

**LIVING LONGER, GROWING STRONGER: THE
VITAL ROLE OF GERIATRIC MEDICINE**

FORUM
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

WASHINGTON, DC

MAY 20, 1998

Serial No. 105-24

Printed for the use of the Special Committee on Aging



U.S. GOVERNMENT PRINTING OFFICE

49-744 CC

WASHINGTON : 1998

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-057500-1

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LIVING LONGER, GROWING STRONGER: THE VITAL ROLE OF GERIATRIC MEDICINE

WEDNESDAY, MAY 20, 1998

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

The committee met, pursuant to notice, at 9:35 a.m., in room SD-628, Dirksen Senate Office Building, Hon. Charles E. Grassley, (chairman of the committee), presiding.

Present: Senators Grassley, Reid, and Reed.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. I thank all of you very much for being patient while waiting for me and particularly the panelists who are all ready to go, and my two colleagues, who are here Senator Reid of Nevada and Senator Reed of Rhode Island. I want to say to Senator Reid of Nevada that what we are talking about today, is a topic he has always been ahead of the curve on, and he has talked about the shortcomings of the medical establishment in training of the medical profession to meet the health care needs of seniors.

So that is the reason for this morning's very important forum to address the importance of geriatric medicine and the shortage of geriatricians that our Nation faces. So I thank Senator Reid and Senator Reed for their interest in this issue and for requesting this forum today.

It is especially timely that we are holding this forum since the month of May is Older Americans Month, and this year's theme for Older Americans Month is "Living Longer, Growing Stronger in America."

Senator Breaux will not be able to be with us today. He is the ranking Democrat on this committee, and he is very attentive to the work of the Senate Special Committee on Aging. But he has additional responsibilities with his role on the Bipartisan Medicare Commission. This takes up most of his time and will continue to between now and next March when the commission reports to Congress. Senator Breaux is an excellent choice to lead the Medicare Commission and its mission to examine reforms to the Medicare program so it is around when the baby boomers retire.

The old saying that an ounce of prevention is worth a pound of cure is really true about the subject we are talking about today. Physicians trained in geriatrics can prevent many health problems of the elderly. We will hear from a woman this morning who was

misdiagnosed and given the wrong medication by her primary care physician. It was not until she was seen by a geriatrician that her problems were correctly treated. We will also hear from experts in the field about the benefits of this training, and the increasing need for geriatricians as our population continues to age.

In light of the aging population and the impending retirement of the baby boomers, the need for geriatricians will be great. For example, in my home State of Iowa, 15 percent of the population is over 65. We have the third highest percentage of retirees in the Nation. Currently, Iowa has only 87 geriatricians. According to the Institute of Medicine, Iowa will need 304 geriatricians by the year 2010 when the baby boomers retire. By the year 2030, we should have 472. Supply is certainly not keeping up with demand.

Panelists today will highlight why we have a shortage of geriatricians. They also will examine possible solutions to this problem, and we will allow time for you and the audience to ask questions. Our moderator is our distinguished Assistant Secretary for Aging, Jeanette Takamura. In addition, we have many distinguished speakers here today. I hope we can all learn something about this very important issue, and I appreciate the panelists, whom I have already welcomed individually, for your availability to participate in this forum.

I now call on Senator Reid of Nevada. He will be followed by Senator Reed of Rhode Island.

OPENING STATEMENT OF SENATOR HARRY REID

Senator REID. Senator Grassley has really set an example of bipartisanship with this Aging Committee. Those who are political scientists should study how this committee is run to find bipartisan cooperation. We have done some very good things legislatively as a result of the hearings held under the guidance of Senator Grassley, and I personally appreciate his fairness and his bipartisanship in this committee.

Currently, 13 percent of our population is 65 years of age or older, but by the year 2030, older Americans—that is, those people over age 65—will comprise about 21 percent of the population. The number of adults age 85 and over will rise from 3.3 million in 1994 to 8.6 million by the year 2030, and then 20 years later to 19 million.

I visited during the Government shutdown a year or so ago the Social Security office in North Las Vegas, and it was shut down so we had a lot of time to talk. As we visited, one of the women there said that her responsibility was to go out and visit people over age 100. There is a rule in Social Security that if you are over 100, there has to be a personal visit from Social Security.

She said this used to happen very, very infrequently. Now in southern Nevada, it happens all the time. There are a significant number of people over 100 years of age in southern Nevada and all over this country.

Some have referred to the challenges this demographic reality will present—that is, so many people over age 65—this reality will present to the health care professions as “the sleeping giant.” We need to act before this giant awakens.

We have a documented shortage of doctors, students, teachers, and researchers who are versed in geriatric medicine and psychiatry. One report concluded that we have 8,000 geriatricians and will need 36,000 by 2030. That is significant. Every State is like Senator Grassley's State. In fact, Senator Grassley, your State may be better served because of the great educational system you have, medical schools, et cetera, in Iowa. But all States have a significant shortage of geriatricians.

We could save billions of dollars if we could merely delay the onset of geriatric diseases like Alzheimer's or Parkinson's. The reason I say that, almost half the people in our extended care facilities or convalescent homes are there because of those two diseases—Parkinson's and Alzheimer's. If we could delay the onset of these diseases and then by some miracle prevent one of those diseases, think of the money that we could save in addition to the pain and suffering of the individuals that have the disease, plus the loved ones around these people.

So we need geriatric researchers to carry on with this important work. We could also save by preventing unnecessary admissions to hospitals due to adverse medical reactions, as indicated by Senator Grassley. We could prevent expenditures that some consider exorbitant to acute care facilities or skilled nursing facilities by treating a patient at home using an interdisciplinary approach that can be monitored by a geriatrician.

Only 2 of the 125 medical schools in this country have a Department of Geriatrics—2 out of 125—but they all have Departments of Pediatrics. Only 12 of 125 schools require a course in geriatrics. Many medical students are not exposed ever to geriatric patients during their rotations. Yet nearly 7 billion of Medicare money go to support graduate medical education. It seems to me that we have a jolting responsibility there.

Of 98,000 residents and fellows funded by GME in 1998, only 324 out of the almost 100,000 were in geriatric medicine and geriatric psychiatry. Medicare taxes are paying the bill, yet Medicare beneficiaries are not receiving the goods. Every senior deserves a doctor who has been exposed in their training to geriatric patients and geriatric training.

With 13 percent of America's seniors enrolled in HMOs and more surely to sign up under Medicare Plus Choice, HMOs will benefit with geriatricians on staff. The value of the interdisciplinary approach designed to ensure seniors get the right treatment in the right setting can't be overstated.

