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THE NATIONAL SHORTAGE OF GERIATRICIANS: MEETING THE NEEDS OF OUR AGING POPULATION

FORUM

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

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FORUM ON THE NATIONAL SHORTAGE OF GERIATRICIANS: MEETING THE NEEDS OF OUR AGING POPULATION

TUESDAY, MAY 14, 1996

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The forum was convened, pursuant to notice, at 9:36 a.m. in room 628, Senate Dirksen Building, Hon. William S. Cohen (chairman of the committee) presiding.

Present: Senators Cohen and Reid.

Staff Present: Mary Berry Gerwin, Priscilla Hanley, Lindsey Ledwin, Beth Watson, Sally Ehrenfried, Victoria Blatter, Jerry Reed, and Lance Wain.

Mr. PERRY. Good morning, and thank you for attending a very important news conference and later a congressional forum on the significant problem of the shortage of physician personnel specifically, geriatricians able to train the physician work force in this country for an older population. Primary care physicians with special geriatrics training are enabled to appropriately diagnose, treat, and rehabilitate older people who are increasingly going to be a significant part of the patient population in an aging America.

Without further comment, I would like to thank Senator Cohen and Senator Reid on behalf of the Alliance for Aging Research and the American Federation for Aging Research for sponsoring a news conference and a congressional forum to follow. We will be discussing a report that is released today by the Alliance for Aging Research called "Will You Still Treat Me When I am 65?" It is a close look at the problems that face us in terms of training physicians for an older society.

Senator Cohen and Senator Reid, we are very, very pleased to have you help give significant national attention to this problem.

Senator Cohen.

OPENING STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN

The CHAIRMAN. Thank you very much, ladies and gentlemen.

The Senate Special Committee on Aging is pleased to join with the Alliance for Aging Research today as it releases its report with its very catchy title. It sounds a very important warning that in the face of a rapidly aging population we are facing a severe shortage

of doctors trained to manage the special health care needs of our older citizens.

I mentioned this last evening—reluctantly—but we are growing older. The demographics are daunting. Last evening, in talking about the need for additional funding for brain research, I mentioned that quoting statistics is much like an inebriate leaning on a lamppost, more for support than illumination. Nonetheless, let me just point out the fact that we now have some 30 million Americans who are over the age of 65. These numbers are going to increase dramatically with the aging of the baby boom population. The number of Americans over 65 is expected to double by the year 2030. Nowhere does the aging of America present more risk—and more opportunity—than in the area of health care.

It is not just that we are going to have older Americans in the next century. It is that the older Americans are living longer. Americans 85 years old—our oldest of the old—are the fastest growing segment of our population. Today there are nearly 4 million Americans over the age of 85. By the year 2040, there may be close to 13 million. So this is the population that is going to pose the greatest risk of multiple and interacting health problems that can lead to disability and the need for long-term care.

As we know from the numbers President Clinton released this last year, the Medicare trustees have indicated that the Medicare Trust Fund is going broke. In just 6 short years, maybe less, that fund will be bankrupt. Yet we have done little, if anything, to change the Medicare Program or Medicaid Program to confront this tidal wave that is approaching.

We know that older Americans use more health care resources than other age groups, and their health care needs are very different. I was just talking to Dr. Beeson a short time ago. In 1975 we created the House Committee on Aging, which has since been disbanded. But during that time in which we had Claude Pepper as our celebrated leader, we tried to change the perception that Americans held of older people. At that point, when one turned 65, he was automatically mandated into old age. We had a mandatory retirement program. One of the first things we did was to try to change the perception that the American people held of older citizens. Everybody aged exactly alike. We all turned old at 65. Of course, we know that is not true. People are not fungible goods. We are unique. Everyone is different.

As we talk about older citizens, we also know that their health care needs are different. They don't suffer necessarily the acute problems of a younger person who might have a particular injury, an acute type of injury that is cured, and that individual goes on. Older people have multiple chronic conditions like heart disease, diabetes, arthritis, and Alzheimer's, or any combination of these types of afflictions. Geriatrics is a medical specialty that is specifically designed to address the complex health care needs of older patients.

The essence of geriatrics is coping rather than curing. It is the emphasis on helping older adults to maintain their ability to function independently, even in the presence of chronic age-related disease and disability. That is an important distinction, helping to cope rather than to cure.

We should also point out that not all older patients need the attention of a geriatric specialist. Routine medical care for most elderly persons should remain the responsibility of the primary care physician. But those physicians should be appropriately trained in geriatrics.

Health promotion, as well as disease and disability prevention, is particularly important in the field of geriatrics. I will give you an example. A geriatrician or a primary care physician with geriatric training would be likely to recommend that an elderly patient participate in a specifically designed exercise program to build strength and improve balance. Why? To reduce the possibility of that person falling and suffering a hip fracture.

Or such a person who is properly trained would be more likely to be alert to the problems associated with the overuse or underuse or inappropriate use of prescription and non-prescription drugs in older patients. They are also more likely to pay attention to the nutritional needs and practices of elderly diabetics in order to help them to better manage their disease and avoid disabling complications like blindness, loss of a limb, or kidney failure.

So with the emphasis on maintaining functional independence, geriatrics offers us a very promising opportunity to reduce health care costs in the future. This is something that we who are concerned about budget reduction and budget cuts, coping with the exploding costs of medical care, ought to be focused upon with greater intensity.

The Alliance for Aging Research has shown that if we were, for example, to delay functional disability, for every month we would save roughly $5 billion in health care and related costs. I mentioned this last evening in terms of just delaying the onset of symptoms for Alzheimer's. If we delayed for 5 years the onset of Alzheimer's, we would save $50 billion a year. If you delay the onset of stroke for 5 years, you save $15 billion. For Parkinson's, it is $3 billion.

We can see that a little more money up front in terms of research can pay very big dividends on the other end. That is how we have to reduce the exploding costs of medical care. The same is true with respect to geriatrics. If we focus more on training our physicians in the field of geriatrics, we are going to save billions of dollars in health care that the Nation can ill-afford to pay.

These are the dramatic opportunities. Unfortunately, the Alliance for Aging Research has found that we have a very serious shortage of physicians who are trained to deal with the health care needs of older people. We have insufficient medical students pursuing gerontology. We have a deficiency of about one-third in the field of geriatrics of what we need. Out of a total of 30,000 that we need, we have roughly 6,700 of those who are trained in the area of geriatrics. We have a shortage of teachers. We have about one-fourth of the teachers necessary to train the new medical students coming up.

This is the discouraging aspect of the report being released this morning. We have a deficiency of students and teachers. This is going to pose dramatic challenges for the future, especially as we look forward to the baby boom turning into the senior boom. We are going to see that we are going to need over 36,000 physicians

with geriatric training by the year 2030—almost 30,000 more than we currently have—to care for 65 million older Americans.

These are challenging times. We are on the cusp of major breakthroughs in the field of research of the diseases of aging. Promises of new drugs and therapeutic treatments to alleviate the pain and enhance the quality of life for millions of Americans is at hand. It seems to us that this report is particularly timely, it is time that we call attention to the Nation that there is a tidal wave of health care costs approaching that we are ill-prepared to deal with. We need to turn it aside and we can do that by focusing our energies and resources on more training for geriatrics in the future.

It is my pleasure to open this particular hearing. We will have another Cohen, Dr. Cohen, who will preside over the session which will be an official meeting of the Senate Aging Committee. I just want to commend all of you for attending and hope it is a very productive session for all concerned.

I now yield to my colleague, Senator Reid.

[The prepared statement of Senator Cohen follows along with prepared statement of Senator Pryor:]

PREPARED STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN

The Senate Special Committee on Aging is pleased to join with the Alliance for Aging Research today as it releases its report, "Will You Still Treat Me When I'm 65?". This report sounds an important warning that, in the face of a rapidly aging population, we are facing a severe shortage of doctors trained to manage the special health care needs of older persons.

America is growing older. Today, more than 30 million Americans are 65 and over, and these numbers will rise dramatically with the aging of the baby boom population. The number of Americans over 65 is expected to more than double by 2030, and nowhere does the aging of America present more risk and opportunity than in the area of health care.

It is not just that there will be more older Americans in the next century. It is also that older Americans are living longer. Americans 85 and older—our "oldest old"—are the fastest growing segment of our population. Today there are nearly 4 million Americans over the age of 85. By 2040, there may be close to 13 million. This is the population that is most at risk of the multiple and interacting health problems that can lead to disability and the need for long-term care.

Older Americans use more health care resources than other age groups, and their health care needs are very different from those of younger persons. While younger people typically come in contact with the health care system for treatment of a single, acute health care condition, older people often have multiple, chronic conditions like heart disease, diabetes, arthritis, and Alzheimer's disease—or any combination thereof.

Geriatrics is the medical specialty or style of practice specifically designed to address the complex health care needs of older patients. The essence of geriatrics lies in coping rather than curing: its emphasis is on helping older adults to maintain their ability to function independently even in the presence of chronic age-related diseases and disabilities.

Not all older patients need the attention of a geriatric specialist. Routine medical care for most elderly persons should remain the responsibility of their primary care physicians—but those physicians should be appropriately trained in geriatrics.

Health promotion and disease and disability prevention are particularly important in the field of geriatrics. For instance, a geriatrician—or a primary care physician with geriatric training—would be likely to recommend that an elderly patient participate in a specially designed exercise program to build strength and improve balance in order to reduce the risk of falls or hip fracture. Or be more alert to the problems associated with the overuse, underuse, or inappropriate use of prescription and non-prescription drugs in older patients. They also would be likely to pay more attention to the nutritional needs and practices of the elderly diabetic in order to help them better manage their disease and avoid disabling complications like blindness, loss of a limb, or kidney failure.

With its emphasis on maintaining "functional independence," geriatrics offers great promise not only for improving the health status and quality of life for older persons, but it also has the potential of reducing overall medical, social and long-term costs. A report released by the Alliance for Aging Research last year estimated that, for every 1 month we can postpone physical dependency for older persons, in the aggregate, the Nation would save at least $5 billion in health and long-term care costs.

Unfortunately, the Alliance for Aging Research has found that we are facing a serious shortage of physicians trained to deal with the health care needs of older people. The report we are releasing today finds that not enough medical students are choosing to take courses dealing with the special needs of older patients. Further, the total number of geriatricians seeing patients and teaching in our medical schools is increasingly inadequate to meet the needs of our rapidly aging population.

This shortage is dramatic: the United States has less than one-third the number of primary care physicians with geriatric training to provide appropriate care for the current population of over 30 million older Americans. Further, there are fewer than one-fourth the number of academic physician-scientists necessary to train present and future doctors in the principles of geriatrics.

This shortage will become even more acute when the "baby boom" turns into a "senior boom." By the year 2030, the United States will need over 36,000 physicians with geriatric training—almost 30,000 more than we have currently—to care for more than 65 million older Americans.

Confronted by the approaching tidal wave of aging Americans, we cannot afford to bury our head in the sand and ignore this warning. Bold new efforts are necessary to overcome this national shortage of physicians trained to meet the special health care needs of an aging population.

Challenging times lie ahead for our Nation's health care delivery system. We are on the cusp of major breakthroughs in research in the diseases of aging, with the promise of new drugs and therapies to alleviate the pain and enhance the quality of life of millions of older Americans. At the same time, we are facing unprecedented changes in our health care system, such as managed care trends, as we try to bring health care costs under control.

This morning the Senate Special Committee on Aging is holding a forum on the implications of this national shortage of physicians trained in geriatrics, particularly in light of these challenges facing our health care system. I am very pleased that several experts in aging policy and geriatrics have taken the time to participate in this forum and I look forward to receiving the recommendation of the panelists.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, thank you for holding today's forum on medical nutrition therapy. I commend the committee for educating members of Congress and the American public on important issues in the field of geriatrics. The report being released today represents a significant contribution to this field.

The timing of this forum could not have been more appropriate. The elderly population is facing exponential growth as the baby boomers approach retirement age. Furthermore, the Congress continues to look for ways to improve quality of life for Medicare beneficiaries while controlling costs in that program. The report indicates that one way that we can achieve this is by incorporating routine nutrition screenings into initial medical examinations.

Malnutrition is a severe problem among the elderly. A recent survey commissioned by the Nutrition Screening Initiative suggests that one-half of elderly hospital patients suffer from malnutrition. The appropriate use of nutrition screening and medical nutrition therapy can lower costs and reduce the overall rate of malnutrition among older Americans.

The effort to combat malnutrition must take place in all facets of the medical community. Physicians, dietitians, nutritionists, pharmacists and mental health professionals must work together to ensure that the patient is being diagnosed properly and that sufficient treatment is being administered. This joint effort should result in the identification of more patients suffering from malnutrition. This should translate into greater efficiency and tremendous cost savings within the Medicare program.

Speaking of cost savings, Mr. Chairman, the report released today indicates the importance of exploring increased use of medical nutrition therapy in the Medicare program. According to the report, total savings in inpatient hospital care for Medicare beneficiaries would have been $156 million in 1994, with estimated cumulative savings over the period of 1996 to 2002 of $1.3 billion. The possible cost savings are

important to the Medicare program, but we must also recognize what accompanies these savings—more efficient patient treatment.

Finally, I would like to thank the members of the Nutrition Screening Initiative for all of their hard work throughout the years. Since 1989, NSI has provided quick and easy self-tests for people to find out if they are at risk of malnutrition. I applaud their latest contribution on this issue and look forward to hearing more from them in the future.

STATEMENT OF SENATOR HARRY REID

Senator REID. Mr. Chairman, thank you very much.

My first elected job in Las Vegas was to a hospital board of then the largest hospital in the State of Nevada. It is called Southern Nevada Memorial Hospital. From the beginning of my political career, I have understood the need for good medical care, but especially did I realize early on the need to have specialists taking care of older people.

In Las Vegas at the time, we had no doctors who specialized in geriatrics. We were a much smaller community then. We are now a community of over 1 million people. The sad part is that we still don't have many physicians specializing in taking care of older people. Many of those that hold themselves out as being specialists in geriatrics aren't. This is a problem we have all over America.

As indicated on the chart to my left and your right, less than 10 percent of the medical schools teach students anything about geriatrics. It is a real problem. As Chairman Cohen has indicated, we could save a lot of money if we had more people who specialized in geriatrics.

There is another report released today that indicates something that we worked on earlier has paid off. We put a little money in the budget last year to allow people in the Justice Department to go after people who were cheating. The report comes out today that for every dollar we spent, the Federal Government received $10 in return.

This is similar to what Chairman Cohen has said. We could save money if we had more people who were trained in geriatrics. For example, medicine. One reason there is so many adverse reactions to medicines that are given to older Americans is that people prescribing the medicines don't understand the overall medical problems that older people experience. These problems can be alleviated and in turn save large amounts of money if people were not overmedicated.

The panel got good publicity all over the country today, but especially in today's Washington Post. The panel today will talk about, "Will You Still Treat Me When I am 65?" The Washington Post covers this extremely well, not in as much detail as we will here today, indicating that geriatricians have a different approach to medicine. There is an extreme shortage of geriatricians across the United States, a scarcity noted in the report being released today.

Thinking that we will never grow up—either we're going to start interesting medical students and physicians in the special needs of older people or we are going to end up paying a whopping bill in terms of misdiagnosis, ineffective care, and unnecessarily crowded nursing homes.

The Alliance is to be complimented for the work here today. The forum which is going to be held is educational and important. We

need to educate not only the general public, but Members of Congress. We have to start giving incentives to medical students and medical schools to become interested in geriatrics. We need to do this, if necessary, by spending more money. We found at the National Institutes of Health that we could not get people—after having run up these huge bills to go to medical school—we could not get them to come and do research. Therefore, we came up with some innovative programs to attract good students who were interested in research—we forgave some of their student loans if they committed to do research.

We are going to have to do something comparable to that with geriatrics. We must have an accelerated program so that next year we start doing better than we did this year. We don't have the luxury of 10, 15, or 20 years until we are in more of a crisis and have an even larger shortage of geriatricians.

I applaud the Alliance for this panel today, but especially, Mr. Chairman, I appreciate the work you have done in chairing this committee. If there were ever an example the American people should look at in bipartisanship, it is the leadership of Senator Cohen on this committee. We don't do things on a partisan basis here, and that is because of principally the leadership of Senator Cohen.

Mr. PERRY. Thank you very much, Senator Cohen and Senator Reid, for being with us, and for helping to bring the level of national attention that this program deserves.

In all of this doom and gloom about shortages, one thing should be noted, and that is that a number of foundations in this country have stepped up to the plate in recent years to zero in on one of the most significant aspects of this shortage. That is the shortage of geriatrics-trained leaders in our medical schools—faculty members—who can serve as role models for young physicians and who can help integrate and mainstream geriatric curricula into all undergraduate and graduate medical education.

We need to have this cadre of leaders at the senior faculty level in medical schools. It was 3 years ago that the John A. Hartford Foundation and the Commonwealth Fund of New York and my own organization, through a special effort by some donor friends, created a fund in excess of $14 million to be spent in the next 3 years to capture the best and the brightest of our physicians and scientists and to draw them into a 3-year fellowship to hone their research skills and to become the future academic leaders of tomorrow in geriatrics. This program is named after Dr. Paul Beeson, who is with us today, now emeritus professor at the University of Washington in Seattle.

With us today also are the first two classes of the Paul Beeson Physician Faculty Scholars in Aging as well as their mentors. We are delighted to have brought this brain power together in this room. We are better off because of the leadership they will provide in the years ahead. Of course, it is not for philanthropy alone, it is not for corporate America alone, or even for Government alone, but for all of those working together to try to address this significant problem.

The report the Senators have referred to—with thanks to John Lennon and Paul McCartney—will also draw together some of these facts and try to raise awareness.

I would like to now call on Dr. Mary Tinetti of Yale University, a member of the selection committee of the Beeson Scholars Program, and herself a mentor in the program and a geriatrician. Dr. Tinetti will provide that perspective for us.

STATEMENT OF MARY TINETTI, YALE UNIVERSITY

Dr. TINETTI. Thank you, Dan.

