriatric nursing, pharmacy, social work, physical / occupational therapy, nutrition, dentistry and public health are greatly needed. Training of these professionals often takes place in traditional university departments and little incentive is given for cross – training between departments. To solve this problem, resources need to stimulate inter – departmental education and research. Recommendations to enhance inter – disciplinary education and research include:

a. Create program grants for Universities to provide recurrent support of health sciences faculty trained or certified in geriatric medicine or gerontology.

b. Mandate universities that receive Federal funds to establish Centers on Aging with explicit missions to advance interdisciplinary education and research on Geriatric Medicine & Human Aging.

c. Expand and extend Geriatric Educational Centers to five year renewable grants.

State Universities & Aging

Each state in the union should establish Centers on Aging at their respective state-funded medical schools. The mission of State Centers on Aging should include:

a) interdisciplinary geriatric education from undergraduate to post – graduate studies,

b) research on urban and rural models of geriatric healthcare,

c) clinical services in Comprehensive Geriatric Assessment, Senior Driving Evaluations, and coordinated healthcare (e.g., Geriatric Medicine & Emergency Medicine)

d) resource center on aging and health for state citizens and public representatives

These Centers on Aging should receive stable and recurrent funding as a Federal – State partnership.

Veterans Administration

The VA has been a leader in Geriatric Medicine for nearly a quarter century. The Geriatric Evaluation and Management programs have been true "GEMs" as models of healthcare for elderly veterans. Furthermore, the Geriatric Research, Education and Clinical Centers (GRECCs) have forged new avenues for understanding and dealing with the aging process. VA medical research has a special section on Aging and Geriatric Medicine. Indeed, the Millennium Act by Congress details for the first time long term care benefits for aging vets. All of these programs have significant merit, but inconsistent application across the country. To rectify regional discrepancies in resources for Geriatric Medicine, the following measures are proposed:

a. Expand GRECC programs. Each major metropolitan area in the country should have a multi-institutional GRECC whereby area medical schools can jointly advance new solutions in geriatric healthcare and education.

b. Further standardize clinical benefits for aging veterans. Mandate that each tertiary VA medical center have a comprehensive Continuum of Care, including in-patient *and* out-patient GEM programs, in-patient hospice units, sub acute care, assisted living and skilled nursing care, and home health care. These programs should be staffed with interdisciplinary teams lead by geriatricians with a target of 1 geriatrician per 500 frail community dwelling veterans.

c. Re-design VA medical research. Firstly, VA research should fund only physician investigators with a provision for PhD collaborators. This provision would attract & retain talented physicians in the VA system who would otherwise flock to the private sector. Secondly, Aging and Geriatric Medicine research should be expanded significantly by increasing funding levels of geriatrician – initiated research grants to the 50% level. This preferential funding level is needed to overcome traditional biases among "old guard" scientists against interdisciplinary research and geriatric medicine in particular. Thirdly, each VISN should receive an equal share of research money for basic and clinical investigations in Geriatric Medicine.

d. Enhance administrative leadership in Geriatric Medicine and Chronic Disease Management. Each VA should have a physician-appointed Associate Chief of Staff in Geriatric Medicine and Chronic Disease Management as well as an administrative equivalent in the Director's office. These administrative leaders should have sufficient support staff to track Geriatric outcomes in frailty and multiple chronic diseases, educate staff about geriatric healthcare and implement facility – specific solutions (e.g., geriatric day hospital).

State Professional Societies in Geriatric Medicine & State Partnerships

The mission of professional organizations such as the American Geriatrics Society and the American Medical Directors Association is to promote good health care for the aging and frail population. These national organizations have state affiliates of physician and allied health professionals who are advocates for senior health and well being. Partnerships between Departments on Aging from each state and State Geriatric Societies offer a unique opportunity for administrators and legislators to understand and solve geriatric problems at the ground level. Thus, to advance a partnership between States and Geriatric Professional Societies the following recommendation is made:

a) Establish funds for a State Commission on Aging as part of the Department on Aging or its equivalent such that geriatricians and allied health professionals can serve as advisors to the DOA, governors office and the state legislative branch.