I have been a supporter for a long time of geriatric education centers for their role in training allied health professionals in geriatric health issues once these professionals enter the field. While we have 43 GEC programs nationally, only 30 will be funded in the President's budget. As such, I have asked for additional funding in this year's appropriations cycle for the other 13. We need a shift in our thinking to ensure that our medical schools and schools of nursing and social work will begin to prepare the next generation to provide services to a population where one in five will be over age 65.

While we acknowledge that longevity is increasing in this Nation, we need a corresponding acknowledgment that our health

care workforce needs a close examination to ensure we are postured to meet it head-on.

I look forward to this forum today, and I would like to personally welcome Dr. Jeanette Takamura, our Assistant Secretary, as did the chairman of this committee. I appreciate, Dr. Takamura, your coming to Nevada for the two field hearings we had. They were extremely helpful and beneficial, and I appreciate very much your efforts.

I would like to welcome all the participants. We have great panelists for this forum, but personally, I would like to welcome two people from Nevada: Dr. Steve Phillips from Reno, who is involved in a very large health management entity, and Mr. Steve Anderson from the Reynolds Foundation, who does great charitable work throughout the United States.

I think I can speak for my colleagues. This is a forum. We are not going to be able to stay through the entire proceeding. We appreciate your being here, Dr. Takamura, and serving as our moderator.

I want to now introduce the other Reed of the Senate. When Senator Reed showed up, I went to him very quickly in the Senate and told him I was going to be chairman of the Reid Caucus. [Laughter.]

In that I am senior to him, he agreed and has been very good in that regard.

Jack Reed is a great asset to the U.S. Senate. He has a background that is significant. He is a graduate of West Point. He has had a good military career, a great career in Government. I met him when he was serving in the House of Representatives, where he had a distinguished career. The people of Rhode Island and this country are very fortunate to have Jack Reed representing the Senate. Senator Jack Reed.

OPENING STATEMENT OF SENATOR JACK REED

Senator REED. Thank you very much, Harry, for that wonderful introduction. I want to commend Chairman Grassley for not only holding this hearing, but also for providing excellent leadership on this committee. It is really a pleasure to serve with you, Mr. Chairman. I know Senator Breaux, our ranking member, can't be here today, but he also has been a significant asset to this committee and its deliberations. Again, I would like to commend my namesake, the more senior Senator Reid, who has distinguished himself for many years and for a long, long time has been in the forefront of these efforts to develop an appreciation of geriatric medicine.

Now, for many, many years, I labored under the misconception that a doctor was a doctor was a doctor. I didn't realize that geriatricians are a very important and, in fact, of growing importance to the health care system because they have special skills that are so essential to the delivery of health care. But I had the opportunity to sit down and talk with Dr. John Murphy of Brown University here today, who is an eminent geriatrician and teacher in Rhode Island. Then I had the opportunity to go out and visit some facilities in my State of Rhode Island, in Cumberland, RI, where we have a seniors center, and they have a physician there at the seniors center who is a trained geriatrician. She explained to me

in detail how much more effective she could be in dealing with senior populations than someone who has been trained simply in internal medicine or another specialty. So this appreciation has helped me to understand the issue and to work toward a more robust geriatric presence on our college and university and medical school campuses.

I was pleased to be one of the authors of an amendment to the Health Professions Act which would create a junior staff development program for the faculties of our medical schools. We hope in this way to begin to expand the number of teachers of geriatrics in our medical schools, which is a key part of our strategy to cope with the increasingly aging population in the United States.

Now, this is a wonderful forum. We will have the opportunity to hear from all of these experts and many people with much more relevant firsthand experiences. But let me just say that this issue is important to our senior population, but it is also important to all Americans, because we are all—we baby boomers are coping with not only our impending entry into the ranks of seniors, but many of us have parents that we have to care for, older relatives. All this is very important to all Americans, and that is why this forum is so very vitally important to us today.

Again, I want to particularly welcome Dr. Murphy, who is joining us. He is one of the many fine physicians and faculty members at the Brown University Medical School.

I am also at this time delighted to be able to introduce the chairperson of this forum, Dr. Jeanette Takamura. Dr. Takamura is an extraordinarily gifted and capable person who joined the administration in 1997 after a distinguished career in Hawaii, where she first headed up their aging office, then was the first deputy of the health department. She is also a professor at the University of Hawaii. She is an expert, and she is also an extremely talented and an extremely energetic individual. She has traveled to Nevada and Louisiana and, most importantly, to Rhode Island.

We had a wonderful time with Jeanette. She saw some of our senior centers, and she was terrific. She brings to this great and challenging job energy, professional expertise, and enthusiasm that is extraordinary.

Ladies and gentlemen, I will now turn it over to the very capable hands of Dr. Jeanette Takamura.

STATEMENT OF JEANETTE C. TAKAMURA, ASSISTANT SECRETARY FOR AGING, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. TAKAMURA. Thank you, Senator Reed, and thank you, Senators Grassley and Reid. I truly appreciate the privilege and the honor of serving as your moderator for this forum on the national shortage of geriatricians. I would especially like to acknowledge the Senate Special Committee on Aging for its commitment to ensuring the concerns of older adults are addressed through responsive policies and programs which meet both current needs and our emergent realities.

This forum is a concrete example of such a commitment. For their steadfast leadership on issues that affect the daily lives of older Americans and their families all across the Nation, I would

particularly like to pay tribute to Chairman Grassley and let him know that I just visited Iowa and found out that you have 789 centenarians; also Ranking Member Senator John Breaux of Louisiana, who could not be here today; Senator Harry Reid of Nevada, who was instrumental in the organization of this forum and whose legislative efforts in the area of geriatric medical education are well recognized; and, finally, Senator Jack Reed of Rhode Island, who I know to be a very intense hard worker on behalf of older Americans.

As many of you know, and as I believe Senator Grassley pointed out, May is Older Americans Month, a month during which we are highlighting the fact that America is indeed blessed with the gift of longevity and, additionally, that our older adult population is growing rapidly in number.

These two realities then—the convergence of longevity and population aging—suggest that we must confront the realities of a workforce shortage, that is, a shortage of geriatricians.

I am indeed pleased to be able to tell you that today represents a very significant step in the process of attending to our Nation's geriatric workforce needs. This forum is cosponsored by the Senate Special Committee on Aging together with the American Association for Geriatric Psychiatry and the American Geriatric Society.

I look forward to the comments and the remarks and the experience that will be shared by our witnesses today. This forum will definitely shed new light upon the essential work which must be done to develop systems of training and health care delivery which ensure that physicians who treat older patients understand the special health nuances which cannot be and should not be ignored.