Probably much of what I would have said was said much better than I could have by the Senators. I am certainly not going to repeat that except to complement what they have said by being somebody in the trenches in the field who, for the last 15 years—after I was drawn into the field by Dr. T. Franklin Williams, one of the recent directors of the National Institute on Aging to try to bring other young people into the field of aging—been increasingly frustrated, if you will, by the lack of ability to bring talented young people into the area of aging and geriatrics. I think a lot of us in the area try to put our heads together to figure out what we can do to encourage people to come into this field.

Those of us who are in it find it to be the most appealing and satisfying area that one can. But I think it is well-identified in the report from the Alliance that the shortage of geriatricians is going to become even more vital unless there is more investment in trying to train clinicians and teachers and academicians in the area of geriatrics.

I think a lot of the fear about this impending baby boomers as we age is scaring everybody to death, and hopefully scaring them into action. But I think the need is even more immediate than that. As these charts well identify, the life expectancy of older people is drastically improving and increasing in this country. Probably even more important for the health care system is the life expectancy of those frail, elderly, chronically ill people. The very health system that has allowed them to live and survive many of their chronic diseases is not prepared to take care of them now that they have these chronic diseases. Again, in many ways it is the very success of the American health care system that now is highlighting the failure of trying to bring in geriatricians to care for them.

Clearly, we need a cadre of physicians that really are knowledgeable in the health care needs of older people. It is important particularly now as we move into the area of managed Medicare and managed HMO's. I think most of us are perhaps—there may be some controversy on this—but I think most of us would at least agree that managed care has been quite successful on containing health care costs by doing things like utilizing primary care physicians and utilizing multidisciplinary teams to really look at prevention as well as treatment of diseases.

I think we need to be particularly careful, as managed Medicare takes care of an increasing number of our old and frail people, that they provide the necessary multidisciplinary care to address the functional and quality of life issues of older people. I also think it becomes increasingly important that we train the primary care physicians who are going to be the major care providers, as Senator

Cohen identified, to take care of the health care needs of older people. The needs of conflicting medications, risk benefit issues, issues of quality of life and ethics as we take care of people's multiple diseases are increasingly necessary to be addressed. They are going to be addressed by primary care physicians and it is our responsibility to train the trainers of these people.

Clearly, the availability of a sufficient number of geriatricians and primary care providers with geriatric expertise is not going to just benefit the older people themselves. It is also going to benefit their care providers, their families. It will also benefit society, who is going to have to pay the bill at the end if we don't pay up front to provide the necessary care.

Better than I can say it, I want to introduce Ms. Laurie Pross, who is involved in the day-to-day care and decisionmaking issues resulting from her mother's multiple chronic issues, rather than me trying to say it in the abstract. She can say it in the reality of her day-to-day existence.

Thank you.

Mr. PERRY. Laurie Pross, of Kensington, MD, would you like to share some of your concerns with us?

STATEMENT OF LAURIE PROSS, KENSINGTON, MD

Ms. PROSS. My name is Laurie Pross. I am here to tell you a little bit about my experience in taking care of my mother, who was quite elderly, and the invaluable assistance my family received during this period from our geriatrician.

My mother passed away about a year ago. She had suffered from renal failure, was on dialysis for a number of years, and was also suffering from dementia. As the health care decisionmaker for my mother, I often had to make very difficult choices.

Her doctor, who is a geriatrician, was a very caring advocate, not just for my mother, but for our whole family. She took a holistic approach to the care of my mother and didn't always just advocate intervention for intervention's sake, but rather allowed our family to work through the options that were available to us when a decision was required.

She acted as an overall coordinator for the health care of my mother, but also as a source of support and solace when we decided to make the decision to discontinue active medical treatment for my mother.

I must say that to this day I am grateful for the attention, care, and respect that my mother's physician displayed during her time of illness. It is my wish that all elderly patients suffering from debilitating diseases and conditions have access to physicians like my mother's who are not only trained but attuned to the needs of patients who are elderly and have complex health care needs, and that they also receive the counsel I was able to receive during difficult times.

Thank you.

Mr. PERRY. One fact you will see in that report is that out of 108 U.S. medical schools, only 11 require a course in geriatrics or a rotation in a nursing home as part of their training. Though many of the schools will offer elective courses in geriatrics, the latest survey by the Association of American Medical Colleges finds that less

than 3 percent of medical students choose to take a course in geriatrics as an elective. You can see that we are far beneath where we should be now, and with the first baby boomers turning 50 this year and only 15 years away from being eligible for Medicare, you can begin to see the steep slope we need to climb.

Again, I want to thank the Senators and the committee for giving us this forum. I would now like to ask Mary Gerwin to help us make the transition from the news conference to the forum arrangement.

Mary.

STATEMENT OF MARY GERWIN, STAFF DIRECTOR, U.S. SENATE SPECIAL COMMITTEE ON AGING

Ms. GERWIN. Thank you and good morning.

I am Mary Gerwin, the staff director of the Senate Special Committee on Aging. On behalf of Senator Cohen, chairman of the committee, our ranking member, Senator David Pryor, and all the members of the committee, I am very pleased to welcome you this morning to the forum that will discuss the critical shortage of geriatric specialists that is facing our Nation today and will become even more critical as we witness the dramatic and unprecedented aging of our population.

As you have heard many times already this morning, we are holding this forum in conjunction with the release of the Alliance for Aging Research report, "Will You Still Treat Me When I am 65?"

As an aside, as my colleagues know, I am an intense Beatle fan, so it gives me great pleasure to be able to have the title of this report be such a surprise. I assure you that we desperately tried to get a reunion of the Beatles here today, but they wouldn't go for a reunion before a congressional committee. So I think it is probably sure that they're not going to have that happen now.

This forum that we are having today is in conjunction with two major themes that the committee has addressed this year. First is the importance of looking at the investment of research as a way to address long-term health care costs in the Nation. As the Senators have indicated, as we have a major budget battle going on, we quite often ignore the short-term expenditures that can result in very long-term gains for our health care system.

All of that investment in research, however, is lost if we do not have the trained physicians who are available to apply that research for the aged population once those new discoveries are made. So, we are very pleased to join in the release of this report today to stress the importance of applying research and disseminating the fruits of that research effectively to the elderly population.

A second theme of many of our hearings this year is the effects of managed care trends on the elderly population. That is certainly a critical issue of the entire health care reform and budget debates. If Medicare itself does not turn mandatorily to a managed care system, certainly the market is moving in that direction nevertheless.

It is important for Congress and policymakers to identify areas of concern as we move toward managed care and to identify the

standards and protections we can put in place for the elderly as the market moves in that direction.

As has been indicated, we have asked Dr. Gene Cohen, certainly one of the true legends in the field of aging, to act as our moderator today. Dr. Cohen is a former director of the National Institute on Aging and is a director of the George Washington University Center on Aging, Health, and Humanities.

Before I turn the program over to Dr. Cohen, who will then in turn introduce the panelists, let me outline the format we will follow for today's forum.

We have asked each participant of the forum to present a brief summary of a testimony they are submitting for the record. We would like to have each panelist present their statements and then open it up to questions from Dr. Cohen as well as from the audience.

Also this morning I would definitely like to welcome the many Paul Beeson Faculty Scholars and the heads of the Pepper Centers who are with us here today. Certainly your programs are a model of geriatric training and research in practice, and they are ones we hope will be emulated throughout the country.

Finally, I would like to recognize the staff of the Special Committee on Aging who put this forum together today: Priscilla Hobson Hanley, Victoria Blatter, Lindsey Ledwin, Sally Ehrenfried, Beth Watson, and Lance Wain. We have an excellent staff on the committee who does a tremendous amount of work here on the Aging Committee. We have the opportunity to look at the overview issues that some of the other committees—such as Finance Committee and Labor Committee—that have legislative jurisdiction over these programs, are often not able to take the time to review. We hope that this record will be a contribution to them for their future decisions in aging policy affecting millions of older Americans.

Finally, my thanks to the staff of the Alliance for Aging Research—I think they have done a spectacular job to get a wonderful discussion here today. Thank you very much for being with us.

Dr. Cohen.

STATEMENT OF DR. GENE COHEN, M.D., DIRECTOR, WASHINGTON, DC CENTER ON AGING, WASHINGTON, DC.

Dr. GENE COHEN. Thank you very much, Mary. It is a real pleasure to be here. I want to also thank Chairman Cohen and the committee, as well as the staff and Mary, for helping coordinate such an important forum and meeting.

I am going to be making a few introductory remarks and then introducing each of the panel members who will then make comments.

None of us needs reminders as to why we are doing this. But nonetheless, the sub-theme of my presentation is not to overlook the obvious. I am reminded of a wonderful opportunity I had a few years ago to do a national public service message with somebody who is an excellent reminder of what is possible in later life, and that was an interview I had with George Burns about 3 years ago. He certainly illustrates how well and how long right to the end one can live and remain in good humor.

At 97, when I was interviewing him and discussing the advances in geriatrics, I said, "With all the advances and new knowledge among doctors, What has your doctor said to you about your smoking and drinking?"

He said, "My doctor is dead." [Laughter.]

But again, he is a reminder of the potential and the advances in the field of geriatrics.

As I mentioned, the sub-theme of my brief comments in geriatric research, education and training is the need not to overlook the obvious. Again, that obvious should not be overlooked. Health problems of older adults represent the greatest risk factors driving the need for long-term care. The elderly population is the fastest-growing age group in America.

It should also be obvious that the best ways to reduce risk factors that drive the need for long-term care are: (1) through research breakthroughs resulting in prevention and cures, and (2) training effectively to translate research findings into clinically effective and cost-efficient treatments. If not obvious, it should be recognized that we are in the midst of a scientific revolution in the tools, techniques, and theories that can enable us to better understand basic mechanisms underlying the process of aging, disease, and disability in later life.

This revolution is the outgrowth of a synergy between progress in health sciences research in general and the unique contribution of geriatric and gerontologic studies. We are in a period where scientific developments and research on aging have been pioneering and unparalleled. It is a historic moment in the fields of geriatrics and gerontology. Whenever a field is at its golden moment, resources invested are leveraged far more than would otherwise be the case because of the sense of history and zeal of the field's pioneers and students.

Such a moment is not the time to put on the brakes, certainly not when it comes to the support of research and training that have launched this new field and catalyzed its advances. It is certainly not the time to put on the brakes when the growth of older Americans is accelerating at a greater rate than ever before.

Harnessing the scientific revolution in research on aging is the best strategy for meeting the challenges of the demographic revolution of older adults. The harnessing process requires a strategy combining research training to train new researchers to build upon the historic momentum of studies in progress with the training of academic leaders who in turn will train practitioners to optimally apply this new knowledge.

The path is clear, but the challenge is great, because our present cadre of academic leaders in aging is too sparse to meet the needs of our population of older adults who exceed in number the entire population of Canada. We have, in effect, a Nation within a Nation of older adults.

At the same time, we have what many consider a revolution in health care with the rapid growth of managed care. About managed care, we should also not overlook the obvious, which is the tremendous focus on efficiency and productivity that often translates into scheduling more doctor visits in less time. Meanwhile,

the fastest-growing patient population is the geriatric patient group.

To state the obvious once again, this is a group who typically have more extensive medical conditions that demand a high degree of knowledge and skill if they are to be managed safely and effectively in limited time. This highlights the need for geriatric training. There is a critical need for geriatric experts who can effectively train primary care providers to appropriately meet the needs and numbers of their older patients. Inadequate training can be literally a life and death matter.

Data from a recent study underline this concern. More than one-third of the older men in this study who committed suicide saw their doctors in the last week of their lives, and over 70 percent in the last month. To what extent were these physicians educated to know that the rate of suicide is greatest in older adults, highest in elderly white males; to what extent were they trained to ask their older patients if they felt depressed or had thoughts of suicide? While the challenges in meeting the needs of older patients have never been greater, so too the opportunities through geriatric research and training to meet these needs never have been greater.

To make one final point that should be obvious, meeting the needs of older patients is not just meeting the needs of elderly individuals; it is also meeting the needs of the family as a whole, who want to do the best by their older loved ones. Society has both the responsibility and the opportunity to make historic contributions in meeting the historic challenges of our booming older population, but it relies on informed health care policies as they affect older Americans and their families.

[The prepared statement of Dr. Cohen follows:]

Gene D. Cohen, M.D., Ph.D.

Geriatric Research, Education, and Training: *The Need Not to Overlook the Obvious*

The obvious should not be overlooked: Health problems of older adults represent the greatest risk factors driving the need for long-term care, and the elderly population is the fastest growing age group in America. What should also be obvious is that the best ways to reduce risk factors that drive the need for long-term care are through (1) research breakthroughs resulting in prevention and cures, and (2) training effectively to translate research findings into clinically effective and cost efficient treatments. If not obvious, it should be recognized that we are in the midst of a scientific revolution in the tools, techniques, and theories that can enable us to better understand basic mechanisms underlying the process of aging and disease and disability in later life. This revolution is the outgrowth of a synergy between progress in health sciences research in general and the unique contribution of geriatric and gerontologic studies.

We are in a period where scientific developments in research on aging have been pioneering and unparalleled; it is a historic moment in the fields of geriatrics and gerontology. Whenever a field is at its golden moment, resources invested are leveraged far more than would otherwise be the case because of the sense of history and zeal of the field's pioneers and students. Such a moment is not the time to put on the brakes—certainly not when it comes to the support of research and training that have launched this new field and catalyzed its advances. And it is certainly not the time to put on the brakes when the growth of older Americans is accelerating at a greater rate than ever before.

Harnessing the scientific revolution in research on aging is the best

strategy for meeting the challenges of the demographic revolution of older adults. The harnessing process requires a strategy combining research training, to train new researchers to build upon the historic momentum of studies in progress, with the training of academic leaders who in turn will train practitioners to optimally apply this new knowledge. The path is clear, but the challenge is great, because our present cadre of academic leaders in aging is too sparse to the meet the needs of our population of older adults who exceed in number the entire population of Canada. We have, in effect, a nation within a nation of older adults.

At the same time, we have what many consider a revolution in health care with the rapid growth of managed care. About managed care, we should also not overlook the obvious—the tremendous focus on efficiency and productivity that often translates into scheduling more doctor visits in less time. Meanwhile, the fastest growing patient population is the geriatric patient group. And to state the obvious, once again, this is a group who typically have more extensive medical conditions that demand a high a degree of knowledge and skill if they are to be managed safely and effectively in limited time. This highlights the need for geriatric training—the critical need for geriatric experts who can effectively train primary care providers to appropriately meet the needs and numbers of their older patients. Inadequate training can be literally a life and death matter. Data from a recent study underline this concern; more than one-third of the older men in this study who committed suicide saw their doctors in the last week of their lives and over 70%, in the last month. To what extent were these physicians educated to know that the rate of suicide is greatest in older adults—highest in elderly white males; to what extent were they trained to ask their older patients if they

felt depressed or had thoughts of suicide?

While the challenges in meeting the needs of older patients have never been greater, so too the opportunities through geriatric research and training to meet these needs never have been greater. And to make one final point that should be obvious, meeting the needs of older patients is not just meeting the needs of elderly individuals; it is also meeting the needs of the family as a whole who want to do the best by their older loved ones. Society has both the responsibility and the opportunity to make historic contributions in meeting the historic challenges of our booming older population, but it relies on informed health care policies as they affect older Americans and their families.

Dr. GENE COHEN. I would like to now move to the presentations by our very distinguished panel, who represent wonderfully a number of the leaders and catalyzers of the tremendous progress that is going on in research, education, and training in America.

The first presentation will be Jerome Kowal, M.D., director, Pepper Centers, Geriatric CARE Center, Case Western Reserve University, Cleveland, OH.

Dr. Kowal.

STATEMENT OF DR. JEROME KOWAL, M.D., DIRECTOR, PEPPER CENTERS, GERIATRIC CARE CENTER, CASE WESTERN RESERVE UNIVERSITY, CLEVELAND, OH

Dr. KOWAL. I want to thank Senator Cohen and the committee for inviting me to participate in this hearing.

Federal and foundation grant support for geriatric training and research initiatives have been of immense benefit in the development of academic research and clinical training in geriatrics. As a result of these initiatives, an increasing body of knowledge has been attained through expanded clinical and basic biomedical research. However, the level of funding on a national level has been largely inadequate to fund more than a small percentage of established medical institutions.

The geriatric medicine program I direct at Case Western Reserve University demonstrates the critical importance of Federal and foundation funding for the development of an academic center in geriatrics. Having been trained as an endocrinologist and research biochemist, I served as chief of medicine and then chief of staff at the Cleveland VA Medical Center from 1974 to 1984. During this time, I became increasingly aware of the geriatric imperative.

Presented with the opportunity to develop a new geriatric medicine program at the Cleveland VA and University Hospitals of Cleveland 12 years ago, I spent 6 months as a visiting professor at UCLA in their Multi-campus Division of Geriatric Medicine and returned to Cleveland to build a geriatric research and training program. A geriatric leadership academic award from the NIA in 1985 provided me with protected time to establish links with a number of experience investigators on campus. This led to the award of an NIA research training grant in geriatrics.

This grant, plus support from the VA and Bureau of Health Professions, as well as from Medicare funding, permitted us to graduate over 30 physicians in geriatrics, all of whom have academic positions right now. Unfortunately, the severe curtailment of funds for Bureau of Health Professions fellowships in 1993 cut the size of our program dramatically.

Funding from the Bureau of Health Professions for the Western Reserve Geriatric Education Center in 1985 resulted in the development of strong interdisciplinary alliances, not only throughout our own campus, but with three other medical schools in Ohio and a number of universities. From 1985 to the present, the WRGEC has provided an extensive array of postgraduate and continuing education programs to literally thousands of professionals in over 20 health care disciplines. Our education center is the principal source of continuing education in aging throughout northern and southeastern Ohio, serving both urban and rural populations.

As a result of these activities, we were designated as one of 13 centers of excellence by the Hartford Foundation and received support for 3 years for new initiatives in recruitment. Funding of our Pepper Center has permitted us to embark on innovative interventions on a specialized Acute Care for the Elderly Unit to improve outcomes for elderly at risk for dysfunctional decline during acute hospitalization. An initial grant from the Hartford Foundation had demonstrated the feasibility and effectiveness of the proposed interventions as well. The ACE Unit program has been replicated in a number of institutions throughout the country and has served as a potential model for future systems of care in the acute hospital.

