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Treating Our Societal Scotoma: The Case for Investing in Geriatrics, Our Nation's Future, and Our Patients

Rosanne M. Leipzig, MD, PhD; William J. Hall, MD; and Linda P. Fried, MD, MPH

In the United States, our society has a scotoma, which prevents us from seeing the necessity of changing our health system in the face of an aging population. It also prevents us from investing in the expertise of geriatric medicine, training an adequate number of geriatricians, and ensuring that all physicians have basic competency in caring for older patients. As we attempt to reform our unsustainable health system, it would be perilous not to recognize and resolve this blind spot.

Geriatricians are experts in helping patients set goals and providing goal-appropriate medical care to an aging population (1–4). Over the past 4 decades, geriatric medicine has developed a robust clinical and academic knowledge base for identifying, preventing, treating, and alleviating diseases and consequences of aging itself, including frailty, falls, and delirium; minimizing the hazards of hospitalization and surgery; and providing appropriate care for vulnerable patients with multiple illnesses, frailty, and disability (5–7). Geriatricians have pioneered models of care for the effective and efficient implementation of best practices on the basis of this evidence. These include methods for identifying and targeting frail older adults; team-based care for patients with multiple and complex illnesses; systems for effective transitions in care across settings and providers; and the development of a coordinated continuum of care, including home, long-term, and palliative care (8). Further, geriatric medicine has identified the competencies that all physicians who care for older adults should master, such as medication management, age-associated atypical presentations of disease, and patient-specific strategies for prevention (9), as well as the skills and expertise geriatricians must develop to care for patients with multiple and complex illnesses (10).

Evidence of the effectiveness of these approaches in improving outcomes for older patients is compelling. Comprehensive geriatric assessment in hospitals increases patients' cognition and their likelihood of being alive and in their own home at up to 12 months after discharge (11). The Hospital Elder Life Program decreases the incidence of delirium from 30% to 50% while also reducing falls, institutionalization, and functional and cognitive decline (12, 13). Dissemination of a multifactorial falls intervention to large parts of Connecticut decreased the rate of serious fall injuries and fall-related use of medical services (14). The Improving Mood-Promoting Access to Collaborative Treatment program doubles the effectiveness of depression treatment in older adults in primary care practices (15).

Work as a geriatrician is vital, engaging, complex, nuanced, and intellectually challenging—and is deeply and humanistically rewarding. In fact, data suggest that geriatrics is near the top of all subspecialty fields in physician career satisfaction (16). However, at the very time that our population is living longer and increasingly could benefit from geriatric care, the number of board-certified geriatricians is decreasing. The field is failing to attract young physicians (17).

The decline in the geriatrician workforce results from many factors. National investment in compensating geriatric physicians for the demanding care that they provide has been vastly inadequate. Geriatrics is the only specialty where less is earned by doing a fellowship than if training had ceased after internal medicine or family medicine residency (18). Most geriatric patients have several illnesses, medications, physician specialists, and caregivers. These patients can be challenging to care for, particularly in time-constrained settings. Geriatricians' "procedures," such as communication, coordination, and sophisticated clinical decision making, are critical to the well-being of the patients and their families. Yet, Medicare does not reimburse these time-consuming and skill-demanding activities. Geriatric fellowships provide training in high-impact systems, such as those previously described, but under fee-for-service, these systems are available only in select settings (19, 20).

The U.S. health care system needs geriatric knowledge and skills to deal with the Medicare crisis. This is the time to strengthen geriatrics expertise and the field itself. Geriatricians' leadership in our health system, clinical care, and evidence generation are essential as we move into the decades during which aging baby boomers will dominate health care use. We propose the following strategies to improve health outcomes for our aging society.

First, the health care system must provide adequate reimbursement to physicians who expertly care for the complex health needs of older adults. If not, young physicians will opt to become dermatologists, anesthesiologists, or other highly paid specialists rather than geriatricians. At the very least, geriatricians must be paid for the multitude of activities that occur outside of face-to-face patient visits, which are currently the only care that Medicare reimburses. Conversations and coordination with families, caretakers, other physicians, and health professionals take time, and geriatricians participate in several of these between ac-

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tual patient visits. In 1 study, geriatricians were found to spend nearly 8 hours per week doing these unreimbursed activities (21).

Second, Medicare must invest in bundled payment for programs, such as the Hospital Elder Life Program, Hospital at Home, and Improving Mood-Promoting Access to Collaborative Treatment, which have been proven beneficial for older patients, but the dissemination of which has been limited by a weak business model under fee-for-service medicine.

Third, to continue to receive Medicare funding, all graduate medical education programs must demonstrate that the physicians they graduate to care for adults have attained competency in geriatric care. After all, Medicare's goal is to improve the health and well-being of the U.S. population aged 65 years and older.