Let me then go ahead and introduce the panelists who are here with us today, and just as a preliminary remark, let me say that each of these panelists have been asked to limit their comments to about 5 minutes. We have a warning system with which I am personally very familiar that we will be using this morning.

Our first panel will be addressing the question: Is there a shortage of geriatricians? I am very pleased indeed to introduce Ms. Violet Cosgrove, who joins us from Glen Burnie, MD. Born in Michigan, Ms. Cosgrove moved to the Maryland area in 1951 when she began working for the Department of Defense. She retired in 1971 due to the severity of her arthritis—and, unfortunately, this is a very, very common experience in America—but has remained very active, devoting a great deal of time and energy to advocacy work on behalf of disabled children.

Ms. Cosgrove is now 72 years old and has just recently begun seeing a geriatrician after having several experiences with sub-standard care. She has so very kindly joined us today to share her story illuminating the very human component of the issue that we will be discussing.

Our second witness on panel one is Dr. John Murphy, who has been affiliated with Brown University in Rhode Island since 1980, when he began his residency in family medicine. Since then, Dr. Murphy has moved from student to faculty at Brown, serving as a professor, a residency director, a department head, and a medical director for a family care clinic. Dr. Murphy's commitment to geriatrics has remained strong throughout his medical career. He is

with us today to describe his own experiences as a geriatric physician.

Our third and final witness on panel one is Dr. Susan Klein, who is the director of geriatric education programs for the interdisciplinary geriatrics and allied health branch of the Bureau of Health Professions, Health Resources and Services Administration. Quite a mouthful, by the way. She manages federally funded geriatric education centers and faculty training projects, is co-director of the Geriatric Education Futures Project, which is indeed exciting, and is the program officer for various geriatric education contracts. Dr. Klein's academic background is in gerontological nursing and community health. She received her doctorate in nursing from the Catholic University of America.

With that, I would like to invite Ms. Cosgrove to present her testimony.

STATEMENT OF VIOLET COSGROVE, OLDER CONSUMER, GLEN BURNIE, MD

Ms. COSGROVE. Thank you. I am Violet Cosgrove, a Medicare beneficiary from Glen Burnie, MD. I am very pleased to be here today to discuss the critical need for more geriatricians and the need for all doctors to become better educated about the health care needs of older people. I especially want to thank Chairman Grassley, Senator Breaux, and Senators Reid and Reed for inviting me to participate in this forum.

I have lived with chronic illness most of my life. Just 2 weeks ago, I met with a geriatrician for the first time, and I must tell you the dramatic impact it has had on my life.

I suffer from severe arthritis and severe osteoporosis. I had polio as a child and developed arthritis in 1941 when I had a bicycle accident. Over the past 50 years, my arthritis has worsened, causing me to have one hip replacement and two knee replacements. Despite persistent pain, I have been leading a very active life, raising a family, working at the Defense Department, and advocating for disabled children.

My most recent health care problems began just last October when I fell. I went to my orthopedic specialist who ordered X-rays on my hips, which did not show any problems. Since I was in quite a lot of pain, I went to my regular primary doctor who I had been seeing for several years. This doctor basically dismissed my complaints and told me: "What do you expect? You're getting old."

Over the next 2 months, my pain increased significantly. I was in so much pain, I needed canes to walk. I also limited my driving to only important trips, such as going to the grocery store. Disgusted with my regular doctor, I finally went to another primary doctor in the hope of receiving more attentive care.

This new doctor did not spend much time with me. She only briefly reviewed my medical history and asked me what I thought was the cause of the pain. I had thought it might be a muscle spasm since the earlier X-rays did not show any broken bones. Without taking a second X-ray, this doctor immediately prescribed physical therapy, as well as a muscle relaxant and a pain medication.

During the week of taking the two medications, I suffered from extreme dizziness, stomach problems, and I just couldn't function well. I spent most of my time in bed. I called the pharmacist to see if it would be safe to stop the medications because some medications are unsafe if you stop them in a hurry. I stopped the medication and the symptoms of the stomach problems and the dizziness disappeared. When I went to the doctor 2 weeks later, she got very angry with me that why didn't I call her. Well, she wasn't available. She was convinced that the stomach problems and the dizziness was not caused by the medication. But I don't agree.

During this time, I also began physical therapy sessions about twice a week. After about 6 weeks, the pain continued to get worse. I decided to go back to my orthopedic surgeon. He immediately ordered a new round of X-rays and discovered that I had a fractured pelvis, made worse by the 6 weeks of physical therapy sessions. The doctor told me to stop the therapy and to rest for several weeks. He also referred me to one of the only geriatricians in my area, who had just recently moved to my area from Philadelphia.

While it took 6 weeks to get my first appointment with the geriatrician, the switch from my previous primary doctor was like night and day. The doctor treated me with respect, empathy, and patience. But what I appreciated most was that she actually listened to me. She did not dismiss my problems as normal aging. She treated me as an adult. She had sent me a lengthy questionnaire about my medical history, to include all the drugs I had taken for the past 5 years, all the doctors I had seen, all the lab reports I had, and all the other information that might be helpful to her.

She spent 2 hours with me at the appointment at the first visit, explaining pieces of information about my medical records that I did not understand. Never once did she dismiss my aches and pains to just plain old age. I was struck that no one else had ever taken the time to listen to me and to explain my health care problems to me in depth like this before. For once, I felt that I was being treated as an adult instead of as a 2-year-old child. I also felt I was being treated as a whole person instead of part by part. This geriatrician is now developing a care plan for me in order to prevent future falls and to keep me healthy and independent.

I pride myself on being a good consumer. I usually go to the library to look up every medicine a doctor prescribes to make sure it is safe for someone my age. I know that some medications are just not safe for older people, especially in combination with other drugs. I also know that the dosage might need to be adjusted for older people or for women my size.

While I believe that everyone should be an educated consumer, I also feel strongly that our doctors should be just as educated and tuned in to the special health care needs of older people. I must tell you that my experiences with the health care system are very similar to many other older people I have spoken to. I can't tell you how many times my friends and I have heard the same phrase, "What do you expect? You're getting old."

I know that the Medicare system is spending a lot of money unnecessarily for harmful care, such as my physical therapy was, or on sessions for health care problems due to adverse reactions from drugs that had been prescribed.

Today, I am 71 years old. I plan on living for a long time. My father lived until he was 90. My mother, who lives in Michigan, is 94. I believe that because I am going to be around for a long while, I ought to get appropriate care.

