STATEMENT OF

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Introduction

Good afternoon Chairman Kohl, Ranking Member Smith and Members of the Committee:

Thank you for allowing the American Geriatrics Society to testify today on the important role of geriatric assessments and chronic care coordination services in improving health and quality of life for elderly patients.

I am Dr. Todd Semla, a registered pharmacist, Clinical Pharmacy Specialist for Pharmacy Benefits Management and the Strategic Health Group at the VA, and Associate Professor in the Department of Psychiatry & Behavioral Science at Northwestern University's Feinberg Medical School. The views that I express today are solely those of the American Geriatrics Society and do not necessarily represent the views of the Department of Veterans Affairs nor Northwestern University.

I appreciate the opportunity to participate in today's hearing as President of the American Geriatrics Society, a non-profit organization of over 6,700 health professionals devoted to improving the health, independence and quality of life of all older Americans. The Society provides leadership to healthcare professionals, policy makers and the public by advocating for and implementing programs on patient care, research, professional and public education, and public policy.

The American Geriatrics Society strongly supports the Geriatric Assessment and Chronic Care Coordination Act, because it will create a patient based approach to healthcare under Medicare that will benefit patients and lower their healthcare utilization rates. We believe that the geriatric assessment and care coordination benefits this legislation would establish will not only dramatically improve the care received by the sickest and most vulnerable patients in the Medicare population, but it will also impact the lives of their loved ones who are their caregivers by providing them the resources to better care for their parents, grandparents, brothers and sisters.

We applaud Senator Blanche Lincoln and Congressman Gene Green for their continued support and leadership of this issue and this legislation.

Today I will briefly outline the need for chronic care coordination under Medicare.. Tantamount to our discussion today are the needs of our parents, aunts, uncles, and other relatives and friends who have multiple chronic conditions, who are in need of care coordination services.

Simply put, care coordination puts the patient at the center of care. The emphasis shifts from disconnected management of illness by multiple professionals to coordinated, comprehensive management of the patient's health. In June 2006, the Medicare Payment

Advisory Commission ("MedPAC") -- an independent group established to advise Congress on issues impacting Medicare -- stated that “[c]are coordination has the potential to improve value in the Medicare program. Even if individual providers deliver high quality, efficient care, overall care for a beneficiary may be sub-optimal if providers do not coordinate across settings or assist beneficiaries in managing their conditions between visits.”

The History of Geriatrics

Before I begin to discuss chronic care issues, it is necessary to place geriatrics in context. Geriatric medicine promotes preventive care, with an emphasis on care management and coordination that helps patients maintain functional independence in performing daily activities and improves their overall quality of life. Geriatric care, and chronic care coordination in particular, emphasizes primary care, which includes continuing care of all medical conditions and is not limited by cause, organ system, or diagnosis.

Geriatricians are physicians who are experts in caring for older persons. Geriatricians are primary care physicians who complete residencies in family practice or internal medicine and who, since 1994, also are required to satisfactorily 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 pass a recertifying exam every 10 years.

Geriatric training emphasizes an interdisciplinary approach to medicine. Therefore, geriatricians typically work with a coordinated team of other providers such as nurses, pharmacists, social workers, and others to coordinate the care provided to these very ill patients. The geriatric team most often cares for the most complex and frail of the elderly population. However, with the aging of the Baby Boom Generation, geriatricians and geriatric teams have been caring increasingly for a larger population of aging, healthy Americans. The American Geriatrics Society enthusiastically supports the patient centered model of care outlined in the Geriatric Assessment and Chronic Care Coordination Act.

The Chronically Ill Population

The number of Americans living longer is large and rapidly growing. In July 2003, 35.9 million Americans were aged 65 and older, which constituted 12% of the US population. The US Census Bureau projects that the over-65 Medicare population will more than double to 72 million in 2030, at which time it will account for nearly 20% of the US population. The number of people over 85 is also expected to double from 4.7 million in 2003 to 9.6 million in 2030, and to double again to 20.9 million in 2050 with the aging of the Baby Boom Generation. America is on the threshold of an historic population shift upward.

As life expectancy increases due to the improving quality of healthcare and the achievements in modern medicine, the number of older Americans living with chronic disease also expands. Partnership for Solutions, a Robert Wood Johnson funded initiative

of which we are a partner, has found that about 78% of the Medicare population has at least one chronic condition, while almost 63% have two or more. Of this group with two or more conditions, almost one-third (20% of the total Medicare population) has five or more chronic conditions, or co-morbidities. It is no surprise that the prevalence of chronic conditions increases with age. Americans are no longer dying from the same diseases as they did in previous generations, now they are living with them.