Program cuts in recent years have seriously retarded the progress that has been made, and further proposed cuts threaten to eliminate opportunities for further program development at both currently funded and currently unfunded institutions. This is occurring despite the fact that the most critically important problem facing geriatrics today is increasing the quantity and quality of geriatric physician faculty to meet national training needs in geriatrics.

As you all know, geriatrics focuses on optimizing functional independence for the most frail and high-risk members of our population, thereby reducing health care costs. The transition to capitated managed care has placed increasing emphasis on equipping primary care physicians to appropriately treat the increasing numbers of elderly patients. More than ever, we need to increase the number of trained academic geriatricians who, in turn, will create incentives for physicians to choose a career in geriatric medicine. We need to provide greater opportunities for clinical and research training as well.

Required geriatric rotations in internal medicine and family practice residency programs have been mandated by their respective boards. Despite this, many schools of medicine—as you have heard—still have inadequate faculty to provide undergraduate or postgraduate training. National surveys reveal that hospital-based training sites considered essential for geriatric training are still lacking in many institutions.

Furthermore, although over 6,000 internists and family physicians have been certified as having added qualifications in geriatric medicine, only a relatively small proportion of them have received formal geriatric training. The current requirement for completion of an accredited 2-year geriatric program has reduced the number eligible for certification to less than 100 per year in the United States. The recent reduction in the fellowship requirement for certification in geriatrics to 1 year should add to this number, but will do little to increase the number of faculty in geriatrics. Trainees in an academic track require at least 2 or 3 years of fellowship experience to achieve competence as educators and investigators.

Looking at the programs themselves, despite budgetary increases in NIA-funded research fellowship, career development, and leadership grants, the level of interest is outstripping funding. In contrast, deep funding cuts have adversely affected the Bureau of Health Professions-sponsored geriatric medical and dental fellowship programs and geriatric education centers. Both programs pro-

vide excellent support for training of a wide range of health care professionals.

The Geriatric Education Center Network extends to 31 States. At its peak in 1990, there were 38 funded education centers. From a high point of $11.7 million in 1991, with an authorization of $17 million, the GEC Network funding level is currently at $7.8 million for fiscal year 1996. Currently, because of these reductions in funding, the number of funded GEC's has decreased to 18. Next year, they are forecasting as little as 12 GEC's that may be funded. There is no funding for competitive renewals in fiscal year 1996 and a number of excellent programs will not have an opportunity for continued funding.

The GEC's provide service to health care professionals in rural areas as well as major urban centers. The rural focus of the GEC's has filled a gap long recognized in health care education.

The VA's Geriatric Research, Education, and Clinical Centers—the GRECC Program—VA-funded geriatric fellowship programs, and specialized Geriatric Evaluation and Management—GEM—Units have addressed national needs for innovative clinical care, research, and training. The VA GRECC's have served as a resource for geriatric research and training within the VA system since the early 1970's. Although 25 GRECC's were authorized originally, only 16 have been funded. Because of funding limitations, there has been no competition for additional centers for the past 3 years. It is fair to say that almost all of the largest and most successful programs have an affiliated GRECC. Despite the rapid increase in the number of aging veterans, budget constraints seriously threaten future funding for geriatric care.

At a 1987 meeting sponsored by the Institute of Medicine, a strategy of funding Geriatric Centers of Excellence was recommended to mobilize successful programs and focus limited case resources for training of investigators and enhancement of creative interaction among scientists in diverse research areas. As people grow older, their independence is progressively threatened by the increasing occurrence of chronic diseases and disabilities, as well as a decline in function associated with inactive lifestyles.

To counter this, the NIA established the Claude Pepper Older Americans Independence Centers Program. The Pepper Program offers research focusing on the maintenance of optimum function and independence of our aging population. The 5-year Pepper Center Program complements existing systems of research support to capitalize on existing strengths and unique capabilities at each institution, particularly atypical research which might not function well in a competitive environment for funding.

The organization of each center includes core functions to stimulate and support individual research intervention projects and disseminate their results. Particular emphasis is placed on translating basic research findings into meaningful interventions to enhance independence and quality of life. It also provides a vehicle for funding pilot projects needed to establish a rationale for larger scale research initiatives.

The poster exhibits to follow this hearing show that all of the Pepper Centers provide opportunities for a great diversity of intervention studies, intervention development studies, and pilot

projects designed to improve independence. Through pilot projects and direct faculty support, junior faculty members are assisted in their move to geriatric academic careers at critical times in their development.

The opportunity to obtain startup support brings new investigators with many innovate ideas into geriatric research. Our Pepper Center at our own institution has funded over 30 investigators in aging research.

Core services in the Pepper Centers also assist aging research by facilitating access to older populations, aging animal colonies, and specialized statistical and other technological support. However, because of funding constraints, the Pepper Program has been limited to only 10 centers nationally, with very intense competition for available awards.

In summary, the future success of geriatric medicine depends on the attainment of a critical mass of academic and clinical geriatricians who will function as advocates for the care of older persons, develop new knowledge in the field, and act as role models and educators for physicians in training at the graduate and postgraduate level. The NIH, VA, and Bureau of Health Professions programs discussed today not only serve to increase the number of geriatric practitioners, but also to enhance research activities in improving the independence of aging citizens and disseminate vitally important information to health care practitioners at all levels.

However, these programs are faced with a declining resource base. To significantly meet the academic needs for geriatric research and training on a national level, we need to have a significant expansion of support to build on current successes and encourage the participation of other emerging programs. An increased investment now in geriatric training and research, as you have already heard, is required to face the health care pressures we see looming as the baby boom population passes 65 years of age. Cost effective management of their care, avoidance of costly institutionalization, and optimization of their quality of life are the critically important outcomes of this investment.

Thank you.

[The prepared statement of Dr. Kowal follows:]

Testimony before the Senate

Jerome Kowal, MD

I want to thank the Committee for inviting me to participate in this hearing.

Federal and foundation grant support for geriatric training and research initiatives have been of immense benefit in the development of academic research and clinical training in geriatrics. As a result of these initiatives, an increasing body of knowledge has been attained through expanded clinical and basic biomedical research. However, the level of funding on a national level has been largely inadequate to fund more than a small percentage of established medical institutions.

The geriatric medicine program I direct at Case Western Reserve University demonstrates the critical importance of federal and foundation funding for the development of an academic center in geriatrics. Trained as a clinical endocrinologist and research biochemist, I served as Chief of Medicine and then Chief of Staff at the Cleveland VA Medical Center from 1974 to 1984. During this time, I became increasingly aware of the "geriatric imperative." Presented with the opportunity to develop a new geriatric medicine program at the Cleveland VA and University Hospitals of Cleveland, I spent six months as a visiting professor at UCLA in their Multicampus Division of Geriatric Medicine and returned to Cleveland to build a geriatric research and training program. Initial support for fellowship slots and an inpatient assessment unit by our local VA Medical Center provided the impetus for recruitment. My receipt of a Geriatric Leadership Academic Award from the NIA in 1985 provided me with the protected time to establish links with 13 experienced investigators on campus for the successful submission of a grant application to the NIA for Research Fellowship Training in Geriatrics. This four year grant was subsequently renewed in 1990 and was competitively renewed once again in 1995. We have trained over 30 physicians, all of whom hold academic positions today. Additional support for fellowship training in medicine and dentistry from the Bureau of Health Professions enabled our fellowship program to grow to one of the largest in the country. Funding of the Western Reserve Geriatric Education Center (WRGEC) in 1985 resulted in the development of strong interdisciplinary alliances, not only throughout our own campus, but with three other medical schools in Ohio and a number of universities. From 1985 to the present, the WRGEC has provided an extensive array of postgraduate and continuing education programs to thousands of professionals in over 20 health care disciplines and has become the principal source of continuing education in aging throughout northern and southeastern Ohio, serving both urban and rural populations. As a result of these activities, we were designated as one of thirteen "Centers of Excellence" by the Hartford

Foundation. Geriatrics became increasingly visible on our campus and led to a successful submission of an application for a Pepper Center. Funding of the Pepper Center has permitted us to embark on innovative interventions on a specialized Acute Care for the Elderly (ACE) Unit to improve outcomes for elderly at risk for dysfunctional decline during acute hospitalization. An initial grant from the Hartford Foundation demonstrated the feasibility and effectiveness of the proposed interventions. The ACE Unit program has been replicated in a number of institutions throughout country and has served as a potential model for future systems of care, both in the acute hospital and during the transition period following hospitalization. Our pilot project program has brought thirty investigators into aging research. We currently have fourteen geriatric trained faculty in our clinical geriatric program and collaborations with over 40 other clinical faculty. Case Western Reserve University ranks 9th in the U.S. in NIA research and training funding. This is also supplemented by funding from the Hartford and other foundations, as well as other NIH institutes and the Bureau of Health Professions.

Program cuts in recent years have seriously retarded the progress that has been made and further proposed cuts threaten to eliminate opportunities for further program development at currently funded and unfunded institutions. This is occurring despite the fact that the most critically important problem facing geriatrics today is increasing the quantity and quality of geriatric physician faculty to meet national training needs in geriatrics, both in clinical care and research in aging.

Geriatrics focuses on optimizing functional independence for the most frail, high risk members of our aging population, thereby reducing health care costs. The transition to capitated managed care has placed increasing emphasis on the important role that training plays in equipping primary care physicians to appropriately treat the increasing numbers of elderly patients. More than ever, we need to increase the number of trained academic geriatricians who, in turn, will create incentives for physicians to choose a career in geriatric medicine and we need to provide greater opportunities for clinical and research training. Required geriatric rotations in internal medicine and family practice residency programs have been mandated by their respective boards. Despite this, many schools of medicine still have inadequate faculty to provide undergraduate or postgraduate training. As a result, even established programs have difficulty in attracting the best residents into geriatric academic careers. National surveys reveal that hospital-based training sites considered essential for geriatric training are still lacking in many institutions.

Although over 6,000 internists and family physicians have been certified as having added qualifications in geriatric medicine, only a relatively small proportion of them have received formal

geriatric training. The current requirement for completion of an accredited two year geriatric program has reduced the number eligible for certification to about 100 per year in the entire U.S. The reduction in the fellowship requirement for certification in geriatrics to one year should add to this number, but will do little to increase the number of faculty in geriatrics who require at least two or three years of fellowship experience to achieve competence as educators and investigators.

NIA-funded research fellowship, career development and Leadership grants have provided opportunities for academic faculty development. The deepest funding cuts have affected the Bureau of Health Professions-sponsored geriatric medical and dental fellowship programs and Geriatric Education Centers, which have provided excellent support for training of a wide range of health care professionals. The Bureau of Health Professions-funded Geriatric Education Center network extends to 31 states; at its peak in 1990, there were 38 funded education centers. From a high point of $11.7 million in 1991, the GEC network funding level is at $7.8 million for FY 96. Currently, because of reductions in funding, the number of funded GECs has decreased to 18, and next year as little as 12 GECs may be funded. There is no funding for competitive renewals in FY 1996. The GECs not only collaborate with Pepper and Alzheimers Centers for dissemination of vital information, but they also provide service to health care professionals in rural areas, as well as major urban centers. The rural focus of the GECs has filled a gap long recognized in health care education.

The VA's Geriatric Research, Education and Clinical Centers (GRECC), VA-funded geriatric fellowship programs and specialized Geriatric Evaluation and Management (GEM) units have addressed national needs for innovative clinical care, research and training. More recently, the NIA-supported Claude Pepper Older Americans Independence Centers offer innovative approaches to research focusing on the maintenance of optimum function and independence of our aging population. The VA GRECCs have served as a resource for geriatric research and training within the VA system since the early 1970s. Although 25 GRECCs were authorized, 16 have been funded and because of funding limitations, no additional Centers have been funded for the past three years. It is fair to say that almost all of the largest and most successful programs have an affiliated GRECC. Despite the rapid increase in the number of aging veterans, budget constraints seriously threaten future funding for geriatric care.

At a 1987 meeting sponsored by the Institute of Medicine, a strategy of funding Geriatric "Centers of Excellence" was recommended to mobilize successful programs and focus limited cash resources for training of investigators and enhancement of creative interaction among scientists in diverse research areas. As people grow older, their independence is progressively threatened by

the increasing occurrence of chronic diseases and disabilities, as well as a decline in function associated with inactive lifestyles. To counter this, a major initiative was developed which led to the inclusion of funds in the NIA budget to establish the Claude Pepper Older Americans Independence Centers program. The five year Pepper Center program complements existing systems of research and training to capitalize on existing strengths and unique capabilities at each institution.

The organization of each center includes core functions to stimulate and support individual research intervention projects and disseminate their results. Particular emphasis is placed on translating basic research findings into meaningful interventions to enhance independence and quality of life. It also provides a vehicle for funding pilot projects which generate information needed to establish a rationale for larger scale research initiatives. The poster exhibits to follow this hearing show that all of the Pepper Centers provide opportunities for a great diversity of intervention studies, intervention development studies and pilot projects designed to improve independence. Through pilot projects and direct faculty support, junior faculty members are assisted in their move to geriatric academic careers at critical times in their development. The opportunity to obtain start-up support brings new investigators with many innovative ideas into geriatric research. Core services in the Pepper Centers also assist aging research by facilitating access to older populations, aging animal colonies and specialized statistical and other technological support. However, because of funding constraints, the Pepper program has been limited to only 10 Centers nationally, with intense competition for available awards.

In summary, the future success of geriatric medicine will center on the attainment of a critical mass of academic and clinical geriatricians who will function as advocates for the care of older persons, develop new knowledge in the field and act as role models and educators for physicians in training at the graduate and postgraduate level. The NIH, VA and Bureau of Health Professions programs discussed today not only serve to increase the number of geriatric practitioners, but also to enhance research activities in improving the independence of aging citizens and disseminate vitally important information to health care practitioners at all levels. However, these programs are faced with a declining resource base. To significantly meet the academic needs for geriatric research and training on a national level, we need to have a significant expansion of support to build on current successes and encourage the participation of other emerging programs. An increased investment now in geriatric training and research is required to face the health care pressures we see looming as the baby boom population passes 65 years of age. Cost effective management of their care, avoidance of costly institutionalization and optimization of their quality of life are the critically important outcomes of this investment.

Dr. GENE COHEN. I am going to ask the panelists to sit down at the table after they make their presentations.

Dr. Kowal's presentation wonderfully illustrates how limited resources can leverage a very impressive program. At the same time, he announces the dangers of breaking that momentum at such a critical time in the growth of programs and the aging population.

The next presentation is going to be by Mark Lachs, M.D., MPH, chief, Geriatric Unit, Division of General Internal Medicine, The New York Hospital-Cornell University Medical College, NY.

STATEMENT OF DR. MARK S. LACHS, M.D., CHIEF, GERIATRIC UNIT, DIVISION OF GENERAL INTERNAL MEDICINE, THE NEW YORK HOSPITAL–CORNELL UNIVERSITY MEDICAL COLLEGE, NEW YORK, NY

Dr. LACHS. Thank you, Dr. Cohen.

I wanted to offer some personal thoughts on how we might entice medical students and physicians in training into our field. I will cut to the chase. I think the most compelling experience for an impressionable young medical student or intern or resident who is considering a career in geriatric medicine is the availability of a role model, a mentor.

When I was in New Haven, I had the benefit of having such a mentor and role model, a geriatrician that many of you know by the name of Dr. Leo Cooney. Since Leo is not here, I can embarrass him.

Let me tell you that Leo could take one look at your grandmother, and usually without the benefit of a lot of high-tech machinery, pretty much figure out exactly what the problem was. Moreover, he could tell you how to fix it in such a way that it would not create more problems than what brought the patient to the doctor in the first place.

I think this is the great appeal of modern geriatric medicine. It is the return to common sense at a time when much of our health care system doesn't seem to make a whole lot of sense. I have no doubt that if there were 100,000 such physicians in the United States, the quality of geriatric medicine would improve exponentially while ironically—as Senator Cohen alluded to earlier—the cost of health care would probably fall.

But it was much more than clinical expertise when Leo and others like him saw a patient at the bedside with medical students grouped around him. There was a certain dignity that filled the room, as if that connection was the most important thing in the world for that moment. Medical students, interns, and residents looked at that interaction and said, "I want to be like that guy." I was one of those impressionable physicians in training. I think every day about those interactions as I interact with my own medical students and interns at the Cornell University Medical College.

But we live in an era now of managed care. As most of you know, managed care places extraordinary pressure on medical school faculty—particularly junior faculty—to be involved in administration and clinical care in a way that is just completely bereft of research and teaching. I think the great virtues of programs like the Paul Beeson Scholars Program and the wonderful programs sponsored by NIA, the academic award programs—it permits faculty develop-

ment. People are able to spend most of their time in research. At the same time, they can make sure that their interactions with interns, residents, and medical students are of the highest possible quality.

In each of those interactions that I am involved with, I try to impart my sincere belief and my enthusiasm that the challenges faced by geriatricians scientifically are in every way as exciting as the challenges faced by oncologists, cardiologists, and surgeons. We are a group of physicians who in our clinical lives fire no high-tech lasers, we yield no expensive catheters, we perform no dramatic surgeries. But I would argue from a policy standpoint that our scientific work, which is improving independence and keeping older adults in the community as long as possible and out of long-term care facilities, is very relevant and perhaps much more relevant from a policy standpoint.

Things have come full circle for me. You can imagine my delight and the look on my face when one of my senior residents—a wonderful young woman by the name of Catherine Sarkisian—told me that on the basis of her interactions with me—and I think probably her general inclination toward medicine—several months ago she told me, "I am selecting a career in geriatric medicine."

How do you put a price on that? You can't. It's priceless. This is a woman who will go out into the community, herself caring for tens of thousands of older adults over the course of a career, and undoubtedly mentor and influence other junior faculty members and cohorts of medical students that will exist in the future.

That is essentially the summary of my comments. There is a more detailed written record that I have provided to Senator Cohen's office. If there are any questions, I would be happy to answer them later.

Thank you.