I urge Congress to make the changes needed to encourage more geriatricians and to make sure that all doctors get the training needed to recognize the health care needs and problems of older adults.

Thank you.

[The prepared statement of Ms. Cosgrove follows:]

**REMARKS OF
VIOLET COSGROVE**

Senate Special Committee on Aging

"Living Longer, Growing Stronger: The Vital Role of Geriatric Medicine"

May 20, 1998

I am Violet Cosgrove, a Medicare beneficiary from Glen Burnie, Maryland. I am very pleased to be here today to discuss the critical need for more geriatricians and the need for all doctors to become better educated about the health care needs of older persons.

I especially want to thank Chairman Grassley, Senators Breaux, Reid and Reed for inviting me to participate in this forum.

I have lived with chronic illnesses most of my life. Just two weeks ago, I met with a geriatrician for the first time and I must tell you what a dramatic impact it had on me.

I suffer from severe arthritis and severe osteoporosis. I had polio as a child and developed arthritis in 1941 when I had a bicycle accident. Over the past 50 years, my arthritis has worsened, causing me to have one hip and two knee replacements. Despite persistent pain, I have been leading a very active life, raising a family, working at the Defense Department, and advocating on behalf of disabled children.

My most recent health care problems began just last October when I fell. I went to my orthopedic specialist who ordered an X-ray on my hips, which did not show any problems. Since I was in quite a lot of pain, I went to my regular primary care doctor who I had been seeing for several years. This doctor basically dismissed my complaints and told me: "What ^{do} can you expect, you're getting old!"

Over the next two months, my pain increased significantly. I was in so much pain, I needed canes to walk. I also limited my driving to only important trips, such as going to the grocery store. Disgusted with my regular doctor, I finally went to another primary care doctor in the hope of receiving more attentive care.

This new doctor did not spend much time with me. She only briefly reviewed my medical history, and asked me what I thought was the cause of the hip pain. I had thought that it might be a muscle ^{spasm} sprain, since the earlier x-rays didn't show any broken bones. Without taking a second x-ray, this doctor immediately prescribed physical therapy, as well as, a muscle relaxant and a pain medication.

During a week of taking the medications, I suffered from extreme dizziness, stomach problems and I just couldn't function well. I called the pharmacist to see if it would be safe to stop taking the medicine. I know that it can be harmful to stop taking medications suddenly. I stopped the medicine and almost immediately, the symptoms disappeared. I later found out that these drugs are often unsafe for a woman of my size and age.

About two weeks later, I returned to the primary care doctor who scolded me for stop taking the drugs. She felt that the drugs were not the cause of the problem.

During this time, I also began physical therapy sessions about twice a week. After about 6 weeks, the pain worsened. I decided to go back to my orthopedic surgeon. He immediately ordered a new round of x-rays and discovered that I had a fractured pelvis, made worse by the 6 weeks of expensive physical therapy sessions. The doctor told me to stop the therapy and to rest for several weeks. He also referred me to one of the only geriatricians in my area, who had just recently moved from Philadelphia.

While it took six weeks to get my first appointment with the geriatrician, the switch from my previous primary doctor was like ~~night and day~~. This doctor treated me with respect, empathy and patience. But what I appreciated most of all was ^{mat}she actually listened to me, and didn't just dismiss my problems as "normal aging". She had sent me a lengthy questionnaire about my medical history, including all the drugs I was taking, before my first visit and asked to see all of my medical records for the past five years. When I went to see her, she had already reviewed all of my medical records and lab reports that I had sent.

She spent about 2 hours with me on this first visit, explaining pieces of my medical history that were confusing and listening to my concerns. Never once did she dismiss my aches or pains, as just plain old age. I was struck that no one had ever taken the

time to listen and explain my health care problems to me in depth like this before. For once, I felt that I was being treated as an adult, instead of a ²two-year old child. I also feel that I have been treated "part by part" and that she was treating me as a whole person. This geriatrician is now developing a care plan for me in order to prevent future falls and to keep me healthy and independent.

I pride myself in being a good consumer. I usually go to the library to look up every medicine a doctor prescribes to make sure it is safe for someone of my age. I know that some medicines are just not safe for older people, especially in combination with other drugs. I also know that the dosage may need to be adjusted for older people or for women of my size.

While I believe that everyone should be an educated consumer, I also feel strongly that our doctors should be just as educated and tuned in to the special health care needs of older people. I must tell you that my experiences with the health care system are very similar to other older people I know. I can't tell you how many times my friends and I have heard the phrase, "What can you expect, you are old". Doctors often tells us this when we complain of pain or other ailments. I know that the Medicare system is spending a lot of money on unnecessary or harmful care, such as my physical therapy sessions or on health care problems that come from adverse reactions from drugs.

While I am 71 today, I plan on living for a very long time. My father lived until 90. My mother, who lives in Michigan, turned 94 this year. I believe that because I am going to be around for a while, I ought to receive appropriate care.

I urge Congress to make the changes needed to encourage more geriatricians and to make sure that all doctors get the training needed to recognize the health care needs and problems of older adults.

Thank you.

Dr. TAKAMURA. Thank you, Ms. Cosgrove. [Applause.]

Thank you for sharing your experience with us and really making the issues here come alive. It is an invaluable contribution.

I would just like to remind our witnesses that the warning system—and I should have probably told you about this earlier—has three lights on it. The green one means you are fine; the yellow one means that it is a warning signal, you may be running out of time; and, of course, the red light means that you need to wind your presentation up.

Our next witness is Dr. John Murphy.

Dr. Murphy.

STATEMENT OF JOHN MURPHY, M.D., ASSOCIATE PROFESSOR AND RESIDENCY DIRECTOR, DIVISION OF GERIATRICS, DEPARTMENT OF FAMILY MEDICINE, BROWN UNIVERSITY, PAWTUCKET, RI

Dr. MURPHY. Thank you very much. That is a tough act to follow.

My name is John Murphy. I am a geriatrician, and I teach and practice medicine in the Department of Family Medicine at Brown University. At Brown, in the Memorial Hospital of Rhode Island, and nationally, the major focus of my activities is on teaching physician trainees to care for older people.

I want to thank Chairman Grassley, Senators Reid, Reed, and Breaux for holding this forum highlighting the national shortage of geriatric-trained health care professionals. I won't bore you with the statistics in the increasing number of older people, and you have heard some of them from the Senators. But 35 million of my closest friends and I will shortly be moving into the over-65 age range, and I would hope that I will get good care, along with my colleagues.