The Board of Trustees of Medicare reiterated two weeks ago that Medicare will be out of money in 2019, unless something is done to control costs. The huge increase in the number of elderly patients with multiple chronic conditions will stress the system more than ever; providing a benefit for chronic care coordination will allow providers to more effectively control costs system wide.

Utilization Patterns

There is also a strong correlation between increasing hospital, physician and prescription drug utilization and the number of conditions for which a patient is being treated.

In terms of physician visits, the average beneficiary has just over 15 physician visits annually and sees 6-7 different physicians in a year. There is almost a four-fold increase in visits by people with five chronic conditions compared to visits by people with one chronic condition. The number of different physicians seen is nearly two and half times greater for people with five or more chronic conditions relative to those with just one chronic condition.

The average community-dwelling Medicare beneficiary 65 years and older takes on average between 4 and 5 different prescription and non-prescription medications regularly; while the average nursing home resident takes an average of 7 to 8 medications with nearly one-third taking 9 or more medications. We know as the number of chronic conditions increases so does the number of medications (and from more medication classes) required to manage them. As the number of medications increases so does the probability for an adverse drug event which can lead to prescribing more medications resulting in a common geriatric syndrome known as Polypharmacy.

These patients with multiple chronic conditions are at very high risk for hospitalization, medication interactions, and poor health outcomes related to their chronic conditions as well as their use of medications.

Chronic care coordination avoids negative medication interactions and prevents hospital stays, because the chronic care team holistically manages and treats illness -- before it worsens to the point where it requires hospitalization.

Care Coordination

Care coordination lays the foundation for a patient centered, consistent care approach across multiple illnesses. As many of us know, coordinating a chronically ill patient's

care creates a bond among the chronically ill patient, and their care givers and family members. Many geriatricians provide care coordination services to frail elderly patients based on their need for extensive family and patient communications, multiple prescription and nonprescription medications, and extensive transitional care as these patients move through different settings in the health care system. In a 2006 survey by USA TODAY, the Kaiser Family Foundation and the Harvard School of Public Health, half of patients and their household members reported problems coordinating care. But at the present time, Medicare does not reimburse care givers for providing these services and, in fact, most geriatricians are unable, for many of their patients, to use the team approach I just described, because they can not afford to develop the infrastructure and hire the staff needed to perform care coordination.

The inability to provide a team approach to care for these patients results in fragmented care offered by many providers who do not communicate with each other, who duplicate tests and treatments, and who prescribe medication without knowing what medicines the patient is on, thereby increasing the risk for hospitalizations, drug interactions and adverse events.

The Medicare system pays on a fee-for-service basis, which encourages a care giver to see patients frequently for short periods of time and does not allow them to formulate a plan that takes into account all of the patient's illnesses. This fragmented system simply does not pay a doctor or other care givers reimbursement for coordinating their activities with others. When large numbers of doctors and care givers treat multiple health conditions, the clashing treatments may unwittingly lead to new illness, or the need for multiple hospital visits. As MedPAC stated in its 2006 report, "[f]ee-for-service payment mechanisms are barriers to coordination among providers and to care management for beneficiaries with complex needs." One might call this a system based on how providers are paid, rather than one based on patient needs.

We believe the data on care of the elderly show that a lot of the care provided to beneficiaries with chronic conditions is not well-coordinated and that this lack of coordination may result in avoidable adverse events and poor health outcomes. In fact, the Partnership for Solutions has found that as the number of chronic conditions increases, so too do the number of avoidable hospitalizations for patients with illnesses that should have been treated more effectively on an outpatient basis. These poor outcomes are likely a result of poor care coordination among many providers who saw the patient.

We are convinced that a new system is required – one that moves the patient to the center of care. A new Medicare benefit for geriatric assessment and chronic care coordination services is an essential element of this patient-centered approach. The health of the Medicare beneficiary is foremost, and the delivery of these coordinated services is vital to the health and well being of those elderly patients with complex and multiple chronic conditions.

Examples of appropriate care coordination services include: (1) a general assessment of all of a patient's illnesses and their overall health that they will use to develop an overall treatment plan; (2) multidisciplinary care conferences; (3) coordination with other providers, including telephone consultations with relevant providers; (4) monitoring and management of medications, with special emphasis on patients using multiple prescriptions, which will avert adverse reactions and emergency room trips; and (5) patient and family caregiver education and counseling (through office visits or telephone consultation).