[The prepared statement of Dr. Lachs follows:]

Testimony of Mark Lachs MD, MPH

Paul Beeson Physician Faculty Scholar
Chief, Geriatric Unit, Division of General Internal Medicine
The New York Hospital-Cornell University Medical College
Before the Senate Special Committee on Aging
May 14, 1996

Members of the Committee:

I have been asked to address this committee on the specific issue of how we can entice more physicians-in-training to select careers in geriatric medicine. I have passionate feelings about this topic, and I am honored to have been asked to share them with you.

I must begin emotionally, and tell you that the most compelling experience for an impressionable young medical student or intern considering a career in geriatric medicine (or any field of medicine for that matter) is the availability and visibility of a mentor and role model. While in New Haven I had such a role model, a geriatrician by the name of Leo Cooney. Leo could take one look at your grandmother, and usually without the need for high tech machinery, figure out exactly what the basic problem was. He could also tell you how to address it in a way that was least likely to cause more problems than what brought the patient to the doctor in the first place. In this way, good geriatric medicine represents a return to common sense. I have no doubt that if there were 100,000 such physicians in the United States, the quality of geriatric care in this country would improve exponentially, and ironically, the cost of health care would fall. But it was more than clinical expertise. When Leo and others like him saw an older adult with medical students grouped around him, I watched in amazement as a certain dignity filled the room. Physicians-in-training at all levels looked at this mentor and said "I want to be like that". I was one of those impressionable doctors, and the attention that Dr. Cooney applied to shepherding my own career is something that I think about every day as I interact with New York Hospital-Cornell Medical Students and Residents.

Because of its explicit mentorship, The Paul Beeson Physician Faculty Scholars Program is a program emblematic of how to develop faculty in geriatric medicine. In addition to having my own research mentor at Cornell (Dr. Mary Charlson) who aids me in my studies of family violence perpetrated against older adults, I have begun to experience a new joy in geriatric medicine - the process of becoming a mentor to young physicians myself. At a time when managed care places extraordinary pressure on medical school faculty to be involved in direct clinical care bereft of teaching or research, programs like the Beeson Scholarship enables me to concentrate the lion's share of my time on research, while also making sure that my interactions with medical students and interns are of the highest possible quality. In those interactions, I try to impart my enthusiasm and belief that the scientific challenges facing geriatricians are in every way as exciting as the challenges that are faced by more "traditional" organ based subspecialists. We perform no dramatic surgery, yet I would argue that our work (improving the functional status and independence of the fastest growing segment of society) is much more important from

a policy standpoint than the work of our non-geriatric colleagues. Imagine my delight when one of our senior residents, Dr. Catherine Sarkisian, with whom I co-authored a paper for a prominent medical journal, announced proudly to me that on the basis of our interactions, she had selected a career in geriatric medicine. How can one put a price on the support that enabled me to guide and influence her decision? It is in fact, priceless. Catherine will care for tens of thousands of older adults over the course of her career, and undoubtedly influence other medical residents the same way that I influenced her.

You also asked me to comment on how a changing health care environment influences the training of future geriatricians. Permit me to distill your question into its most basic form: Is managed care good or bad for geriatric medicine? You may be surprised by my answer. While in 1996 America it is easy to find cynical physicians who bemoan the advent of managed care, I would argue that managed care offers both exciting opportunities as well as clear dangers for those contemplating a career in geriatric medicine. Allow me to be more specific.

For over a decade, geriatricians have been the underclass of modern medicine. We wield no reimbursable catheters. We fire no expensive lasers. Our interventions are low tech and common sense. We stop more medicines than we start. We reconsider elective surgery. The funding arrangement of traditional fee-for-service medicine has certainly played some role in fostering the salary perversity that has led promising young students away from geriatric medicine. How is it that a geriatric internist can agonize for weeks over the decision to send his 80 year old patient for elective hip replacement, carefully weighing the risks and benefits given her other medical problems, while the surgeon who performs the replacement may paid literally 20 times what the geriatrician earns?

To its credit, managed care turns that arrangement on its head. As the primary care physicians charged with managing the clinical care (and the global health care budget) for an older individual under capitation, we have become the gatekeepers to the highest utilizers of health care services in society. Suddenly we are very popular. I look at the world of medical care and I see physician and institutional excess capacity in one area (acute care institutions and acute care physicians) and an appalling shortage in another (long term care institutions and long-term care physicians - geriatricians). When capitation truly becomes global and health care institutions are given a fixed amount for all the care provided for an older adult be it at home, in a hospital, or in a nursing home, we become forced to find innovative strategies to keep older adults at the highest level of functioning because an independent older person is less expensive to care for than one who is dependent. The danger of course, is that needed services will be withheld under managed care so that the physical condition on an older adult who might otherwise live independently with some assistance at home declines to the point that a nursing home is required. Fixing this serious lesion will require not only regulatory oversight of managed care, but also and end to the cost shifting that takes place in our fragmented system of payers (e.g. between private insurers and the Medicare program or between the Medicare and the Medicaid program).

And therein lies the challenge to the next wave of academic geriatricians. Let me articulate it precisely because it is a research question that is among the most compelling in all of

modern medicine. Given a global budget for all the acute and long term care for an older individual, what are the most cost effective interventions that maximize the functional status of an older adult? I view this form of "outcomes" or "health services research" as important as any experimentation in gene therapy or molecular biology.

In summary, my recommendations to increase the number of academicians in teaching and clinical care are:

1. To provide role models in academic medical centers who typify the research, clinical, and educational approach of the consummate geriatrician. Given the fiscal pressure on academic institutions, faculty development programs like the Paul Beeson Physician Faculty Scholars Program from the American Federation for Aging Research becomes crucial to protect the time of faculty who are under enormous clinical pressure in our current health care environment. They must be available to perform research, teach, and mentor the research of others.

2. To fund both patient-oriented and basic research in geriatric medicine. Researchers supported by The National Institute of Aging have made extraordinary advances in the field of aging. Funding for this research must continue and physicians-in-training at all levels must hear the message that the scientific challenges faced by modern geriatric medicine are as exciting as in in cardiology, infectious disease, or cancer. Additionally, the policy implications of patient-oriented research in geriatric medicine are far reaching for this nation.

3. To continue to recraft the reimbursement system for health care in the United States - through either market forces, legislative edict, or both - in such a way as to recognize the extraordinary cognitive skills that geriatricians bring to the care of patients who require much more attention than younger counterparts. The fragmentation of systems and payers must also end if the "seams" in the continuum of care are to be removed.

I believe that because of a variety of converging forces - managed care, a growing outcomes research movement, and an appreciation for the kinds of multidisciplinary (and often low tech) interventions that geriatricians employ, this is a most exciting time for our field. I am honored to have been asked to address you.

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Dr. GENE COHEN. Thank you very much, Dr. Lachs.

Again, I think he eloquently makes the case of common sense as to what is going to make a big difference in courting the interest, curiosity, motivation, and accumulation of knowledge of people in basic training. How is any of that going to happen without the role of a knowledgeable teacher, somebody trained in geriatrics, for imparting knowledge in aging?

The third presentation is given by Mary Tinetti, M.D., associate professor of Medicine, Yale University and director, Yale Claude D. Pepper Older Americans Independence Center, New Haven, CT.

STATEMENT OF DR. MARY E. TINETTI, M.D., ASSOCIATE PROFESSOR OF MEDICINE, YALE UNIVERSITY AND DIRECTOR, YALE CLAUDE D. PEPPER OLDER AMERICANS INDEPENDENCE CENTER, NEW HAVEN, CT

Dr. TINETTI. Thank you, Dr. Cohen.

I wanted to start by presenting a case that those of you in the audience who take care of elderly patients will not find at all surprising. Those of you who have aging parents will also not find this very surprising.

Mrs. H. is a 78-year-old woman who, in spite of an increasing burden of diseases including Parkinson's disease and osteoporosis, has been able to maintain independent living in her own home. Her two daughters, who also have young children and work full-time, take turns doing her laundry and housekeeping. They have repeatedly offered to pay for a housekeeper, but Mrs. H. is a very private person and doesn't want anyone else besides family in her home.

During a routine visit by her doctor, who has been taking care of her for 20 years—and really knows her quite well—found that her cholesterol was elevated. Following appropriate guidelines by many eminent organizations began her on a cholesterol-lowering drug. These were guidelines developed from data on younger people. Because we have no data on older people, we extrapolate to older people.

Soon after beginning this medication, she noticed difficulty getting in and out of chairs. One day while getting out of the bathtub, she fell and broke her hip.

She came into the hospital, had a surgical repair of her hip. On the third day, the orthopedist thought she was doing terrific. Knowing that she was close to outstaying her DRG stay, called in discharge planner.

While she was talking with the nurse about a discharge home, she developed some very excruciating chest pains and was transferred rapidly to the coronary care unit, where she was found to be having a heart attack. While in the coronary care unit she became agitated and confused. A psychiatrist was called and started a medication to calm her. While on this medication she now became immobile, increasingly confused, and now became incontinent.

She couldn't work with the physical therapist who was trying to help her to learn to walk to get back home. After 29 days in the hospital she was transferred to a nursing home. Mrs. H., who didn't even want somebody in her house to help her vacuum her

rug, now needed the help of strangers to do personal tasks such as bathing and dressing.

I think her story, unfortunately, is really not atypical and didn't result from the lack of care by competent physicians and wasn't because of substandard hospital care. Indeed, she received state-of-the-art care for her heart diseases and state-of-the-art care for her orthopedic problems. Rather, I would say that the health care system failed her because of the lack of knowledge of how to take care of patients like Mrs. H.

We don't know if cholesterol-lowering drugs help asymptomatic older women. Do the benefits outweigh the risks? We don't really know how to prevent the osteoporosis. We don't really know how to prevent the likelihood that she is going to fall. We don't know how to prevent the devastating effects of acute hospitalization. The health care system fails her because of the lack of knowledge. It has failed her because of a lack of a sufficient number of physicians who are trained in caring for patients like her.

Because of repeated cases played out every day in the health care system in the nursing homes and hospitals and physician's offices throughout the country, we need to drastically and rapidly increase the number of people who can take care of the problems such as Mrs. H. We need academic geriatricians and we need primary care physicians with special expertise. We need the academic leaders to teach medical students how to take care of patients like Mrs. H., and also to conduct the desperately needed—and until very recently largely neglected—research to try to answer the questions of how best to take care of Mrs. H.

As the majority of health care will be appropriately under the direction of primary care physicians—a trend that is clearly going to increase as we move increasingly into managed care—we need these physicians to be trained in caring for the special care needs of older patients such as Mrs. H.

The answer to the why and why now are quite obvious. Certainly the well-known demographic trends that have been discussed repeatedly already this morning are an important reason. But as I said earlier, although the demographic trends have crystallized our need for looking for an increasing number of physicians to care for older people, it is not that simple. Again, as I mentioned earlier, it is ironic that the vast health care system that has allowed frail and chronically ill older people to survive is exactly the health care system that fails them. The health care system is not meant to take care of people like Mrs. H. once they have survived acute diseases.

We need to have physicians who can care for people like Mrs. H. I think she exemplifies these people use a disproportionate amount of our health care system. It is neither appropriate nor cost effective to treat people like Mrs. H. one disease at a time. Indeed, I think you could argue that Mrs. H.'s cardiologist could claim success. She survived the heart attack, something that older women tend to do less than older men. Her orthopedic surgeon could also claim success; her hip fracture was healing. However, it is doubtful that Mrs. H., her family, or society that is left paying the bill would claim that Mrs. H.'s story was a success. Neither would any geriatrician taking care of her.

I think as the debate is focusing on how to contain the spiraling health care costs, we also need to add to this debate how to spend any limited resources that are available. This is the question that is of interest to geriatric researchers who are attempting to understand the many disease processes associated with aging and to determine how to most efficiently, effectively, and safely care for older patients.

It is also a question of concern to geriatricians who, at present, must frequently help patients with major gaps in knowledge of how best to do that. At a time when we are attempting to control costs, it is more imperative than ever that we train a cadre of geriatricians who are equipped with the knowledge and skills to match the needs of individual older patients with the most appropriate and effective care.

I would say this for any complex, multifaceted problem. There is unlikely to be any single solution to the shortage of geriatric researchers, teachers, and practitioners. Several organizations have made some very important suggestions. I would only highlight a few of them that are being played out in the next few days right here in Washington, DC.

I would say the Claude D. Pepper Older Americans Independence Center is one example of an innovative and successful strategy. I think it is well exemplified by the work that is being displayed by these junior investigators. This work has been well worth the effort. Certainly I would say that more support for these centers would be a great investment in the future.

I would say that it is not an exaggeration to state that the Pepper Center support will be a deciding factor in launching the careers of many talented junior geriatricians toward careers in the field of aging. These leaders in training, in turn, are going to be the ones that will provide our increasing knowledge of aging and—just importantly—they are going to train the next generation of clinicians, educators, and researchers. I think that just a small investment in Pepper Centers can have a great pay-off in the future.

I think, similarly, the number of dollars allocated to the NIH through the National Institutes on Aging and other institutes devoted to aging issues is minuscule in comparison to the billions of dollars we spend on providing the health care in the hospitals and nursing homes. Again, a small investment today in research yields a greater pay-off in the future for your health care dollars needed to be spent to treat these frail, chronically ill people who are failed in our present health care system.

Dr. Cohen has well spoken to increasing support for fellowships and other training support is increasingly necessary. It is very necessary right now to get the message out as Medicare and the VA system are pulling back on training support. It is particularly important to get the message out that where we don't want to pull back is on training the geriatricians and the primary care physicians who are going to be caring for the burgeoning number of older patients.

Again, it is well articulated in my written documents and those of other people, other mechanisms such as making sure there is sufficient reimbursement for the care providers is going to entice people to come into the aging field and to stay in the aging field.

This reimbursement needs to reflect the need for multidisciplinary care as physicians are not equipped alone to care for the combination of physical, psychological, social, and economic needs faced by many older people.

We need to recognize that the contacts are not just one-on-one with the patient. There is contact with other care providers, contact with family members by phone. The reimbursement system needs to reflect that if we are going to get primary care physicians who are willing to come in and take care of the complex problems of older people and maintain that field. We need to address issues of reimbursement.

Finally, I would like to conclude by saying that I cannot determine whether patients like Mrs. H. would have fared better under a managed care system or under a fee for service system or any other alternative system, but I can say confidently and without hesitation that she would have fared much better under the care of a geriatrician.

Thank you.

[The prepared statement of Dr. Tinetti follows:]

THE CURRENT AND FUTURE NEEDS FOR GERIATRIC TRAINING: SENATE SPECIAL COMMITTEE ON AGING, Tuesday, May 14, 1996

Mary E. Tinetti, M.D.

Yale University School of Medicine
Director, Yale Claude D. Pepper Older Americans Independence Center

I would like to begin by describing the story of Mrs. H., a 78 year old woman who, while suffering from Parkinson's Disease, arthritis, osteoporosis, and chronic lung disease was able to live alone in her own home. She was able to take care of herself and did her own cooking although she was having increasing difficulty with walking and could no longer handle the stairs. Her two daughters, both of whom work full time and have young children, took turns doing their mother's laundry, shopping, and house cleaning. They had offered to pay a housekeeper, but Mrs. H., a very private person, did not want anyone but family working in her home. During a routine checkup, her physician who had cared for Mrs. H. for over twenty years, found her cholesterol to be elevated. Following guidelines supported by several eminent organizations - guidelines developed from data on younger persons - her physician conscientiously started her on a commonly used cholesterol lowering drug after attempts at diet control failed to lower her cholesterol. After about three months, Mrs. H. noticed increased difficulty with getting up from chairs and walking which she related to leg weakness, a well-recognized although uncommon, side effect of her cholesterol lowering drug. One day, while getting out of the bathtub, Mrs. H. fell backward and broke her left hip. Three days after her hip surgery, her orthopedic surgeon, happy with her surgical repair and postoperative course, was ready to discharge Mrs. H. During her interview with the nurse discharge planner, Mrs. H. experienced severe chest pain and was transferred to the Coronary Care Unit where she was found to be experiencing a heart attack. While in the Coronary Care Unit, Mrs. H. became confused and agitated. A psychiatrist was called who recommended a medication to calm Mrs. H. On this medication, she became lethargic, immobile, and incontinent. She could not work with the physical therapist who was trying to help her learn again how to get out of bed and walk. Mrs. H. developed open areas on her buttocks and heels. After 29 days in the hospital, Mrs. H. was discharged to a nursing home confused, incontinent, and unable to walk without help. Mrs. H., who had not wanted strangers to vacuum her rugs, now depended on people she did not know to help with such personal tasks as dressing, toileting, and bathing. Her acute hospital care cost over $300,000. Her nursing home care, which was covered for a few weeks under Medicare, and then for a few months by self-pay, and eventually by Medicaid (Title 19) once her savings had been depleted, was over $5,000 a month.

The Need for Geriatric Researchers, Teachers, and Practitioners

Mrs. H.'s story, unfortunately not at all uncommon, highlights the need for medical researchers, teachers, and practitioners skilled and knowledgeable in caring for the complex, multifaceted health problems of older persons. The healthcare system failed Mrs. H., not because of incompetent physicians or substandard hospital care. Indeed, Mrs. H. received "state-of-the-art" care for each of her individual problems by excellent clinicians. Rather,

the healthcare system failed Mrs. H. because of the lack of knowledge concerning diseases in older persons (e.g. do cholesterol-lowering drugs in an asymptomatic older woman reduce the rate of heart attacks and does their benefit outweighs their risks?; how best to slow osteoporosis and to prevent the resulting fractures; how to prevent the devastating manifestations of delirium and confusion among sick older hospitalized persons?) and because of the lack of a sufficient number of physicians and other care providers skilled in diagnosing and treating the health problems of multiply and chronically ill older persons such as Mrs. H.