I would, however, like to share with you my experience in going through medical school and residency training, because I think it speaks to some of the issues that Ms. Cosgrove raised.

My medical education as a family physician first was very strong, and I think I went to some of the best training programs there are. However, when I first started practicing medicine on the faculty of Brown after finishing my residency, it became very clear to me that there was one group of patients that I always had difficulty caring for. I always got into trouble with the very frail, very elderly patient. No matter how many consultants or other people I involved in the care of that patient, things seemed to get worse.

At that time I decided to take a leave of absence from the department and was granted it and was supported in taking that leave of absence to pursue geriatric fellowship training. The fellowship training I took provided me with additional knowledge and skills that really made a tremendous difference in my effectiveness in caring for my older patients. More importantly for me personally, it made practicing medicine much more fulfilling. That is an issue that I will come back to in a few minutes.

As you know, older people have unique characteristics, and these characteristics really play out in the medical setting. For that reason, the training of physicians who care for older people needs to include special training about older individuals.

I see three important and related problems which need to be solved if we are going to be able to face the demographic imperative in the next 20 years. First, there is a severe shortage in the number of physicians who are trained as geriatricians. Second, there is a lack of training for health care professionals, and particularly physicians, in professional schools. Third, there is a lack of training for currently practicing physicians and other health professionals.

A geriatrician is a physician who has been first board certified in family medicine, internal medicine, or psychiatry, and then goes on to pursue additional fellowship training. A geriatrician must pass a certifying examination at the end of the training and is required to continue to pass recertification exams every 10 years thereafter if they are to maintain their certification.

Right now, as you heard, there are less than 9,000 geriatricians in this country, and I think we are going to see those numbers drop precipitously in the next decade right before the baby-boom generation starts to hit Medicare age.

There is a paucity of fellowship positions currently in the United States. Out of the 98,000 house staff physicians that are funded by Medicare, as we heard, only slightly over 300 are in geriatric medicine and psychiatry, and we desperately need to increase the number of geriatricians in medical schools, in practice, and increase the geriatric curriculum in all health professionals' training.

We also need physicians who are going to lead clinical research and academic geriatricians to teach not just geriatric physicians but primary care physicians so that the primary care physician that you met, Ms. Cosgrove, will have some of the skills that they need to be able to care for the more common problems of older individuals.

Clinical geriatricians are needed to be able to care for the very complex, the very frail elderly, and also to consult to primary care physicians, because we will not have enough geriatricians trained, even if we greatly increase the numbers, to care for all of the older people, but we should be able to increase the numbers to provide the consultants and the academicians that are needed.

The reasons for the shortage of geriatricians are many, and the financing of health care for geriatrics is often raised as one key issue. Although what physicians are paid may be a piece of the pie, I don't think that this is the whole story.

The physician payment system currently does not provide coverage for the coordination and management of care that is necessary for complex older patients, except in a few situations, and this system fails to pay for the scope of assessment and management services that are needed, such as the 2 hours necessary to find out what was really going on with Ms. Cosgrove. I maintain that the real problem in recruiting physicians to geriatrics is not so much the salaries or the dollars put into it, but the fact that those physicians don't feel fulfilled in caring for older people because they don't have the payment systems that will allow them to provide the interdisciplinary team care that is necessary to do good quality medicine for complex older patients.

Clearly, there is a need for all health care professionals to be trained in the care of older adults, and I think there is a major role

for the Federal Government in this regard. Through Medicare and Medicaid, we are putting a tremendous amount of money into the financing of health care for the elderly, and I would like to just suggest three of the ten recommendations that I made in my written statement.

First, we need to change the current Medicare payment system to provide for management services for the complex chronically ill patients.

Second, Congress needs to pass bills that have been introduced a year ago by Senators Reid, Grassley, and Glenn to institute loan repayment for geriatric fellows.

Third, Congress should approve new programs to increase the number of geriatric academicians in Senate bill 754.

I want to thank the Senators and everyone for the opportunity to speak here today.

[The prepared statement of Dr. Murphy follows:]

STATEMENT OF

JOHN MURPHY, MD

ASSOCIATE PROFESSOR, RESIDENCY DIRECTOR AND DIRECTOR OF THE
DIVISION OF GERIATRICS
BROWN UNIVERSITY DEPARTMENT OF FAMILY MEDICINE

ON

BEHALF OF THE
AMERICAN GERIATRICS SOCIETY

ON

THE VITAL ROLE OF GERIATRIC MEDICINE
FOR THE
SPECIAL COMMITTEE ON AGING FORUM
U. S. SENATE

May 20, 1998

I am Dr. John Murphy, Associate Professor, Residency Director and Director of the Division of Geriatrics, in the Brown University Department of Family Medicine. I am a geriatrician. Within the Brown University School of Medicine, at Memorial Hospital of Rhode Island, and nationally, a major focus of my professional career is on educating physicians in the care of older persons. In this capacity, I serve as a member of the Education Committee of the American Geriatrics Society. I appreciate the opportunity to participate in this forum today on behalf of the American Geriatrics Society.

I applaud the Senate Special Committee on Aging for holding this forum highlighting the national shortage of geriatric-trained health professionals. As a 1995 Department of Health and Human Services' report concluded, the need for adequately trained health care providers to identify and manage older persons' health care needs is urgent.

My testimony today will:

- Describe how our country's health care workforce is ill equipped to care for the aging of the baby boomers;
- Detail the key reasons for the shortage of geriatricians;
- Provide examples of current initiatives of the American Geriatrics Society to address this problem; and
- Suggest recommendations to increase the numbers of geriatric trained health care professionals in order to improve the quality of health care services provided to our Medicare beneficiaries.

THE PROBLEM: The U.S. health care workforce is ill equipped to care for the aging of the baby boomers.

Our country is aging rapidly. In 1900, there were 3.1 million Americans age 65 and older, and at the close of this century, there are roughly 35 million people. By the end of the next decade, we will see an even more dramatic increase in the growth of the older population, as a result of the post World War II "baby boom". By 2030, it is projected that one out of every five Americans will be over age 65. People age 85 and older is the fastest growing segment of the elderly, with expected growth from 4 million people today to 19 million by 2050. The implications of this "demographic imperative" are dramatic and we are not prepared.

In addition to longer life spans, the nature of illnesses are changing. Americans are not dying from the same diseases they did in previous generations. Chronic conditions are now the major cause of illness, disability and death in this country, accounting for 75 percent of all deaths today. People are now living longer with disabling chronic conditions, primarily as a result of medical advances, surgical interventions and pharmaceuticals. On average, by age 75, older adults have between 2 to 3 chronic medical conditions.