Fourth, we must increase the geriatric workforce to meet anticipated needs. Estimates are that by 2030 we will need at least 26 000 geriatricians to care for elders with multiple illnesses and frailty (1). There are currently fewer than 7000 certified geriatricians (17). Only a fraction of this workforce will be provided by fellows in current 1-year geriatrics fellowship programs, so other pathways to geriatrics training are needed. One option would be to encourage internal medicine subspecialties to replicate the geriatric oncology fellowship model (22), in which fellows are board-eligible in both disciplines by the end of the 3 years of traditional medical oncology training because certain clinical rotations fulfill requirements for both. If physicians who treat adults are taught about geriatric care relevant to their own discipline, many older adults will not need the specialized care of a geriatrician (23).

Another option is to establish a 4-year Accreditation Council for Graduate Medical Education medicine–geriatrics program for internal and family medicine residents. At least one half of the clinical content of the current 1-year geriatrics fellowship could be integrated into the traditional residency, with a weekly geriatrics ambulatory session added in year 2 or 3. The fourth year would provide the opportunity for additional training in medical education, health systems, and research and for continued development of geriatrics clinical expertise.

Some geriatrics fellowships must be expanded to 2 to 3 years to develop leaders in geriatrics research and health system design and master educators who can teach other physicians the basic principles of geriatric care (22). Federal investment is needed, through the Health Resources and Services Administration or the Centers for Medicare & Medicaid Services mechanisms, to support these programs, which are similar to those that established the current cadre of academic leaders in geriatrics.

Last, we propose that geriatric medicine consider a nonfellowship pathway for clinical certification in geriatrics that may be implemented through maintenance of certification programs for mid-career physicians who want to focus their practice on the care of older adults.

These strategies would lay the foundation for a health system that improves both outcomes and costs of care for older adults. The clinical skill set of well-trained geriatricians are precisely the tools demanded as we move toward more bundled payment systems. Expertise in enhancing quality of care for those with multiple chronic diseases, reduction of polypharmacy, efficient use of acute hospital services or alternatives, and seamless transition among multiple sites of care will produce added value to justify any enhanced reimbursement to geriatricians. We need a health system whose leaders understand the numerous factors that affect the capacity of patients and physicians to sustain health for older adults, physicians who can see beyond the patients' organ systems to their preferences and goals, and medical schools and training programs with faculty who can teach this kind of care. We need basic clinical health services and translational researchers to advance the science of geriatrics. Young physicians who are exposed to these types of leaders will find that geriatrics is an attractive career choice. In summary, we must resolve the scotoma that prevents our society from seeing the critical need for a health system and workforce that embraces the challenge of providing high-quality, cost-effective, compassionate care to our aging population.

From Mount Sinai School of Medicine and the Mailman School of Public Health of Columbia University, New York, and University of Rochester School of Medicine, Center for Healthy Aging, Rochester, New York.

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Requests for Single Reprints: Rosanne M. Leipzig, MD, PhD, Brookdale Department of Geriatrics and Palliative Medicine, Mount Sinai School of Medicine, 1468 Madison Avenue, Box 1070, New York, NY 10029.

Current author addresses and author contributions are available at www.annals.org.

References

1. **Fried LP, Hall WJ.** Editorial: Leading on behalf of an aging society [Editorial]. J Am Geriatr Soc. 2008;56:1791-5. [PMID: 19054197]
2. **Reuben DB, Tinetti ME.** Goal-oriented patient care—an alternative health outcomes paradigm. N Engl J Med. 2012;366:777-9. [PMID: 22375966]
3. **Reuben DB.** Medical care for the final years of life: "When you're 83, it's not going to be 20 years". JAMA. 2009;302:2686-94. [PMID: 20040557]
4. **Fried LP, Ferrucci L, Darer J, Williamson JD, Anderson G.** Untangling the concepts of disability, frailty, and comorbidity: implications for improved targeting and care. J Gerontol A Biol Sci Med Sci. 2004;59:255-63. [PMID: 15031310]
5. **Fong TG, Tulebaev SR, Inouye SK.** Delirium in elderly adults: diagnosis, prevention and treatment. Nat Rev Neurol. 2009;5:210-20. [PMID: 19347026]
6. **Arora VM, McGory ML, Fung CH.** Quality indicators for hospitalization and