We need, therefore, to rapidly and drastically increase the number of physicians, and other care providers, trained in geriatric and health issues related to aging. We need both academic geriatricians and primary care physicians with special expertise in the care of older persons. Academic leaders in geriatrics are needed to teach medical students and young physicians in training, to provide continuing education to practicing physicians in all specialty areas, and to conduct the desperately needed - and until recently largely neglected - research on age-related diseases. The majority of medical care for older persons is provided by primary care physicians, a trend that will likely only increase with the move towards "Managed-Medicare". These primary care providers must be appropriately trained in geriatrics during medical school, graduate medical education, as well as through continuing geriatrics education programs. I will not repeat the projected numbers of academic and primary care geriatric physicians needed to meet the needs of the ever increasing number of older and chronically ill persons as these projections have been well presented and justified by many groups including the Institute of Medicine and the Alliance for Aging Research. I will only reinforce the urgency of the need for training these individuals.

Why and Why Now

The answers to the why and why now questions are obvious: the well known demographic trends in the U.S. population and the changing healthcare system. While fears of the impending impact of the "aging baby-boomers" on the healthcare system have clearly crystallized interest in the need for gerontologic research and geriatric care, the need is more imminent than suggested by this demographic trend alone. Not only has overall life expectancy increased dramatically in this country over the past several decades, more importantly for the healthcare system, the life expectancy of multiply and chronically ill persons has also increased markedly. It is somewhat ironic that the high quality, specialized healthcare system that has at least partially been responsible for increased survival among older persons such as Mrs. H., is not equipped to provide the care she now needs. We now need a cadre of physicians knowledgeable and skilled in preventing and treating the health problems of frail, multiply and chronically ill older persons. As exemplified by Mrs. H., these frail older persons use a disproportionate amount of healthcare services. It is neither appropriate, nor cost effective, however, to continue treating older persons merely "one disease at a time". Indeed, Mrs. H.'s cardiologist could well claim a "good outcome" as she survived her heart attack without heart failure; her orthopedic surgeon could also claim success as her hip fracture was healing. However, it is doubtful that Mrs. H., her family, or society who is left paying the bills would feel that Mrs. H.'s outcome was a "success". Neither would most geriatricians caring for Mrs. H.

As Congress, employers, and increasingly the public, recognize the potentially exploding costs of health care for the burgeoning number of older persons, the debate is

focusing on how to contain the spiraling costs. Added to the debate of how much to spend, must be an informed discussion of how to spend it. The latter question is the one of interest to gerontologic and geriatric researchers who are attempting to understand the many disease processes associated with aging and to determine how to most efficiently, effectively, and safely care for older persons with complicated illnesses and disabilities. It is also the question of concern to geriatricians who, at present, must frequently help patients and families make important health care decisions with vital gaps in knowledge. At a time when we are attempting to control costs, it is more imperative than ever that we train a cadre of researchers, teachers, and clinicians who are equipped with the knowledge and skills to match the needs of individual older patients with the most appropriate and effective care.

How to increase geriatric training to meet the health care needs of an aging population

As for any complex, multifaceted problem there is unlikely to be a single solution to the shortage of geriatric researchers, teachers, and practitioners. Several organizations, such as The American Geriatrics Society, The Gerontologic Society of America, and The Alliance for Aging Research, have suggested several possible solutions for increasing the number of well trained gerontologists and geriatricians. Certainly, the Claude D. Pepper Older Americans Independence Center is one example of an innovative and successful strategy. As is well exemplified by the outstanding work displayed by the young investigators from the institutions supported by these Pepper Centers, the support of such centers is an excellent investment in the future. Indeed, it is not an exaggeration to state that Pepper Center support will be a deciding factor in launching many of these talented young geriatricians towards careers as the leaders in the field. These leaders in training in turn, will add to our knowledge of aging and train the next generation of researchers and practitioners. At present, only ten academic institutions are supported through Pepper Centers. Thus, only a limited number of geriatric academic leaders are presently being trained. An increase of the number of Pepper Centers would be a small investment with a large potential return. Similarly, the number of dollars allocated to the National Institutes of Health, through the National Institute on Aging and other institutes, for research on important aging health problems is minuscule in comparison to the healthcare dollars spend on hospitalizations, medications, homecare, and nursing home care. Again, a relatively small investment in research has enormous potential for return. Increasing research support would have an immediate, and tangible, effect on the number of geriatricians electing academic careers. One of the most often cited reasons by physician-scientists for avoiding academic careers is the perception that research funding will increasingly be limited in the future.

Both clinical and research fellowship training depends upon availability of funds. At a time when Medicare, the Veteran's Administration, and other traditional funders of residency and fellowship training, are cutting back in training support, special recognition must be given to the urgent need to train persons capable of caring for the burgeoning number of older persons. Training institutions including hospital and medical schools need the financial incentives to encourage additional training in geriatrics. Financial incentives to individuals, through approaches such as medical school loan forgiveness, would also be an inducement to medical students and residents to consider geriatrics. Government bodies could also help in nonfinancial way by helping get the message out to young people that geriatrics is a viable and productive career option. Medical students, like everyone else, make career choices at least partially based on perceptions of availability of rewarding jobs

in the future.

The availability of a sufficient number of geriatricians and primary care providers with geriatric expertise will depend in large measure on sufficient reimbursement for services. Increasing efforts must be made to ensure that reimbursement reflects the increased complexity and greater time required to care for chronically and multiply ill and disabled older persons. Reimbursement must also reflect the need for multidisciplinary team care as a single practitioner is not equipped to handle the combination of physical, psychological, and functional problems faced by many older persons. Further, reimbursement for geriatric care needs to reflect that much of this care is provided in nursing homes or in older person's homes and includes not just face-to-face contact with patients, but, as importantly, interaction with family members, and other healthcare providers, in person or by telephone. While efforts have been made by the Health Care Financing Association toward addressing these issues, the efforts have been inadequate to date. Further, as an increasing number of older persons are cared for under managed care and HMOs, careful attention needs to be given to ensuring that these organizations provide the multidisciplinary care and care in the multiple settings (home and nursing home as well as hospital and clinic) that are necessary to ensure optimal and effective care for older persons. While I cannot determine whether patients like Mrs. H. would fare better under a "managed care system" or under a "fee for service" Medicare system, I can confidently say that she would have fared better under care directed by a physician knowledgeable and skilled in geriatric care.

Dr. GENE COHEN. Thank you, Dr. Tinetti. I think in that wonderful case example one might retitle your presentation, "Lessons from Hippocrates in the Late Twentieth Century in Treating Those Late in the Life Cycle: Above All, Do No Harm and Apply Our New Geriatric Knowledge That Can Help."

The next presentation is going to be by Donna Regenstreif, Ph.D., senior program officer at the John A. Hartford Foundation in New York, a foundation that has clearly made an important contribution in advancing training in geriatrics.

STATEMENT OF DONNA REGENSTREIF, SENIOR PROGRAM OFFICER, THE JOHN A. HARTFORD FOUNDATION, NEW YORK, NY

Dr. REGENSTREIF. Thank you, Gene.

Thanks to the Senate Special Committee on Aging and the staff for this opportunity to present testimony on this very important subject that I know is near and dear to the hearts of all of us in this room.

There are two messages that I want to be sure to leave you with: first, is the need for training many health professionals in many disciplines, not only geriatricians but nurses, social workers, therapists, and physicians in primary care and almost all specialties, regarding the special care needs of elders; and second, is that this work requires not only substantial investment, but sustained long-term commitments from government, philanthropy, medicine, and the corporate sector, increasingly including health-related private corporations.

The Hartford Foundation has had two major thrusts, one relating to academic geriatrics and training and one focused on ways to improve the quality and the integration of the many services elders need. I am going to focus on academic geriatrics and training in my following remarks. Our service programs will be included in more extended testimony available for the record.

The Hartford Foundation's academic geriatrics and training program, with its explicit commitment to geriatric training, is now well into its second decade. Between 1985 and 1994, over $20 million in commitments were made, mainly for physician recruitment to academic geriatrics and their career development. In 1994, a program to increase the geriatric content of primary care residency training in both general and internal and family medicine began. In 1995, the trustees committed to a $10 million concept to advance geriatric interdisciplinary team training. Many other national community and corporate foundations have made commitments which directly and indirectly benefit geriatric research and training. While we applaud these programs, additional explicit efforts must be developed to advance our ability to meet the health care needs of our aging population.

To humanely and effectively meet the needs, with their associated higher rates of chronic illness and disability, we need more faculty to devote their talents to research and teaching. Our ability to delay the onset of disability and increase the likelihood of a longer healthy life span requires both improved ways to prevent and manage these illnesses.

The medical advances of the past 20 years must have a parallel improvement in the coming decades in the way we treat chronic illness and geriatric syndromes. It is to this end that the Hartford Foundation has dramatically increased its spending, to both stimulate such research and translate it rapidly into clinical practice advances.

Recently, in partnership with donors to the Alliance for Aging Research and the Commonwealth Fund of New York City, we committed more than $14 million to create the Paul Beeson Physician Faculty Scholars in Aging Research Program. The program will provide support for some 30 junior faculty, each of whom will receive 3 years of support for protected time and research expenses.

Ten Beeson scholars are selected each year. We hope they will be the next generation of experts in aging research and geriatric care. They will both advance our understanding of aging-related diseases and conditions and train our Nation's health practitioners in the complexities of their humane and effective management. We are fortunate to have the first two cohorts of Beeson Scholars and their mentors with us now. Right now, we are midway through a meeting to review the progress of their research, to create important scientific and career development connections for them, and to encourage dissemination of their findings. This is a model program that deserves expansion and replication.

Foundations have pursued a variety of strategies in response to the critical need for geriatric research and training. Even so, the gap between supply and demand remains large. Why hasn't a concerted and substantial effort already occurred, given the very clear demographic imperative? One reason may be the false impression that government efforts are solving the problem. Not only is this not the case, but hard-won gains of the past are now in jeopardy as part of deficit reduction efforts.

The Bureau of Health Professions' resources supporting Geriatric Education Centers and fellowship training are being cut. Support for geriatric research and training through the Veterans Administration, a vital force in development of the field, is being threatened. Support available through the National Institutes of Health and Institute on Aging, as well as investigation into the effectiveness of alternative treatment approaches for elders through the Agency for Health Care Policy and Research and others, are losing ground just as the demographics require an even stronger advance.

Even Medicare's contributions to teaching are being threatened through a combination of direct revenue reductions and diversion of education funds through flawed Medicare managed care payment formulas. Last, but not least, academic medical center support for geriatric education and research will require clear commitment from university presidents, medical school deans, department chairs, and other leaders.

As we look ahead, corporate, foundation, and individual philanthropy, along with the government and our education institutions, must reinvigorate their efforts to enhance geriatric training at all levels. Older Americans must know that their physicians, in tandem with other health professionals, have the knowledge to provide them with effective, humane care. This cannot be done without drastic changes in attitudes about, and support for, geriatric train-

ing. Anyone professing an interest in strengthening American families would surely attach a high priority to addressing these needs.

Thank you for your attention.

[The prepared statement of Dr. Regenstreif follows along with additional information on service programs:]

TESTIMONY BY DONNA I. REGENSTREIF, Ph.D.

OF THE JOHN A. HARTFORD FOUNDATION

BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

ON MAY 14, 1996

I would first like to take the opportunity to thank the Senate Special Committee on Aging for the opportunity to present testimony on this very important subject. I am Donna Regenstreif, Senior Program Officer at the John A. Hartford Foundation in New York City. There are two messages which I want to emphasize. One is the need to train many health professionals in many disciplines -- not only geriatricians, but nurses, social workers, therapists and physicians in almost all specialties -- in care of elders. The second is that this work requires not only substantial but sustained long term commitments from government, philanthropy, medicine and the corporate sector (including health-related corporations).

The Hartford Foundation has two major thrusts, one relating to academic geriatrics and training, and one focused on ways to improve the quality, and the integration, of the many services elders need. (I will focus on the first of these in these remarks and will submit additional information on our service programs for inclusion in the Congressional Record through excerpts from our Annual Report.)

The Foundation's Academic Geriatrics and Training Program, with its explicit commitment to geriatric training, is now well into its second decade. Between 1985 and 1994, over $20 million in commitments, mainly for geriatric physician recruitment and development were made under this program. In 1995, a $10 million program

concept to advance geriatric interdisciplinary team training was endorsed by the Foundation's Trustees who are particularly interested in the vital roles of nurses in care of elders. Many other national community and corporate foundations have made commitments which have directly and indirectly benefited geriatric research and training. While we applaud these programs, additional explicit efforts must be developed to advance our ability to meet the healthcare needs of the aging American population.

To humanely and effectively meet the needs of the rapidly increasing cohort of elders, with their associated higher rates of chronic illness and disability, substantial investment in faculty who will devote their talents to research and teaching are required. Our ability to delay the onset of disability and increase the likelihood of a longer healthy lifespan requires improved ways to prevent and manage these illnesses. The medical advances of the past twenty years must have a parallel improvement in the coming decades in the way we treat chronic illness and geriatric syndromes. It is to this end that the John A. Hartford Foundation has dramatically increased its spending - to both stimulate such research and translate it rapidly into clinical practice advances.

Recently, Hartford, in partnership with donors to the Alliance for Aging Research and The Commonwealth Fund, committed more than $14 million to create the Paul Beeson Physician Faculty Scholars in Aging Research Program. The program will provide support for some 30 junior faculty, each of whom will receive three years of support. The Beeson Scholars (ten are selected each year) will lead the next generation of experts in aging research and geriatric care. They will both

advance our understanding of aging-related diseases and conditions and train our nation's health practitioners in the complexities of their humane and effective management. We are fortunate to have the first two cohorts of Beeson Scholars with us here now. We are mid-way through a meeting to review the progress of their research, create important scientific and career development connections, and encourage dissemination of their findings. This is a model program that deserves expansion and replication.

Foundations have pursued a variety of strategies in response to the critical need for geriatric research and training. Even so, the gap between supply and demand remains large. Why hasn't a more concerted and substantial effort occurred, given the clear demographic imperative? One reason may be the false impression that government efforts are solving the problems. Not only is this not the case, but hard won gains of the past are now in jeopardy as part of deficit reduction efforts. The Bureau of Health Professions' resources supporting Geriatric Education Centers and fellowship training are being cut. Support for geriatric research and training through the Veterans Administration, a vital force in development of the field, is being threatened. Support available through the National Institutes of Health and Institute on Aging, as well as investigation into the effectiveness of alternative treatment approaches for elders through the Agency for Health Care Policy and Research, are losing ground just as the demographics require an even stronger advance. Even Medicare's contributions to teaching are being threatened through a combination of direct revenue reductions and diversion of educational funds through flawed Medicare managed care payment formulas. Last, but not least, academic medical center

support for geriatric education and research will require clear commitment from university presidents, medical school deans, department chairs, and other leaders.

As we look ahead, corporate, foundation and individual philanthropy, along with the government and our educational institutions, must reinvigorate their efforts to enhance geriatric training at all levels. Older Americans must know that their physicians, in tandem with other health professionals, have the knowledge to provide them with effective, humane care. This cannot be done without drastic changes in attitudes about, and support for, geriatric training. Anyone professing an interest in strengthening American families would surely need to recognize the importance of these efforts.

Thank you

ADDENDA TO

TESTIMONY BY DONNA I. REGENSTREIF, Ph.D.

OF THE JOHN A. HARTFORD FOUNDATION

BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

ON MAY 14, 1996

Although 1994 was a turbulent year for health care in the United States, one constant was the continued growth of the older population. Yet the Hartford Foundation is one of the few national foundations with its major focus on the field of aging. Over the past decade Hartford has committed a total of $53 million, about half its grants, to aging research. Significant and unique contributions have been made and a great deal has been accomplished with Foundation support.

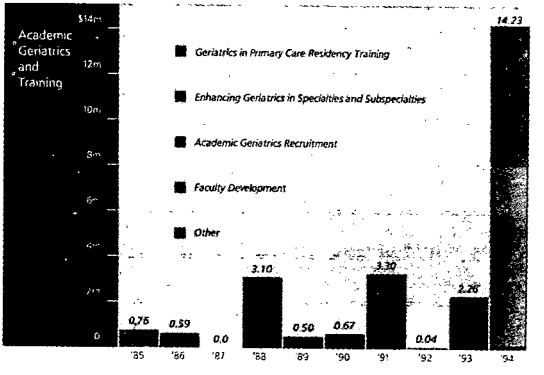
But much work remains to be done. The demographics of the aging population are startling. There are now nearly four million Americans over the age of 85, and this figure should quadruple by the middle of the next century. Beyond the year 2000, most doctors can expect to spend at least 50 percent of their time caring for geriatric patients. Yet the supply of physicians trained and skilled in geriatric care is appallingly low.

Moreover, the health care system for the elderly is fragmented, inefficient, and expensive. The rising costs of elder care will be borne by a combination of public programs (Medicare, Medicaid), private insurance, and elders themselves. The demand from all of these sectors for improved outcomes and cost effectiveness lends urgency to the Foundation's efforts.

Therefore, the Hartford Trustees have decided to substantially augment Foundation giving in the Aging and Health area over the next several years, to up to about 80 percent of the grants budget.

Academic Geriatrics and Training

Hartford has already begun to dramatically increase spending in its Academic Geriatrics and Training program. This initiative began in 1983 with a program to encourage mid-career faculty to pursue advanced training in geriatric medicine. In 1988 Hartford, at the suggestion of a Foundation-supported study by the Institute of Medicine, supported ten "centers of excellence" at ten medical schools to attract outstanding individuals to careers in academic geriatrics. By 1991 the program had been so successful that a further commitment was made for grants to 13 such centers. In 1993 the Institute of Medicine recommended special attention to geriatrics in primary care training and in the training of medical and surgical specialists, as well as continuing faculty fellowship support. Thus, over the past decade, the Foundation's Academic Geriatrics and Training program has diversified and grown, with more than $14 million in grants awarded in 1994.