Aging is a significant women's issue. On average, women live 7 years longer than men and have more chronic illness and disability. Moreover, women occupy over 70 percent of nursing home beds in this country.

Geriatrics is a relatively new field. Medical science has learned a lot about aging and how to prevent and manage disease and chronic illness. Unfortunately, this geriatric research and knowledge is not being spread through the health care workforce.

Geriatric medicine promotes wellness and preventive care, with emphasis on care management and coordination that help patients maintain functional independence and improve their overall quality of life. With an interdisciplinary approach to medicine, geriatricians work with a coordinated team of nurses, geriatric psychiatrists, physician assistants, pharmacists and others. Geriatricians strive to balance the use of expensive high-tech interventions with the potential harm these procedures can cause in older persons with multiple chronic illnesses.

I would like to share with you my reason for becoming a geriatrician. My medical education as a family physician was very strong. Yet, when first practicing as a junior faculty family physician, I found that I consistently ran into difficulty when caring for very frail older patients, unlike my experience in caring for other age groups. I was not alone in this experience, but very few colleagues were willing or able to seek the remedy that I chose. Most just shied away from the care of frail older patients. I decided to take a leave of absence from my faculty position and pursue fellowship training in Geriatrics.

In my fellowship, I learned skills that had a dramatic impact on my ability to care for frail older adults, and this enhanced effectiveness also led to a sense of fulfillment, a feeling that was previously missing.

Older persons have unique characteristics that differentiate them from younger populations. Thus, special training is needed to identify them from younger populations. Too often, illnesses in older people are misdiagnosed, overlooked or dismissed as the normal process of aging, simply because health care professionals are not trained to recognize how diseases and drugs affect older patients. This can translate 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.

Three important and related problems need to be solved if we are going to deal effectively with the aging of our country:

1. **Shortage of geriatricians – physicians who specialize in caring for older adults:** Geriatricians are physicians who are first board certified in family practice, internal medicine or psychiatry, and then complete additional years of fellowship training in geriatrics. Geriatricians must pass a special certifying exam upon completion of training and pass a recertification exam every ten years thereafter.

Today, there are less than 9,000 certified geriatricians in the United States. This number is expected to drop by the year 2000, just as the baby boomer generation begins to reach Medicare eligibility. Many high level Federal panels, including the Institute of Medicine and HHS have documented this severe shortage and have called for significant increases in geriatricians.

Of the approximately 98,000 medical residency and fellowship positions supported by Medicare in 1998, only 324 were in geriatric medicine and geriatric psychiatry.

An increased number of trained geriatricians are critically needed as:

- **Academic Geriatricians:** Increases in geriatricians in medical schools are essential to train primary care, specialist physicians, and other professionals to diagnose and treat problems common in older persons. They are also needed to lead clinical research activities in developing cures and treatments for the diseases that affect this population. Unfortunately, the situation for geriatricians in academic settings is getting worse. Geriatricians are being required to use a greater percentage of their time to generate clinical income to support their positions, which translates into less time for their teaching and research.
- **Clinicians:** Geriatricians are needed as consultants to primary care physicians and as direct primary care providers to the most frail, chronically ill

Medicare beneficiaries. Trained geriatricians can be more effective primary care providers for frail older persons, who have complex chronic health care problems. For these patients, geriatricians are often able to manage their care in the least resource intensive settings, obviating the need for more costly hospitalizations and nursing home placements.

Geriatric psychiatrists are needed to identify and manage the complex interactions of psychiatric disorders, the aging process, medical illness, and disability, as well as the psychological, social, cultural, economic and environmental factors that are relevant to the proper assessment and treatment of elderly patients. Of the 32 million Americans age 65 and over, an estimated 4 million suffer from dementing disorders such as Alzheimer's disease and nearly 5 million suffer from serious and persistent symptoms of depression.

2. **Lack of training in schools for all professionals:** All health care professionals – doctors, nurses, and others – need adequate training in geriatrics. As the country ages, almost all health care professionals, except pediatricians, will be caring for growing numbers of older people.

However, medical schools and other professional schools have just recently begun to teach geriatrics, but current training is inadequate to prepare the country to care for the exploding numbers of older people. This lack of training has been

documented by many studies, including those done by the Institute of Medicine and HHS.

For example, in academic year 1994-1995, only 10 percent of all U.S. medical schools required their students to complete a separate required course in geriatrics. Most other schools either offered geriatrics as an elective or included it as a small segment of another required course. When offered as an elective, most students are not taking geriatric courses.

A recent General Accounting Office (GAO) report underscores this problem. A key area of geriatrics training is palliative and end-of-life care. This GAO found that training was inadequate, with only about one-half of medical schools and residency programs educating students about end-of-life care.

- 3. Lack of training for current practicing professionals:** The vast majority of current practicing physicians and other health care professionals have never had geriatrics training. Since there is a long pipeline before current students will be practicing, the country must train current practicing professionals in geriatrics to care for the growing numbers of older people.

Some examples of how illnesses of older people are misdiagnosed or dismissed as "normal" aging are:

- **Drug reactions:** Older patients can react differently to prescription drugs than younger people, and often take multiple drugs, ordered by multiple physicians, without any physician coordinating this use. A 1995 GAO study, commissioned by Senator Wyden, documented these problems and cited an FDA estimate that inappropriate drug use resulted in hospitalizations costing about \$20 billion annually.
- **Urinary incontinence:** Because it can trigger a series of other health care problems, incontinence is a leading cause of nursing home admissions in this country. However, this problem is usually treatable by exercises or medication. Unfortunately, this problem often goes undetected or is not treated properly.

Key Reason for Shortage of Geriatricians: 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.

A recent article in the American College of Physicians Observer illustrated that geriatrics is one of the only specialties where a physician will spend additional years in medical school, only to reduce his or her earnings potential.

The Medicare fee-for-service system acts as a serious disincentive for physicians to provide quality care for Medicare beneficiaries, especially those who are frail and chronically ill:

- The physician payment system does not provide coverage for coordination and management of care, except in very limited circumstances, and does not support an interdisciplinary team of health care professionals. While the Medicare physician payment system provides reimbursement for hundreds of costly procedures, this system fails to pay for the scope of assessment and case management services provided by geriatricians and an interdisciplinary team of professionals that enhance care to patients. **I maintain this is the real problem in recruiting physicians to geriatrics.** The reimbursement system makes it difficult to provide effective care and few health care professionals can find fulfillment in doing a lousy job.
- Another issue is that the Medicare physician reimbursement system 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. This is true not only for geriatricians, but for all primary care physicians who want to focus on caring for older Medicare beneficiaries.