This coordinated care approach also should result in savings to both Medicare Parts A and B from fewer hospitalizations, emergency room visits, and diagnostic tests. Numerous studies show that an interdisciplinary team providing ongoing geriatric care coordination and management can lower emergency room visits and hospital stays, even though there is be a period of time before care coordination results in a decreased rate of utilization. (In addition, the Comptroller General of the U.S. Government Accountability Office recently recommended case management for beneficiaries with multiple chronic conditions as a means of reforming Medicare "to improve the quality and efficiency of care delivered and avoid inappropriate care." ("Medicare Taking Care of Your Future?", The Honorable David M. Walker, Feb. 22, 2007, GAO-07-526CG)).

I want to make a few comments about the interim study recently released by CMS on its chronic care coordination demonstration project where organizational providers, including disease management companies, are delivering care coordination services to Medicare beneficiaries. While this interim study found that care coordination had not yet significantly altered patient self-help behaviors or overall utilization, it did find a trend towards lower hospitalization rates in a number of programs where care coordinators were experienced and where physicians were involved. In general, the programs that did not do well in terms of improving care and decreasing costs were those run by disease management companies, where physician involvement was minimal. The programs that did do well were those where the physician was deeply involved in the management plan, where care delivery was integrated, and where community based providers were the usual point of contact for the patient.

The chronic care coordination outlined in the Geriatric Assessment and Chronic Care Coordination Act puts the physician and the team caring for the patient at the center of the assessment and care coordination effort on an ongoing basis. This is quite different from the type of care provided in most of the CMS care coordination demonstration projects. The Geriatric Assessment and Chronic Care Coordination Act provides incentives for primary care givers and makes them accountable for their relationship to the beneficiary at the point of care. This is the type of coordinated care, under the CMS demonstration, that has, thus far, achieved the most positive results.

Disease Management and Multiple Illnesses

The concept of disease management typically refers to the management of a single illness. We believe disease management is an appropriate practice for certain Medicare

beneficiaries who do not have multiple chronic conditions, such as those people with only diabetes, asthma or hypertension.

Generally focusing on one illness at a time, the disease management approach is not necessarily designed to address the number of issues involved with frail elderly patients that have multiple chronic illnesses and/or dementia. For example, treating a patient with dementia, hypertension, and diabetes in the absence of care coordination could result in unnecessary hospitalizations, polypharmacy, and easily avoided adverse events. Further, disease management often involves only self-management and patient education. For obvious reasons, this simply will not work for people with Alzheimer's disease or another type of dementia. And disease management does not always address functional issues brought on by old age or the complications that arise from multiple chronic illnesses, such as those leading to a dramatically increased rate of falling.

Unlike disease management, care coordination envisions individually tailored care for the patient with multiple chronic conditions. The care coordination team actively cares for the patient's multiple illnesses using a care plan that is constantly reviewed and updated. The care coordination plan would not only address all of the beneficiary's medical conditions but would also take into account the beneficiary's ability to self-manage their healthcare, any functional issues, and their support system. It is also important that there is a trusting, on-going relationship with the patient. We believe it is essential to have frank discussions among the care coordination team, and the patient and family regarding why forgoing certain treatments is medically appropriate, or may be more consistent with a patient's wishes. The nature of chronic illness requires this comprehensive approach utilizing a variety of interventions that change over time and contain both a clinical and a non-clinical component.

Conclusion

The American Geriatrics Society believes that older Americans with multiple chronic conditions will truly benefit from a Medicare geriatric assessment and coordination benefit, with an emphasis on preventive care. For this reason, we strongly support the Geriatric Assessment and Chronic Care Coordination Act sponsored by Senator Blanche Lincoln.

To provide high-quality, cost-effective care to the growing population of elderly individuals with multiple chronic conditions, the Medicare Program must be redesigned. The Geriatric Assessment and Chronic Care Coordination Act of 2007 will redesign Medicare by authorizing coverage of geriatric assessment and chronic care coordination for beneficiaries with complex and multiple chronic health conditions. The Act will properly align the financial incentives within Medicare to encourage the coordination of care and increase the quality of health care provided to the most vulnerable Medicare beneficiaries. By reducing hospitalizations and increasing the efficient delivery of health care through care coordination among providers, it will also create cost savings for the Medicare program.

We hope to work with this Committee and Congress to pass and enact the Geriatric Assessment and Chronic Care Coordination Act as well as on other issues to improve the health and quality of life for Older Americans. The changes embedded in this bill should be strongly considered as the Congress debates how to modernize the Medicare system. We thank you again for inviting us to participate in today's important hearing.

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