The John A. Hartford Foundation Aging and Health Grant Commitments, 1985-1994

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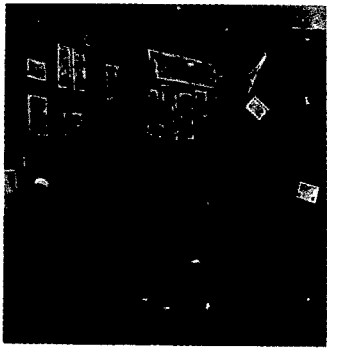
Midway through 1994 the Foundation's Trustees asked a small group of national geriatric and gerontologic leaders to review Hartford's current program initiatives and brainstorm about possible future opportunities for enhancing health services for elders. One of their conclusions was that the Foundation, by focusing solely on physician training, had failed to address the need to better prepare other health professionals to care effectively for the elderly. Indeed, the concept of the "interdisciplinary team"—close cooperation between doctors and other professionals such as nurses, nurse practitioners, home health workers, and social workers—is widely praised but little utilized in most training programs. So the Trustees funded a Foundation-Administered Project to explore the training needs of elder caregiving teams and identify opportunities for strengthening this training.



The Foundation also expanded its efforts in academic geriatrics in 1994 with major commitments to aging research, geriatric faculty development, and geriatric training in a range of disciplines. These initiatives were stimulated by the 1993 recommendations of the Institute of Medicine's Committee on Strengthening the Geriatric Content of Medical Training.

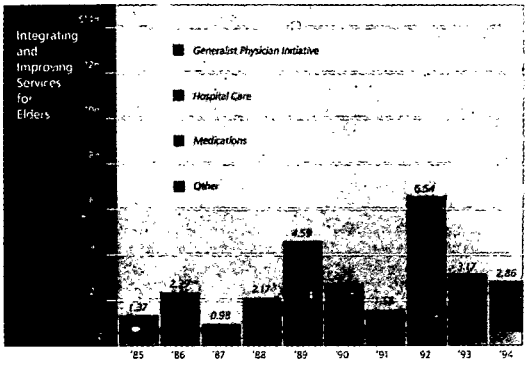
Hartford has joined with other funders to create what is now the Paul Beeson Physician Faculty Scholars in Aging Research Program. Named for the distinguished clinician, scientist, and teacher who profoundly influenced many of the young physicians now leaders in geriatric medicine, this project awards stipends to help outstanding junior faculty conduct research and develop careers in academic geriatrics, under the guidance of a faculty mentor. The funds are sufficient to protect three-quarters of the Beeson Scholars' time for research-related activities for three years.

A second major initiative seeks to develop models to strengthen the geriatric content of residency programs in internal medicine and family medicine. Commitments totaling $5.1 million were made in 1994 to nine institutions. Seven academic medical centers will develop innovative primary care training models that will explicitly include elder health care. A Hartford Foundation grant to the American Academy of Family Physicians Foundation will assist community-based family medicine residencies to improve their geriatric content. Finally, the Foundation will support the creation of a resource and coordinating center at Stanford University to facilitate information exchange and evaluation and to disseminate successful innovations.

There is a need to better integrate geriatrics into the subspecialties of internal medicine, such as oncology, cardiology, and endocrinology, because subspecialists often assume ongoing clinical responsibility for elderly patients with serious medical conditions. A 1994 award to the American Geriatrics Society will bring together subspecialists, general internists, and geriatricians, along with representatives from subspecialty and certifying organizations, at a series of retreats and meetings. The grant will also support publications and further educational activities.

Integrating and Improving Services for Elders

The Foundation's efforts to integrate and improve services for elders date from 1983, with its support for the On Lok project in San Francisco, which utilizes prepaid funds from Medicaid and Medicare to deliver fully integrated medical and social services to frail older people who might otherwise be in nursing homes. Other grants in the 1980s likewise helped organizations in Milwaukee and Rochester coordinate services to provide and finance long-term care for frail and indigent elders. In the past ten years Hartford has supported projects addressing the inappropriate use of medications, and has made grants to test the effectiveness of different strategies for reducing the functional deterioration associated with the hospitalization of elders. And in 1992 the Trustees approved the Generalist Physician Initiative – model projects that foster teamwork among physicians and other health and social services personnel, and that develop care plans which integrate clinical and community-based social and supportive services.



The John A. Hartford Foundation Aging and Health Grant Commitments, 1985-1994

During 1994 a grant was made to Arizona State University for collaboration on documentation and dissemination among the nine projects in the Generalist Physician Initiative. Another grant to Interfaith Health Care Ministries renewed support for a program to reform Rhode Island's elder care services according to the principles of the "Aging 2000" statewide initiative – including a demonstration of the use of caregiving teams to integrate medical and psychosocial services, and an assessment of financing alternatives for statewide implementation.

Dr. GENE COHEN. Thank you very much.

I think Donna has very well illustrated both the importance and the need for a creative focus on developing the infrastructure of training in general and leaders in particular. I think she has provided very good examples of well-placed resources leveraging very impressive results.

The final panel presentation before we open it up to further discussion among the panel members and the audience is going to be by David Reuben, M.D., division chief in Geriatrics, UCLA Medical School and chairman, Education Committee, American Geriatrics Society, Los Angeles, CA.

STATEMENT OF DR. DAVID B. REUBEN, M.D., DIVISION CHIEF IN GERIATRICS, UCLA MEDICAL SCHOOL AND CHAIRMAN, EDUCATION COMMITTEE, AMERICAN GERIATRICS SOCIETY, LOS ANGELES, CA

Dr. REUBEN. Good morning.

I also direct the UCLA Claude D. Pepper Older Americans Independence Center, but I am here today on behalf of the American Geriatrics Society. The American Geriatrics Society is an organization of over 6,000 geriatricians and other health care professionals who provide care for older persons.

I wish to echo many of the sentiments that the previous speakers have made already, but I would like to focus on two particular points.

In addition to the shortage of academic geriatricians, there is a significant shortage of geriatricians to provide primary care for frail, chronically ill older Medicare beneficiaries. Trained geriatricians can manage complex care in less intensive settings, such as in the home, sub-acute rehabilitation units, compared to very expensive settings such as hospitals and nursing homes. The very nature and very training of a geriatrician emphasizes this primary care in less expensive and intensive settings.

Geriatrics is a very new discipline. It has only been around for 20 or 30 years. It can actually help—as indicated earlier—save Medicare dollars and improve health care. Older people are simply different, just as children are different. You wouldn't think about trying to treat a child or infant with the same medications and the same approach as an adult. The same thing holds true for an 85-year-old or 90-year-old person. Their bodies are just different. The diseases manifest differently and they respond to medications and treatment differently.

Too often, illnesses in older persons are misdiagnosed, overlooked, or dismissed as an aspect of normal aging simply because the doctors today and the other clinicians today don't know how to recognize these disorders and treat them in older persons. This can translate into needless suffering, unnecessary Medicare hospital admissions, emergency room visits and nursing home admissions.

I would like to give you an example. Last Wednesday night at 10 p.m. in my home, I was called by the caregiver of an 86-year-old woman for whom I provide primary care. Ironically, her children are very active in government in California. Every one of the committee members knows this family. About 3 years ago, she and her husband sought primary care from me because they felt that

their internist was no longer able to manage the kinds of problems they were having.

As mentioned, they called me at 10 p.m. The crisis at hand occurred when she was going to the theater. Before the theater started she wanted to void—empty her bladder—so that she wouldn't have to get up. She was transferring from a wheelchair to a bathroom seat and she fell. At that time, her caregiver called me. She was in a lot of pain and had probably fractured her ribs. She had also abraded her forearm.

She did not want to go to the hospital. She wanted to be managed at home. On the phone, I prescribed a pain medication that she already had in the house and made plans for home health to see her the next morning.

The subsequent chain of events for this woman—included my spending a large part of the next 4 days providing care for this lady. This included arranging services, calling four pharmacies until I could find one that actually carried the medication that she needed, a home visit by myself and home health providers, and two to three phone calls per day to her and to each one of her children. The last call I made before I got on the plane yesterday afternoon was to her daughter. The first call I made when I arrived here was to her caregiver.

This is an example of an extremely frail elderly woman who can be managed by a geriatrician. Most internists either cannot or are not willing to commit that kind of care to older persons.

The second major issue I want to address is the financing of this. This woman that I was caring for—I probably spent 4 hours a day in terms of telephone calls and checking on this lady and taking care of these arrangements. My reimbursement for caring for this woman was one home visit that I will be reimbursed for. I would also be eligible for 30 minutes of reimbursement under the oversight management code that was recently adopted. However, since I am also the medical director of our home health care agency, I won't receive any reimbursement for this coordination of her care.

Reimbursement is a naughty term because doctors are supposed to be altruistic. On the other hand, the current physician reimbursement system actually drives students, residents, and other providers from caring for an older person. They just can't make a living caring for older persons.

The complex physician reimbursement system does not pay for coordination of managed care, except under very limited circumstances. In fact, because of these inadequate payments, it is difficult to find geriatricians in private practice in many areas of the country. For example, I just recently received a phone call from someone—in fact, I have received many of these phone calls—looking for a primary care geriatrician. This phone call actually happened to come from somebody whose mother lived at Leisure World, which is a community of 25,000 people over the age of 55. There was not one geriatrician who was available to care for them. I heard a similar story in Fort Lauderdale where they could not find a geriatrician to provide primary care for that patient.

In addition, the academic geriatricians in our group practices in many of the centers around the country are required to spend a greater percentage of their time to support their salaries as gen-

erated by clinical income. This detracts, because of the poor reimbursement rate, from their ability to teach residents, medical students, and other providers how to care adequately for older persons.

The future may be brighter. Hopefully, it will be. I think one of the great possibilities is managed care. Managed care has a tremendous amount of potential. I just reviewed an article that described a program that is being conducted at one of the HMO's in Colorado that actually saves money and has better patient outcomes because they have direct control over reimbursement costs.

On the other hand, these HMO's have to be responsible. I think that many of the plans that are seeking the input of geriatricians on how to manage these frail older persons are doing the right thing.

Regardless of the promise of HMO's, we can anticipate that about half the Medicare enrollees over the next coming decades will remain in fee for service structures. Currently, the reimbursement system for these geriatricians is truly inadequate. If you ask if this is truly a disincentive to people going into geriatrics, let me cite one statistic.

There are approximately 16,000 medical students each year who graduate from U.S. medical colleges. We can anticipate about 50 to 60 of these per year will actually go into geriatrics. When you ask them why they won't go into geriatrics, they frequently won't tell you to the face, but they will tell you that when they are confronted with $70,000 worth of loans, they just can't afford to care for people in a reimbursement system that doesn't recognize the work they do.

With that, I will cease talking and open this up for questions.

[The prepared statement of Dr. Reuben follows:]

THE AMERICAN GERIATRICS SOCIETY
SHAPING THE FUTURE OF HEALTH CARE FOR OLDER ADULTS

Statement of David B. Reuben, M.D.
on Behalf of the American Geriatrics Society

May 14, 1996

The American Geriatrics Society (AGS) -- an organization of over 6,000 geriatricians and other health care professionals dedicated to caring for older persons -- applauds Senate Special Committee on Aging Chairman Cohen for holding this forum highlighting the national shortage of geriatricians.

PROBLEM: ***There is a significant shortage of geriatricians to meet the health care needs of the rapidly expanding population of Americans over age 85.***

The Institute of Medicine, the National Institute on Aging, and other expert panels have all called for significant increases in trained geriatricians.

Today, there are over 8,400 certified geriatricians in the United States. This number is expected to drop by the year 2000, as many geriatricians practicing today are expected to retire over the next 10 to 15 years. The number of geriatrics faculty is also expected to decline in the next decade.

An increased number of trained geriatricians are needed as:

- **Academic Geriatricians**: Increases in geriatricians in medical schools are essential to train primary care and specialist physicians to diagnose and treat problems common in older persons, and to guide clinical research activities in developing cures and treatments for the diseases that affect this population.

- **Clinicians**: Geriatricians are needed to provide direct primary care services to frail, chronically ill Medicare beneficiaries. Trained geriatricians can be more effective primary care providers for persons over age 75, who have complex chronic health care problems. For these patients, geriatricians are able to manage their care in the least resource intensive settings, obviating the need for more costly hospitalizations and nursing home placements.

Geriatric Medicine Improves Health Care and Can Save Medicare Dollars

Geriatrics is a relatively new field. Advances in aging research have expanded the body of knowledge about the health of older persons that has led to therapies and interventions that can improve the quality of life.

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Disease manifests itself differently in older persons. Too often, illnesses in older persons are misdiagnosed, overlooked, or dismissed as the normal function of aging simply because physicians are not trained to recognize how diseases and drugs affect older patients. This translates 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.

Key Reason for Shortage: 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.

The Medicare fee-for-service system is problematic for geriatricians for two reasons:

- The Medicare physician reimbursement 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.

- The physician payment system does not provide coverage for coordination and management of care (except in very limited circumstances), or for an interdisciplinary team of nurses and other health professionals. Geriatrics emphasizes the use of these services and personnel.

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.

In addition, academic geriatricians are now being required to use a greater percentage of their time to generate clinical income to support their positions. This translates into less time for their teaching and research roles, and is a particular problem for geriatrics because of the inadequate Medicare payment policies.

The Future Outlook

AGS believes the future for geriatrics may be brighter as more beneficiaries enroll in Medicare HMO capitated systems. Medicare HMOs, if organized well, have the potential to improve care for older persons by: implementing health promotion and prevention programs, targeting high risk frail elderly persons, coordinating and managing care, and using an interdisciplinary team of physicians, nurses, and other professionals.

However, about half of all Medicare beneficiaries are likely to choose to remain in the fee-for-service system over the next decade. To care effectively for these people, the Federal Government should revise the current fee-for-service payment system to promote care management services for chronically ill beneficiaries. These services will not only improve the quality of care, but will reduce unnecessary Medicare spending on duplicative and potentially harmful services. Refining the fee schedule will also be key to attracting physicians and other professionals to a career in geriatrics.

Dr. GENE COHEN. Thank you very much, Dr. Reuben, for finishing with this reality check that we have to deal with. I think you have very poignantly illustrated the interplay of not only opportunities but also obstacles.

In Dr. Tinetti's presentation, she reminded me of my favorite admonition by H.L. Mencken who said, "For every complicated problem there is a simple solution, and that simple solution always fails." Clearly, we have a daunting challenge to look at the challenges and opportunities along the whole gamut of research training practice and reimbursement.

I was also struck by examples given by Dr. Reuben and others with regard to a phenomenon that I named as the geriatric landscape, the growing number of settings where older people both reside and receive treatment, with the proliferation of settings outside of the hospital as additional places where people are living and in need of services. These sites are proliferating at a very great pace. I wonder if any of the members of the panel would like to comment any further about the obvious shortage in needs of research issues in those different settings, which again run the whole gamut from nursing homes, to assisted living facilities, to day programs, to retirement living. A large number of sites are proliferating at a tremendous pace.

Would anyone like to comment further about that in terms of the issues and the magnitude of the challenge?

Dr. REUBEN. One of the things we know is true about aging is the tremendous heterogeneity of older people. I have a set of three slides where I show three different examples of aging. The first is a man named Jack Bishin who lives in our area in Santa Monica. He is 90 years old. This shows him in a road race. He does 10K races at the age of 90 years old.

The next slide is another patient of mine who is an 83-year-old woman. This is a slide of her dancing at 83. She does a lot of benefits. She has always been in the entertainment industry. She does have chronic diseases, though. I explain to those students and residents that the vast majority of older persons have at least one chronic disease.

The third is somebody who is very frail and in a nursing home. You could see in this woman's expression—she has a vacant expression on her face—that she probably has Alzheimer's or another dementia.

In any event, when you see this diverse heterogeneity of what older people are like, you have to also realize that the appropriate settings for care for them are going to range this gamut, from the very, very frail people who need very intensive nursing care and custodial care, to very healthy people who need primarily preventive type of measures. The health care industry has really responded by basically having a spectrum of types of care anywhere from home care to assisted living to sub-acute rehabilitation. The idea is that this is kind of a laminar flow that each older person should be able to be cared for in the setting that is most appropriate to their specific needs at that moment.

The coordination of this care is really what has been the obstacle, particularly in fee for service settings where there is no coordination of care. This also represents the greatest challenge to HMO's,

who can coordinate this care, but they are still in the infancy of learning how to do so.

Dr. GENE COHEN. Thank you.

Let me throw the meeting open to both the panel and the audience, if any panel members would like to raise questions to one another or any members of the audience would like to raise questions.

Let's start with the panel. Would anyone like to raise a question at this point?

They are deferring to the audience.

Let me encourage anybody who is going to raise a question to please come to the microphone so that the reporters can record your questions and comments. Please identify yourself.

QUESTIONS AND COMMENTS FROM THE AUDIENCE

STATEMENT OF SUE LOTKROFT

Ms. LOTKROFT. Hi. I am Sue Lotkroft from Harvard Medical School, but I am here today as the president of the National Association of Geriatric Education Centers.

Basically, I wanted to really reiterated what Senator Cohen said earlier and what many of the panelists have said. The focus of geriatrics is often coping and not curing and how we can keep older people to maintain their maximum functional independence as they experience the many chronic conditions of old age.

Also as Senator Reid and other panelists commented on, there is a dramatic shortage of geriatricians and is compromising the health care and quality of life of our older persons in this country.

I would like to add that these shortages are similar to shortages that we experience in the fields of nursing, social work, dentistry, and the allied health professions including OT's and PT's. These shortages are just further compromising the health care system's ability to care for its elderly population.

As Dr. Kowal mentioned, Geriatric Education Centers have been funded since 1983. These centers focus on the short-term training of both academicians who are teachers as well as primary care practitioners from the disciplines of medicine, nursing, social work, dentists, and all the allied health to respond to the multiple and complex needs of our aging population. These disciplines are critical to what everyone has mentioned here today, which is the focus on preserving maximum functional independence for our aging individuals as they cope with the many chronic diseases they experience.

Finally, Dr. Cohen and Dr. Kowal mentioned an urgent need to translate and disseminate the research findings that individual researchers such as the Beeson scholars and OAAC trainees—it is very important to be able to translate and disseminate these findings into clinically meaningful treatments that can be implemented by primary care practitioners and all the practitioners entering managed care organizations to be able to benefit the elderly population.

Thank you.

Dr. GENE COHEN. Thank you very much.

Any other questions?