In addition, we believe many more candidates would apply, despite the future financial implications, if they did not have such large, immediate loan payback obligations associated with financing their medical education.

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.

Current Initiatives of the American Geriatrics Society

The American Geriatrics Society (AGS) – the organization of over 6,000 geriatricians and other health care professionals specially trained in the management of care for older patients – has developed and implemented special programs to address the concerns of professionals and the public on aging issues. A key objective is to provide educational materials for current practicing health care professionals and students about the special health care needs of older patients. Some of these projects include:

- **AGS Clinical Practice Guideline: The Management of Chronic Pain in Older Persons** was just released this month. This new guideline seeks to dispel the myth that pain is a normal part of aging. Pain in older adults is underrecognized and

undertreated. It is estimated that one out of every four older adults suffers from chronic pain. These first-ever guidelines seek to educate health care professionals and the public on how to recognize, assess, and treat pain in older Americans.

- **The Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine** is the Society's ground-breaking continuing education program for primary care providers. This detailed self-assessment program on the medical care of older adults has helped to define the knowledge base of geriatrics.
- **The AGS' Complete Guide to Aging & Health** is the Society's reference guide for the public on aging and health.
- **Hartford Geriatrics Training Initiatives**, funded by the John A. Hartford Foundation, advocate improved geriatric care in all medical and surgical specialties, as well as to practicing primary care physicians. The Initiatives reach out and make the principles of geriatric medicine accessible across disciplines and throughout the training and continuing education continuum.
- **The National Blue Initiative for Quality Senior Care**, begun in 1997 is a partnership between the AGS and the Blue Cross Blue Shield Association to develop and conduct educational programs for primary care physicians participating in BCBSA member plans with the purpose of promoting high quality care for older

adults. Dr. Kanwal from Anthem Blue Cross and Blue Shield will be describing this program in more detail.

- **Geriatrics at Your Fingertips** is a new pocket-sized reference guide to clinical geriatrics which provides up-to-date, practical information on the evaluation and management of diseases and disorders that most commonly affect older persons.

Recommendations to Increase the numbers of geriatric trained health care professionals

Clearly, the need to train all health care professionals - students and current practicing professionals - about the special needs of older adults and the need to encourage increased numbers of geriatricians should be a major priority of the Federal Government.

Through Medicare and Medicaid, the Federal Government is financing the vast majority of health care services to older Americans. The lack of appropriately trained health care providers translates into costly and unnecessary Medicare and Medicaid spending and poor quality of life for older people.

We urge Congress to consider adopting the following recommendations:

1. **Revise the current Medicare physician payment system to promote care management services for chronically ill beneficiaries.** While enrollment in Medicare managed care plans is expected to increase significantly, many older Americans who are frail or chronically ill are likely to choose to remain in the traditional fee-for-service program for the foreseeable future.

Therefore, the traditional fee-for-service Medicare program must be revamped to provide incentives to better manage care for frail, chronically ill patients. These patients need coordination and management services and care by an interdisciplinary team. These services will not only improve the quality of care, but will reduce unnecessary Medicare spending on duplicative and potentially harmful services. Medicare payment policies should reimburse for coordination and management services and interdisciplinary teams, and make special payments for professionals who spend extra time with frail, older patients. Refining the fee schedule will also be key to attracting physicians and other professionals to a career in geriatrics.

2. **Institute loan repayments for fellows in geriatric medicine.** S. 780 introduced one year ago by Senators Reid, Grassley and Glenn would forgive \$20,000 of educational debt incurred by medical students for geriatric fellows. Physicians who

have an interest in pursuing geriatric fellowships are often discouraged because of their large educational debt.

3. **Increase Medicare graduate medical education (GME) payments for fellows in geriatric medicine.** S. 779 introduced one year ago by Senators Reid, Grassley and Glenn would provide increased GME payments to provide incentives to teaching institutions to promote the availability of fellowships and recruit geriatric fellows.
4. **Institute a new program for geriatric academicians:** S. 1754, the health professions reauthorization bill, approved by the Senate Labor and Human Resources Committee last month, would create a faculty development program for geriatrics health professionals. Specifically, it would provide salary support for junior faculty who will learn teaching methods and implement these in health professions schools. Senator Reed of this Committee, from my home state of Rhode Island, was instrumental in obtaining this provision.
5. **Provide adequate funding support for Title VII geriatric programs:** It is essential that adequate appropriations be provided for geriatric education centers, geriatric faculty training programs, and for primary care training programs which emphasize geriatric curriculum.

6. **Provide an exception to the overall graduate medical education cap for geriatricians:** The 1997 Balanced Budget Act instituted an overall cap on the number of graduate medical education slots that will be supported by the Medicare program. This provision should be amended to exclude geriatric fellows. In addition, the cap should be revised to include in the base those primary care residents who were training in outpatient and long term care settings when the base year was established.

7. **Provide payment for GME to non hospital providers:** The 1997 Balanced Budget Act authorized GME payments to non-hospital providers. HCFA has just issued a proposed rule to implement this provision that would not reimburse nursing homes, and hospice for training. It is critical that residents and fellows are trained in these settings in order to provide high quality care to Medicare beneficiaries.

8. **Institute incentives for medical schools, as well as all professional schools, to incorporate geriatrics into training programs:** All health care professional schools, at all levels, must immediately incorporate and highlight geriatrics, including palliative and end-of-life care issues, into their curriculum.

9. **Institute incentives for current practicing professionals to take geriatrics continuing medical education:** Medicare policies should be revised to provide incentives for all health care professionals to have some level of geriatric continuing medical education credits, including end-of-life care and palliative care training.

10. Conduct innovative demonstrations that promote high quality

Interdisciplinary care, such as MediCaring: HCFA should conduct new demonstration programs to promote better models of coordination for chronically ill patients. Improving quality of care and functional status should be a key element of these demonstrations. A high priority should be placed on conducting models that would improve end-of-life care, such as MediCaring. The goal of MediCaring would be to reduce unnecessary, high cost, acute care services at the end of life, thereby leaving more financial opportunity for coordination, continuity and comfort.

11. Assure new evaluation and management documentation guidelines are

workable for geriatricians: New Medicare documentation guidelines would place an extraordinary burden on geriatricians and have unintended consequences for frail, older persons with chronic illnesses. While these guidelines are now being revised, Congress should assure that any revisions reflect the types and complexity of services provided by geriatricians. Moreover, these guidelines should be pilot tested, prior to implementation, at a representative sample of geriatric practices.