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surgery in vulnerable elders. J Am Geriatr Soc. 2007;55 Suppl 2:S347-58. [PMID: 17910557]
7. **Tinetti ME, Kumar C.** The patient who falls: "It's always a trade-off". JAMA. 2010;303:258-66. [PMID: 20085954]
8. **Committee on the Future Health Care Workforce for Older Americans, Institute of Medicine.** New models of care. Chapter 3. In: Retooling for an Aging America: Building the Health Care Workforce. Washington, DC: National Academies Pr; 2008:75-122. Accessed at www.nap.edu/openbook.php?record_id=12089&page=75 on 18 March 2012.
9. **Leipzig RM, Granville L, Simpson D, Anderson MB, Sauvigné K, Soriano RP.** Keeping granny safe on July 1: a consensus on minimum geriatrics competencies for graduating medical students. Acad Med. 2009;84:604-10. [PMID: 19704193]
10. **Warshaw GA, Bragg EJ, Fried LP, Hall WJ.** Which patients benefit the most from a geriatrician's care? Consensus among directors of geriatrics academic programs. J Am Geriatr Soc. 2008;56:1796-801. [PMID: 19054198]
11. **Ellis G, Whitehead MA, O'Neill D, Langhorne P, Robinson D.** Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane Database Syst Rev. 2011:CD006211. [PMID: 21735403]
12. **Inouye SK, Bogardus ST Jr, Charpentier PA, Leo-Summers L, Acampora D, Holford TR, et al.** A multicomponent intervention to prevent delirium in hospitalized older patients. N Engl J Med. 1999;340:669-76. [PMID: 10053175]
13. **Caplan GA, Harper EL.** Recruitment of volunteers to improve vitality in the elderly: the REVIVE study. Intern Med J. 2007;37:95-100. [PMID: 17229251]
14. **Tinetti ME, Baker DI, King M, Gottschalk M, Murphy TE, Acampora D, et al.** Effect of dissemination of evidence in reducing injuries from falls. N Engl J Med. 2008;359:252-61. [PMID: 18635430]
15. **Unützer J, Katon W, Callahan CM, Williams JW Jr, Hunkeler E, Harpole L, et al; IMPACT Investigators.** Improving Mood-Promoting Access to Collaborative Treatment. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA. 2002;288:2836-45. [PMID: 12472325]
16. **Leigh JP, Tancredi DJ, Kravitz RL.** Physician career satisfaction within specialties. BMC Health Serv Res. 2009;9:166. [PMID: 19758454]
17. **Geriatrics Workforce Policy Studies Center.** Comparison of number of certificates awarded to number of active certificates in geriatric medicine (family medicine and internal medicine). Cincinnati, OH: American Geriatrics Soc; 2011. Accessed at www.ipittr-test.uc.edu/GWPS/files/Figure%201_3.pdf on 18 March 2012.
18. **Geriatrics Workforce Policy Studies Center.** Total annual compensation for private practice physicians, 2006-2010. Cincinnati, OH: American Geriatrics Soc; 2011. Accessed at www.ipittr-test.uc.edu/GWPS/files/Table%201_7.pdf on 18 March 2012.
19. **Inouye SK, Studenski S, Tinetti ME, Kuchel GA.** Geriatric syndromes: clinical, research, and policy implications of a core geriatric concept. J Am Geriatr Soc. 2007;55:780-91. [PMID: 17493201]
20. **Siu AL, Spragens LH, Inouye SK, Morrison RS, Leff B.** The ironic business case for chronic care in the acute care setting. Health Aff (Millwood). 2009;28:113-25. [PMID: 19124861]
21. **Farber J, Siu A, Bloom P.** How much time do physicians spend providing care outside of office visits? Ann Intern Med. 2007;147:693-8. [PMID: 18025445]
22. **American Board of Internal Medicine.** Subspecialties/geriatric medicine policies. Philadelphia: American Board of Internal Medicine. Accessed at www.abim.org/certification/policies/combinedss/comgeri.aspx on 18 March 2012.
23. **Boult C, Counsell SR, Leipzig RM, Berenson RA.** The urgency of preparing primary care physicians to care for older people with chronic illnesses. Health Aff (Millwood). 2010;29:811-8. [PMID: 20439866]

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Current Author Addresses: Dr. Leipzig: Brookdale Department of Geriatrics and Palliative Medicine, Mount Sinai School of Medicine, 1468 Madison Avenue, Box 1070, New York, NY 10029.
Dr. Hall: University of Rochester School of Medicine, Center for Healthy Aging, Box 58, 1000 South Avenue, Rochester, NY 14620.
Dr. Fried: Columbia University Medical Center, Mailman School of Public Health, 722 West 168th Street, Room 1408, New York, NY 10032.

Author Contributions: Conception and design: R.M. Leipzig, W.J. Hall.
Analysis and interpretation of the data: R.M. Leipzig, W.J. Hall.
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Administrative, technical, or logistic support: R.M. Leipzig.

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