Dr. REGENSTREIF. Gene, I would just like to give a delayed response to the many settings in which elders receive their care. We shouldn't forget that probably 98 percent of the care elders receive is delivered in their own homes. The extent to which we can figure out improved ways to sensitize geriatricians, primary care physicians, and others about both the limitations and opportunities of this setting the better off we will be. I am hoping that our efforts to improve residency training, geriatric content, and sensitivity will help to come up with some ways to reengineer that kind of training to achieve these outcomes.

Dr. GENE COHEN. Excellent point. Thank you for mentioning that.

Dr. Williams.

STATEMENT OF DR. WILLIAMS

Dr. WILLIAMS. There are many things one could comment on. I think the whole context has been very much to the point, so I won't try to reiterate anything that has been said, but I would like to bring in perhaps one other perspective. In this whole effort to try to see that we move forward in these fields of geriatric education, development of academic leadership, and a broader training of all professions at all levels—as has been said—because the bulk of all medical practice from now on and the bulk of all health practice by all professionals is going to be with older people.

I would just want to emphasize the importance for convincing our leadership to take a leadership in these fields. Our foundations can take more steps to bring the deans, the vice presidents for academic health centers, the presidents of universities, the heads of research programs in various fields—like cancer and others—to realize that their future and our future depends on giving a priority to aging and geriatrics. One illustration that hits very much at home in Rochester right now is the new vice president for the academic health affairs at Rochester has made aging and development one of his three priority strategic goals for the University of Rochester. I think that really makes a difference.

But what we really need in this field are the people at the top—as well as those of us on down the line—to make these types of commitments. We have to figure out how to reach them most effectively. I think the same applies in almost any organizational structure.

I have just one other small anecdote on this. As many of you know, my wife has worked a great deal with others on improving individualized care and getting rid of restraints in nursing homes. I think that is a concern to all of us professionals and one of the arenas in which we have great importance. But what has been apparent throughout is that the key people are the administrator and director of nursing. If they are for a program of improving individualized care in nursing homes, things change. If they are not, they don't change much, no matter how much more you do.

I would say the same thing about our universities and our other research and training centers. We have to see that we reach the people at the top. Perhaps our foundation imaginative people, as well as our Federal imaginative people, can figure out how to con-

vene and convince and educate those at the top to give the leadership in this field.

Dr. GENE COHEN. Thank you very much. Those are all excellent comments that need to be considered in the complexity of this problem and in making a difference.

Any other questions?

Dr. BLASS. I stand here as a president afar. I would like to ask Mary Tinetti a question.

One of the things which is booming at the present time is knowledge in the biomedicine of aging. This is not only the increasing prospects for active treatment of Alzheimer's disease, osteoporosis, but also a whole burgeoning field of what is now called molecular geriatrics of risk factors and their identification.

I wonder how you envision this coming into geriatric teaching and/or teaching of geriatric medical care. Also, do you think there is going to be money around to pay for the efficient application of some of this? It raises a lot of ethical questions as well, but it is also part of the geriatric enterprise.

Dr. TINETTI. Why are you asking me that question? [Laughter.]

I think some of the work that is going on in molecular geriatrics—which I think is a nice term—is really astonishing and wonderful. A couple of weeks ago I had to give a talk at our medical school. We have a mini-medical school where we bring in people from the community. I sort of give an overview of aging. So I had the opportunity to review some of the work that is being done at a molecular level. It is really fascinating. We get the feel that we are on the brink of something. I am not sure what we are on the brink of, but it is certainly people coming from a developmental area, people coming from the different sort of models. It is really quite fascinating.

One of the things I was particularly struck by as I was reading some of the work that is being done at the molecular level—it is not that different from the things that are being done at a complete human level. If we are going to try to understand the genetics of aging and the way the different genes interact, when one gene changes it sort of changes everything else and the cumulative effect of multiple genetic defects is probably going to cancel a lot of diseases.

One of the things I was particularly struck by is how molecular research very much complements clinical research. The more we can bring together the spectrum of researchers the better off we will be.

In terms of bringing that knowledge into both a teaching arena plus eventually a practice arena certainly are challenges ahead. Bringing it into a teaching arena is certainly something that is hopefully happening at least at the 11 medical schools and hopefully over time an increased number of medical schools. Bringing it into the clinical arena is a combination challenge for the molecular biologists to help us who are doing the teaching and practice to bring it about. It is also important for us practitioners to find out about it.

Those will be playing out in the years ahead. Certainly the research dollars that are needed—it is really needed for the entire

spectrum of research. I particularly am very excited about some of the things that are happening in molecular aging.

Do I think that the answers to aging and the answers to Mrs. H. are found at a molecular level and isolation of the social and psychological? Probably not. Certainly not in our lifetimes and probably not in our grandchildren or great-grandchildren's lives. I think we can always strive for that, but I think there will always be problems that molecular biology alone can't answer. Certainly it is an important complement, increasingly important.

If I had to think of an area to target, there are so many things that we are learning about it that it is certainly an important area to put a lot of resources in right now. I have a sense that we are on the brink of something.

Dr. GENE COHEN. Any other questions or comments?

Ms. HANLEY. I am Priscilla Hanley, staff with the Senate Special Committee on Aging.

Dr. Tinetti, can you explain how Mrs. H.'s case would have been different if a geriatrician had been involved in her care?

Dr. TINETTI. To begin with, one would like to talk to Mrs. H.—and probably her family as well—as to what her goals are. Is her goal to have a low cholesterol? Or is her goal to maintain her independence as long as possible at home?

I am faced quite often with the issue—one of the things I do in our geriatric assessment—I see people who have difficulty with walking. One of the things I have been particularly struck by is the number of people who have developed myopathy, muscle weakness, as a result of cholesterol-lowering drugs. It really highlighted to me that the goals of therapy need to be established and discussed before we decide what to treat. Do you treat her diseases, or do you treat the patient?

I think that is where things could have changed right from the very beginning. Once the cascade of problems came down upon her, each step of the way is trying to step back and determine what it is we are trying to accomplish. Are we trying to make it so that she survives her heart attack. Or are we trying to maintain her mobility and get her up moving as soon as possible?

The major thing a geriatrician would have done differently would be to identify the goals and make any treatment decision based on Mrs. H.'s articulated goals and not the goals of treating numbers and treating diseases.

Dr. LACHS. I would like to make a few comments about managed care.

While it is easy to find a physician to bemoan managed care, Dr. Reuben is right. Managed care offers substantial opportunities. One of the things that one needs to recognize is that the cost of caring for an older adult—a frail older adult who is at risk for a functional decline—is inversely related to functional status. The more impaired you are, the more cost to provide medical and domiciliary care for you.

Not incidentally, the major goal of modern geriatric medicine is the maximization of functional status. For the first time under managed care and capitation, the goals of managed care—which is cost-containment, after all—and the goals of geriatric medicine—which is functional status optimization—can be aligned. There are

dangers and opportunities in that process, but under a fee for service system, there is no global budget and fee for service care is in fact unmanaged care, uncoordinated care, and all of the sub-specialists who were involved in the care of Mrs. H. were completely insulated from the global costs of her care.

Under global capitation, there is an opportunity for them not to be insulated from those costs. This is what makes the research we do so exciting. What are the most cost-effective interventions that keep people living in the community as long as possible? The cost of living in a community is much less than living in a long-term care facility.

Dr. GENE COHEN. I think a corollary of this discussion—going back to the theme of my opening comments about not overlooking the obvious—where there is an understandable focus on the effects of these interventions in containing costs, there is also this equally important question: What are the costs by not applying this training? As in the case of Mrs. H. and the impacts there, this is a very, very serious issue.

The other thing I was struck by in the presentations—again to emphasize the obvious—is the very high pay-off of these programs in terms of the goals they strive from, whether from very poignant personal anecdotes that Dr. Lachs gave or the interesting data that Dr. Kowal gave with regard to the numbers trained and going into roles of leadership. It would be useful to look a little bit more about that.

Dr. Kowal, with all the programs going on at Case Western, would you like to elaborate on that a little more? I think your programs are impressive in how you have leveraged both Federal and foundation dollars. The pay-off seems very significant indeed.

Dr. KOWAL. Certainly money talks. We have had a lot of interactions with a number of groups on campus. Actually our geriatric program—although we have 14 trained geriatricians as faculty—is a relatively small program compared to other programs. We actually have involved people from general medicine, epidemiology, biostatistics, and a number of the basic sciences.

It has been interesting. We are preparing for our Pepper renewal right now.

I would like to add one thing of concern, though. Last week at the American Geriatric Society meeting we also had a meeting of the Association of Directors of Geriatric Academic Programs. There was a rather—rigorous discussion of the issue concerning 1-year fellowships.

As many of you probably know already, in an effort to increase the number of physicians into geriatric training, the American Board of Internal Medicine established eligibility for the geriatric qualifying examinations after a 1-year program in geriatrics, provided that it was inclusive of all the features that were needed. The hope was that this would increase the number of people coming into geriatrics, with the assumption that people who were in debt—like Dr. Reuben alluded to—would be willing to do a 1-year program rather than a 2-year program.

The down side of that, of course, is the issue of funding. If HCFA and the VA decide that 1 year is enough to fund, then we are going to have a dramatic problem in terms of the second and third years

of fellowships, which are needed desperately for academic training. We may need the Bureau of Health Professions or other agencies to assist us with second and third year levels of funding in order to provide the kind of impetus we need for increasing the number of geriatric faculty.

Dr. GENE COHEN. That's a very good point.

Dr. Santos.

STATEMENT OF DR. JOHN SANTOS

Dr. SANTOS. I am John Santos, formerly the chair of Psychology at Notre Dame. Retired, thank God. [Laughter.]

I am also director of the Gerontology Center.

I know Dan is going to say, "Here he comes again."

I wanted to point out that we just completed—and picking up on a couple of comments that were made—we just completed about 3 years of survey of the availability of funding for geriatric health care professionals through the Retirement Research Foundation and Notre Dame. The results were pretty startling.

Medicine, psychiatry, and nursing were not too bad in terms of what was there. Incidentally, this was like pulling teeth trying to get this information. It took us about 3 years to get it. Psychology, social work—dentistry is pretty good, too—OT, PT, nothing. Rehab, almost nothing.

This is pretty serious because one can ask another question in addition to the one that was pointed out here. Who is going to take care of me when the doctor leaves? The picture is not very good. Since I am from Notre Dame, I thought we might use something of a football analogy. I think it is great to develop marvelous coaches—and God knows you need them—but somewhere along the line we better be sure that if we're going to play the game somebody recruits players.

Those data from the survey indicate that we are going to need an awful lot of players to be there to pick up the ball later on.

Thank you.

Dr. GENE COHEN. That is a very important point and certainly relates to this very impressive—yet at the same time disturbing—graphic as to the discrepancy between the large number of medical schools and the large number of required courses and undergraduate medical training in geriatrics and just how that translates into better trained doctors, both at the general and specialty level.

Dr. TINETTI. I would like to highlight that.

One of the purposes of this meeting today was to talk about physicians, but through the entire discussion I was having the same feeling that we are really only part of the team. Certainly there is a push toward reducing physical therapists and replacing them with physical therapy assistants and the same with occupational therapy and nursing being replaced by nursing aids.

Again, at a time when we have an increasing number of people who are able to take care of older patients, there are also other forces that are decreasing the number of them. I would like to very much reinforce that statement that it is not just physicians that we need to be training.

Dr. GENE COHEN. Again, this is highlighted in the wide range of programs that Dr. Kowal, for example, outlined, the very important

interplay they assume on the medical team. Thank you for highlighting that.

STATEMENT OF DR. HARVEY COHEN

Dr. HARVEY COHEN. I am Harvey Cohen from Durham, NC, where I direct the Geriatric Research Education and Clinical Center in the VA and the Duke University Center for the Study of Aging and Human Development.

I want to comment on an area that has briefly been alluded to but requires a little more highlighting, and that has to do with the Department of Veterans Affairs role in geriatrics education, training, and research.

This was alluded to by a couple of the speakers, but I think it is well to remind people that the Department of Veterans Affairs has played a major integral and pivotal role in the initiation and continuation of geriatrics programming in this country. It plays a major role in the training of all physicians, as most of you know, as well as many other health professionals.

In the area of geriatrics, it has staked out a role of continuing importance, in part because the department recognized that its cadre of patients was aging more rapidly than the rest of the country. So we now have reached a point where over half of all men over the age of 65 in this country are veterans. So there were major needs the department saw.

The reason for bringing this up now—as at least one person has alluded to and maybe a couple—is that the stability of many of these programs is really in jeopardy at this time. As many of you know, the Department of Veterans Affairs is undergoing reorganization and going from a more centralized system to a more decentralized system with the creation of health networks across the country. In and of itself, I think that actually will be a very beneficial reorganization.

But one of the things it places in jeopardy are special programs that are central in nature. Those special programs include the geriatrics program, the Geriatric Research, Education, and Clinical Centers, after which many of the subsequent programs in the private sector and others have been modeled. It includes the Geriatric Fellowship Program. Again, this was one of the earliest fellowship programs and has trained more academic geriatricians than any other single program existing today.

These programs I feel are in some jeopardy because of the decentralization. In theory, at least, the way in which these programs are to be managed will come under the aegis of a decentralized system.

The reason to bring this up in this forum is that we need support to emphasize that the continuation of programs of this sort—centralized special programs dealing with geriatrics at all levels for education, training, and research—are vitally important within the VA system not only because they are important to the VA system—which I believe they are—but because they are integral parts of the entire fabric of geriatrics education, research, and training in this country.

Jerry Kowal alluded to the fact that there are few of the major programs which do not have a tight integration with the geriatrics

program in the Department of Veterans Affairs. So the importance of these programs transcends the VA alone and requires a very strong measure of support from many avenues if we are going to continue the success of these programs and continue to have them be linchpins for the success of their affiliated programs. I urge strong support for those programs.

Thank you.

Dr. GENE COHEN. I think it is a doubly important point. What is interesting is the tremendous success of a number of people who have been trained in the VA system and then those coming in and applying for Federal research grants on aging and how the outcomes of those efforts have translated not only in training and the impact on the VA system, but on the American scene in general through the fruits of the VA investigators.

STATEMENT OF SUSAN COOLEY

Ms. COOLEY. I am Susan Cooley from the Department of Veterans' Affairs. I am in the Office of Geriatrics and Extended Care.

I wasn't planning on making any remarks today, but I was really appreciative of the fact that several of you comments on VA's leadership role, pioneering role, and expressed some concern and support for the continuation of VA's programs in this area.

Harvey has mentioned this, but I would like to reinforce the fact that the Under Secretary for Health of the Department of Veterans Affairs, Dr. Ken Kaiser, has voiced support for VA's key role in geriatrics and the fact that he has had actually in the May 1st JAMA—he has a column that he does. His most recent one was on VA's role in geriatrics. I think he has support for VA's continuing role in keeping geriatrics as a special area, but—as Dr. Cohen was mentioning—under the reorganization efforts that are happening now, all of VA's programs are being looked at for the value added.

That is something that everybody in the private sector has to think about, too. But in VA we are increasingly having to look at outcomes and a demonstration of added value for all programs. I agree in having recognition for VA's historical role, but also its role in the future. The need for public support is very important. It can reinforce the fact that within VA we are trying to promote increased collaboration and leveraging of resources so that as dollars shrink in the entire system, we can use them better to increase the collaboration VA has historically had with outside organizations, but even more now I think it is important.

This is a collaborative effort and VA has had a major role, but we will need increased support from those we have collaborated with and had partnerships with in order to ensure the future of those programs.

Dr. GENE COHEN. Thank you very much.

Dr. REUBEN. I have one other comment I would like to pick up on, something that Jerry Kowal said.

As all the geriatricians in the room know, both the American Board of Internal Medicine and the American Board of Family Practice have changed the eligibility requirement so that instead of having 2 years of fellowship training to become certified in geriatrics, it will now only be a year of clinical training.

There is nobody in this room who thinks that by providing a physician with a year of training in geriatrics that you can have the products of research that are so ably exemplified by the Pepper Centers that you will be hearing about over the next few days, nor the Beeson Scholars Program. You just can't do it with only a year of training. It generally takes 2, 3, 4, or more years of research training.

Few in this room would also argue that you can train somebody to be an educator to teach geriatrics to students, to residents, and to practicing physicians with only a year of geriatric fellowship training.

One of the things that we have to figure out as a discipline—but more so as a society—is how to preserve that our teachers and our researchers will have the protected time and the training to allow them to conduct this research and to train our generalist physicians, who in fact are going to be providing the vast majority of primary care to older persons. We have to protect these teachers. Otherwise, this discipline will dry up, shrivel, and go away if there aren't teachers or researchers in geriatrics.

It is really our obligation to ensure that there is funding for these second and third years of fellowships.

Thank you.

Ms. PROSS. I am just a lay person, but I have a broad question having to do with what I would perceive to be a need to redirect residency training, broadening the settings, and perhaps lessening the focus on acute episodes, and perhaps broadening the perspective of physicians in training to incorporate more of the life issues that geriatricians face, and perhaps fewer encounters of a more dramatic nature of the doctor going in and rescuing somebody at the last minute—which is, of course, necessary under certain circumstances. But in many ways, particularly since we are an aging population, it would seem to me that what we really need is a broader base of training and a broader base of settings. Indeed, most of the care—as was already mentioned—is indeed not given in acute settings, or perhaps shouldn't be given in acute settings.

Would someone be willing to address that?

Dr. REUBEN. Donna, would you like to talk a little about the work the Hartford Foundation has been sponsoring to dramatically change how residents are taught?

Dr. REGENSTREIF. Thank you, David. I would be glad to.

Thank you for an excellent question.

Clearly the acute care setting is not only an inappropriate place to train—for primary care, particularly—but it also is consuming less and less of the total health care resources. So however you look at it, it is true.

It creates some humongous logistical problems to move people out of such a convenient setting where if they are not in the emergency room they are in the ICU or CCU or one of the acute wards. But nonetheless, we have seven projects all over the country that are trying to do this. We regard them as leading edge both in their geriatric capability and in their primary care training capability. We hope that they will develop models that we will then be able to disseminate as to what type of precepting these people need in diverse settings, how do they do at HMO's, at hospital-based ambu-

latory clinics, in nursing homes, in continuing care retirement communities, public housing, health centers, senior centers—there are really an incredible number of excellent places to train young people in primary care medicine. We are increasingly using them.

It is very difficult to do this in a 5-week period. Dan Perry's report talks about the very limited amount of direct exposure to geriatrics during the course of a 3-year residency period for general internal medicine. Nonetheless, with the more explicit geriatric attention in any rotation—which these days will include large numbers of older individuals—as well as a longitudinal focus and more explicit precepting, more attention in grand rounds, morning reports, tutorials, and training sessions, as well as electives. Many of our projects are approaching 9 months rather than 9 weeks, which had been thought of as a very good level of geriatrics.

We think there will be some models that prove that it is not mission impossible.

Ms. PROSS. I hope it is a good gestation period.

Thank you.

Dr. KOWAL. Also in response to your question, we are going through an evolutionary process. Those of us who are at or near Medicare age can remember in our training when the hospital was the most cost-effective place to evaluate somebody with a diagnostic problem, e.g., fever of unknown origin. It was not uncommon to have people go into the hospital for weeks on end for studies. That just doesn't exist anymore.

Medical students were trained in those settings because they had the greatest chance to see pathology in the shortest period of time. Now, with the rapid turnover in the hospital and limited amount of activity that goes on in terms of diagnostic work—once the patient is in, you want to get them out as quickly as possible—the setting is changing. More and more diversion toward ambulatory care is going on right now.

The down side of that, of course, is that in ambulatory care settings you don't see as much pathology in a given amount of time. You have to see a lot more patients. So that is a problem.

But there is no question that this is changing. Over the next 15 to 20 years I would probably see much more of an emphasis on ambulatory care and long-term care than we have right now.

Dr. LACHS. I would like to suggest that are two sides other than the hospital that are potentially very exciting and may be the job of academicians would be to figure out how to do this. One is the home. Home care and the house call is making a resurgence. I had the opportunity to bring an intern and resident and medical student to the home of an older adult. That is a transforming experience. It really is very interesting and is one of those things that gets people hooked on geriatric medicine. There is no substitute for seeing how someone is doing in the environment in which they function.

The other site is the nursing home. The majority of nursing home care provided by physicians in this country is not provided by geriatricians. It is provided by general internists and family practitioners. For a medical resident to come through a 3-year residency and not have had a nursing home experience I think is a real disservice.

One of the challenges is how to organize systems of teaching for these settings. I think there are ways to do that and we will have growing pains doing it, but we will learn how to do it.

Dr. GENE COHEN. I might just say that the majority of the patient encounters that I have had over the past 25 years have been home visits. Among other things, it has been a wonderful setting for learning humility. My training was as a geriatric psychiatrist. I remember one day visiting a patient who I had followed for 8 years. When I saw her in her apartment, her best friend came in and she proudly introduced me to her friend as her podiatrist. [Laughter.]

I tried to recover from that and said, "I would like to believe I treat people from head to foot." [Laughter.]

But in one of those settings we set up a very interesting training program for psychiatric residents. That led to their first publication. That is one of the things about these settings, they are so open for learning and education. It is a wonderful source for making an impact on the part of the students in the literature in both education and training as well as research.

Dr. SMITH. I am Glen Smith, one of the 1996 Beeson scholars from Baylor.

Medical education is not just training, but also constant retraining throughout life. Seeing the statistics here is very daunting considering the number of people who are currently practicing medicine and attempting to treat the geriatric aging population.

To what degree can courses such as continuing medical education be possibly required of our general practitioners and our specialists—myself included—throughout life to train us better to take care of the elderly population to provide immediate answers while we are trying to train our new generation of physicians to be better carers for the elderly?

Dr. GENE COHEN. That's an interesting question. It is also a corollary of what Dr. Frank Williams had raised in terms of people where they sit—people from the top, people who are involved with credentialling or reaccreditation—what rules govern the expectations of practitioners in the development of students.

Would anyone here like to address that?

Dr. TINETTI. I just want to address it a bit.

I spend a lot of my time involved with continuing education, so I think it certainly is one way to get some of the message out to people post-training. But people involved in education or involved in adherence well know that continuing education has very little effect on practice patterns. A drug company can put an article on the television and it changes physician behavior much better than the kinds of things we do in continuing education.

It is necessary, but it is certainly not sufficient. The way that we are really going to endow practicing physicians with the issues related to aging is really to see it in practice and get rewarded for it in practice and have mechanisms for getting rewarded and reimbursed for those kinds of care. It is certainly necessary, but not sufficient. There are much better ways to change physician behavior.

STATEMENT OF DR. LENA ALBETA

Dr. ALBETA. I am Lena Albeta, one of the Beeson scholars from Duke University.

I wanted to bring up the subject that you mentioned earlier concerning molecular biology and the basic biology of aging research.

The major breakthroughs in medicine and what makes this country uniquely great is the basic molecular studies. All the breakthroughs have come from the molecular studies in medicine. Having grown up in a Third World country, I also have the perspective that what made this country uniquely great is the research and the basic research that has taken place and that has advanced medicine and makes medicine the best in the world in this country.

I know that many foundations have supported basic research very generously. But one of the areas we are still lacking in is in recruiting very young physicians at the level of M.D., Ph.D., or at the level of residency fellowship to train them in basic biology of aging at that level.

I wonder if there are any possible solutions or ways that we could recruit people at this younger stage as other specialties do.

Dr. REUBEN. Donna, do you want to talk a little bit more about some of the other programs Hartford is supporting to try to capture students earlier in research?

Dr. REGENSTREIF. Go ahead, David.

Dr. REUBEN. The Hartford Foundation, through the American Federation of Aging Research, has a program that really aims to do exactly that: to capture students. We don't restrict it only to students who are interested in molecular biology, but other aspects of care that are related to care of older persons, through a medical student's scholars program in geriatrics.

Roughly, 80 to 85 students participate from institutions all around the country. There are four training centers that allow students to come from visiting schools, but other students can participate at their own institution.

This has actually been a wonderful program. We have had experience at UCLA with this for about 6 years now. The kind of work these students do and the amount they learn in a summer of research is just terrific. It is really too early to tell whether these are actually going to be people who enter as geriatrics faculty. They haven't finished their training yet. But in fact, this is a very stimulating program. It may be one of the first real efforts to try to capture those students early, maintain their interest, and then foster their attitudes so we have good recruitment into geriatrics.

Dr. GENE COHEN. It's very gratifying to see the role of foundations like the Hartford Foundation in this regard. It is equally disturbing to see the flattening and the falling of the slopes of Federal research, particularly at such a critical time and the impact these programs have had in such a short period. Harvey Cohen was talking about the VA and reminded us of how recent a phenomenon all this tremendous growth has been. It was only in 1975 that the National Institute on Aging appointed its first director, the VA GRECC Program was established, the Center on Aging and the National Institute of Mental Health was set up—in other words, high-powered research on aging is only a fourth quarter of the 20th century phenomenon.

For such a phenomenon and a momentum to be facing brakes at such a critical time in its development—it's hardly reaching adolescence—is one of great concern. The other side of that is how much has been accomplished in such a short period of time. I think that highlights the tremendous potential and promise of the field.

Dr. KOWAL. Also in response to your question about M.D.'s and Ph.D.'s, I think the problem is related to the lack of mentors and role models. If we had more senior faculty in research directing their interest to aging, I guarantee you would see more M.D. and Ph.D students doing work in research.

Perhaps Dr. Christofollo could speak to this. He has been involved in basic research in aging and knows some of the more recent research on senescent cells and oncogenes which may bring aging and cancer research closer together.

Are there any other areas where you can see a potential for stimulating interest in research in aging?

STATEMENT OF DR. CHRISTOFOLLO

Dr. CHRISTOFOLLO. As each of you spoke, I was puzzling over why this problem exists at all. As several of you said, it is a problem deriving from the lack of role models and mentors. There are lots of opportunities in molecular geriatrics—that is the first time I have heard that term—but certainly molecular approaches to problems of the geriatric population.

Bringing together the role models with the researchers to somehow provide an image of attractiveness to young people to apply those most modern research techniques to questions of aging and sinessence is probably where the answer lies, although I don't off the top of my head have a more defined answer.

Dr. KOWAL. Certainly it is fair to say that a lot of people are going through the neurosciences because of the tremendous amount of money supporting Alzheimer's research, wouldn't you say?

Dr. CHRISTOFOLLO. They do enter neurosciences because of the tremendous amount of money. Yes, I am sure that is true. That happened for awhile in aging research, but that has since levelled out.

Mr. BROWN. My name is Peter Brown. I am with the Special Committee on Aging for Senator Pryor.

Could you comment on what could be done at the medical schools to encourage them to offer more geriatric types of courses for the students?

Dr. GENE COHEN. That is a very good question hitting right at this graphic.

Dr. KOWAL. I could answer it directly by saying that the Robert Wood Johnson foundation has had a tremendous impact on primary care type training by actually giving money to medical schools in order to develop new programs. It is interesting to see how the medical schools have responded by actually creating separate primary care tracks. So the same thing could be done in geriatrics if there were a source of support for it.

Dr. GENE COHEN. We will have to finish with those people in line right now to wrap up.

STATEMENT OF DR. ELAINE ANDRICE

Dr. ANDRICE. I am Elaine Andrice, an epidemiologist at the University of Rochester.

We have been hearing about the need for basic research. As an epidemiologist, I work at the other end of the scale, at the population level. I think over the last decade epidemiology has found itself greatly enhanced by the basic sciences so that embracing the tools of genetic epidemiology and molecular epidemiology have made research a lot better. On the other hand, the issue of epidemiology entering, for example, genetic research has greatly enhanced the ability to design studies, analyze them, and move that field forward.

We are talking about training physicians. I can tell you that I don't know much about the basic training that physicians get, but I do know something about the lack of population-based medicine that many medical schools find difficulty in embracing.

It is very hard to sell managed care to physicians who are currently practicing or to medical students without the evidence that comes forward from population-based research. I can tell you that it becomes very challenging to talk to incoming medical students about the potential for increased knowledge and ability to care for patients that comes from research at this larger level.

We are talking about interdisciplinary issues in terms of managing patients. Also in terms of research and training, we should recognize that there has to be thinking that embraces both the very narrowest and smallest aspect of health, from cells or subcells up to evidence from the population itself.

Dr. GENE COHEN. Thank you very much.

STATEMENT OF DR. MAY REID

Dr. REID. My name is May Reid. I am a 1996 Beeson scholar.

It is the 10th anniversary of my graduation from medical school, and I feel very fortunate in terms of the way I have been supported in terms of my academic development. But another issue I want to point out is that the students who are coming up behind me—medical students in particular—are not only concerned about the income they would make in choosing geriatrics, but they are very concerned about the increasing squeeze on the amount of loans and the time period in which they have to pay back those loans as residents and fellows. It is very difficult to take on a 3- to 4-year academic fellowship if you find that your deferment and grace period expire after 9 months or 12 months.

I was fortunate, but I think that's an issue that should be addressed.

Dr. GENE COHEN. Thank you very much.

STATEMENT OF DR. BILL HALL

Dr. HALL. My name is Bill Hall. I am from the University of Rochester where I am involved in our Pepper Center and also in the Hartford generalist project.

In apropos of today, one of my proudest possessions is a letter from Dr. Beeson telling me that I was accepted to his house staff training program 30 years ago.

One of the things we are learning—particularly through our Hartford initiative—is emphasized here, and that is how terribly critical the role of the mentor is in encouraging our students and residents to enter into geriatrics. I think this cannot be emphasized too much. With all the exciting advances and all the incredible reasons for people to pick this as their clinical and academic career choice, somebody has to give them permission to do that. It has to be a respect clinician and/or scholar.

This becomes one of the most cost-effective ways of solving some of these trends that are up on the bulletin boards. While it is somewhat less tangible than other endpoints, I think it constantly bears emphasis.

The other area, though, is at the tail end of this. I would like to address this question to both Drs. Tinetti and Reuben, who had such outstanding success in outcomes research in geriatrics.

How do we really go about proving that it really makes a difference to have these geriatricians in the pipeline and in academic and in clinical positions? Do you think we have oriented our research programs enough to be able to answer that critical question to Members of Congress and others who will continue or not continue the funding?

Dr. TINETTI. I think that is an excellent question.

It is as imperative for us to show that we make a difference as it is to any other drug or anything else that we do. Many of us would love to address those questions. I was thinking today when Dr. Lachs was saying that it was cheaper to take care of people at home or in nursing homes—we haven't really shown a lot of those things. The very crux of geriatric care is the multidisciplinary team.

In essence, it seems like it makes a difference, but we really don't know. The problem is that at this point in time, if you think there is not much funding for molecular biology, for these kinds of research it is even more expensive. I think it is possible to develop methodologies to address these issues. It is work that needs to be done and can be done. The Pepper Centers is certainly one of the mechanisms for doing that. We do need to show that what we do is not only effective but cost-effective as well.

Dr. REUBEN. The bad news is that you will never be able to design a study that will prove the value of geriatrician. The good news is that no other discipline has ever proven their value either. I don't think that this is the right question.

The right question is actually, "Is the kind of work that geriatricians do the kind of work that saves money and improves patient outcomes?" In fact, much of the work that Mary and others in this room have done have really revolutionized how we care for older persons. In fact, this is what really defines a discipline's value. You don't see generalists, for the most part, undertaking these kinds of research developments and innovations because that is not their training. You also don't see as much that generalists are implementing these lessons into their care in the same way as geriatricians.

So if you think of geriatricians as leading the field and also being the implementers of where the field is going, that is probably as good as we are going to be able to do scientifically. In fact, the de-

velopments that have changed and improved the care of older persons have really been attributable to geriatricians. There is no experiment you will ever be able to do that will justify their existence.

Dr. GENE COHEN. Just one other point and then I will conclude and turn it back over to Dan Perry.

This is reflected in today's Post. The other key factor is that this is what an increasingly sophisticated public is increasingly demanding: more knowledge in geriatrics in terms of their providers. Returning to my original theme about not overlooking the obvious, when we look at this graph—and even if we add 2050—this is not science fiction in terms of thinking of the future and the ramifications. To state the obvious, everybody who will be 85 in 2050 is alive today and everybody who will be 65 in 2050 is alive today. So the entire population should be extremely concerned about this graphic.

One more obvious point, with all of the excitement and the tremendous potential in all these fields that have been mentioned, there is no doubt about it that they are all very important. But even more important is the people who develop those fields. That is what training is all about. That is what this forum is all about.

I want to personally thank all the distinguished panel members and the audience for highlighting that and turn it back over to Dan.

Ms. GERWIN. I will just briefly wrap up and thank you once again on behalf of Senator Cohen and the rest of the Aging Committee. Dr. Cohen and the rest of the participants have laid a valuable foundation for our message that we want to send to multiple audiences.

First and foremost, our audience is the Members of Congress. As the last question suggested, we do have to lay the evidence before them that geriatric training is a priority. I think this is the first beginning of a good debate brought about by the Alliance for Aging Research's excellent report.

We have other audiences as well. Certainly we have the audience of the medical community and the educators, as many of the questions and comments reflected and the third party payers either in the fee for service setting or in a managed care setting, as well as Medicare and Medicaid. Each of these have to be taught that geriatric services are a high priority that they have to provide and reimburse for.

Finally, perhaps the most potent audience we have, and the most important one is the consumer audience. We can do all we can to establish and improve the supply of geriatric-trained physicians, but the demand must also be there, as Dr. Cohen pointed out. Consumers will increasingly have more choice over the type of health care coverage and health care plans that they are able to choose, be it in a fee for service or managed care setting, and they have to be convinced that—perhaps the low-tech, comprehensive, holistic approach to their care can be cost-efficient and important for their own quality of life.

This forum is ended now after I turn it over to Dan. The record will remain open for 30 days, however. So if any of you would like to submit statements, you are welcome to do so. We will also be

soliciting statements from other experts in the field as well. Then we will continue to work as a committee on the goal of increasing the training and the opportunities for the geriatric specialist.

Thank you very much for being with us today. [Applause.]

Mr. PERRY. Thank you, Mary, for those closing remarks.

I would just like to leave you with this thought.

We have identified a problem. Everyone in this room is a part of the solution. We are not alone. We have heard of a multiplicity of efforts pushing in this direction. The Beeson Program—the Pepper Centers have shown a terrific model for establishing the all-important role models in medical schools. We have heard of the Geriatric Education Centers, the NIA's academic awards program, the all-important VA—truly the cradle of geriatric medicine in this country—and many foundations as well as the Federal Government and industry are going to help us lead in this direction.

We have heard of the tremendous potential of managed care to help drive this into practice. I am pleased to say that we have in the audience one of the senior officers of the largest Medicare managed care organization in the United States, Pacificare Secure Horizons. Craig Schub in the back of the room has been observing all of this. We can expect that part of industry will help us drive geriatrics into better patient care as well.

I thank all of you very much. I thank Gene Cohen, especially, for being our moderator, and all the other Dr. Cohens in the audience—[Laughter.]

Mr. PERRY [continuing.] And the audience itself.

A bit of housekeeping—for those of you that would like to get to know more about the specific research projects that are being undertaken by the Beeson scholars and the Pepper Center directors, we are having a poster session this afternoon that begins at 2 p.m. in the foyer of the Rayburn House Office Building. Most of you have maps, but right inside the front door of the Rayburn House Office Building, to the right will be the setting for the poster session, which begins at 2 p.m.

Right now, all of you are invited to join us for a scheduled luncheon. This begins at 12:30 p.m., so you have about 30 minutes to get there. It is in the Cannon House Office Building, the Caucus Room on the third floor, Room 345. As you turn left out of this room and go to the end of the hall, you are on the sixth floor. Go to the ground floor. When you walk out of the building, you are still headed in that same direction, south. Walk down First Street about three long blocks. The Capitol will be on your right. The Supreme Court and Library of Congress will be on your left. When you get to Independence Avenue—about three long blocks away—you will be facing the Cannon House Office Building. It is only about a 5-minute walk and it is a lovely day.

Again, thank you all very much for participating in this. I look forward to seeing you during our luncheon.

Thanks to the panel. [Applause.]

[Whereupon, at 12:02 p.m., the forum was adjourned.]

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