We would like to work with this Committee, the Medicare Commission, and others to obtain these important changes. The challenge will be looking beyond the Medicare system to reform the way we approach medical care for older Americans in general. Failure to act in this area is likely to result in billions of Medicare and Medicaid dollars being spent for ineffective services, as well as, poorer quality.

Dr. TAKAMURA. Thank you, Dr. Murphy. I know that as I was listening to you, I really appreciated your mentioning the interdisciplinary nature of geriatric care, because truly we do have a full spectrum of professionals who are involved.

Let me just remind you at this time or perhaps inform you at this time that there will be cards made available to you, if they have not been already, that you can use to write any questions that you might have. We have staff who actually will be collecting these from you so that we can raise these and perhaps have our witnesses respond to your questions.

If any of you are lacking a question to ask, I would suggest that you ask Dr. Murphy for the other seven points that he was about to make before he had to end his testimony.

Our third witness on panel one is Dr. Susan Klein.

STATEMENT OF SUSAN KLEIN, HM, DNSC, RN, BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES AND SERVICES ADMINISTRATION, ROCKVILLE, MD

Dr. KLEIN. Thank you, Jeanette.

As Jeanette said, my name is Susan Klein, and I represent the Bureau of Health Professions of Health Resources and Services Administration, which later I will just say as "HRSA," an agency in the Department of Health and Human Services.

We, too, as with Dr. Murphy and Ms. Cosgrove, have heard the roar of 76 million baby boomers charging toward the new century and to advanced age. We began in 1994 what the editor of the American Society on Aging's newsletter called the Human Genome Project to address the coming labor shortages in health care. We call it the Geriatric Education Futures Project.

Today I will discuss the Futures Project, the challenges in geriatric education which it addresses, and the challenges of the future.

The impetus of the Futures Project came from precipitously changing demographics in this country. Seven national studies within a 5-year period highlighted four major problems. First, few clinicians have even minimal geriatric training, as Dr. Murphy has indicated. There is a severe shortage, second, in the number of health care faculty of any discipline capable of teaching geriatrics. Third, almost none of the efforts to address the problem have been interdisciplinary, and we know that the care especially of the old-old is by nature interdisciplinary. Finally, there was a noticeable lack of any agenda for action to respond to the geriatric educational needs of such a radically changing health care environment.

So the goal of the Futures Project was to promote and improve geriatric education in the health professions and thereby respond to a critical national health care need.

Under the creative leadership of Bernice Parlak, chief of the Geriatric Initiatives Branch, the Futures Project was created. The Futures Project is a three-phase evolving process which allows all the stakeholders in geriatric education to have a role in its implementation. This is not a book that gets dusty on the shelf. This is a living process.

The first phase of the project was the development of the document "A National Agenda for Geriatric Education: White Papers."

Sixty recognized leaders in geriatrics and related fields submitted 11 White Papers. These leaders held diverse and sometimes opposing positions. Their task was to come to consensus on the current state of geriatric education, the direction which the field should take, and the actions necessary to accomplish its goals.

Specific cross-cutting issues that are mentioned in the White Papers included managed care, long-term care, case management, interdisciplinary education, and ethnogeriatrics. There are six discipline-specific White Papers, which and you can refer to in the White Paper books that have been distributed.

The papers are action-oriented. This is unique. Each one presented a critical review of the state-of-the-art of geriatric education in its topic, described a vision to meet the projected need, and provided specific policy recommendations to achieve the preferred future. Most importantly, each recommendation listed required actions, assigned responsibility to various groups, and suggested measurable outcomes.

Phase two, the national forum on geriatric education and training, took place in the spring 1995. Over 100 geriatric experts, funding agents, providers, consumers, educators, and policymakers met to assess the outcome of programmatic approaches to date, examine funding strategies, and identify factors that affect the education and training of health care professionals in geriatrics and gerontology.

The results were very gratifying. First, over 3,000 copies of the "National Agenda of Geriatric Education: White Papers" have been distributed in the United States and in other countries. Several associations have officially adopted its recommendations as their goals.

Second, the HRSA-funded geriatric education centers have acknowledged the White Papers as the standard of geriatric education for health care professionals.

Third, grant-making foundations use these guidelines as a basis for awarding funds in the field of aging education and training.

Finally, and perhaps most importantly, this process developed a consensus among various geriatric organizations. You will note that Dr. Murphy's testimony today represents a unified body of opinions among the experts. I am proud to say that our efforts have contributed to this unity of opinion. Everyone is really now on the same team.

Phase three of the Geriatric Education Futures Project involves national innovative educational collaboratives. It continues catalytic activities directed toward the implementation of a national agenda for action in geriatric education. The initiatives mentioned in my written testimony are important because they represent joint efforts among disciplines, some of which have never collaborated in the past. Professions such as medicine, nursing, dentistry, public health, social work, allied and associated health professions have risen above the turf battles which so often limit progress. Funding sources from both public and private arenas have been used synergistically.

HRSA has been able to invest seed money in a very cost-effective manner because of this unity. We have brought these groups together to form partnerships which will continue in other areas.

We have begun to address some issues, but other challenges must be faced. I will mention only three.

First, cross-cultural competency in geriatric care must be incorporated into all levels of health care education. The aging population is becoming culturally much more diverse. As many as one in four older adults will be a member of a minority ethnic group by the year 2030. Cultural differences affect areas of health care for the elderly. The Ethnogeriatric Collaborative, a partnership of 41 Geriatric Education Centers nationwide, is accomplishing a great deal in this regard. However, much work in the area of ethnogeriatric curricula development remains to be done in the health professions schools.

Second, workforce needs must be quantified. The accompanying chart that is over to your right shows that 6.7 million health care professionals do not have geriatric education or training. These workers represent another "sleeping giant" that Senator Reid mentioned before of potential resources to attack the problems of our frail elders. The GECs have done a yeoman's job in reducing the number down from the 7 million in over the past 14 years. There remains a need for 15,000 faculty of all disciplines to be educated and trained; 3,750 minority faculty must receive education and training.

Unfortunately, these numbers are extrapolated from varied and inconsistent figures. There is no workforce data base that has adequate geriatric education information. Medicine and nursing are the only professions who have some reliable figures, and these are often limited and reliant on individual interests and available research funds. Further, over 200 allied and associated health professions have no geriatric education data available.

Dr. TAKAMURA. Dr. Klein, I am going to have to ask you to wind up your testimony.

Dr. KLEIN. OK. A workforce analysis of the need of the health professions faculty, clinicians, and researchers obviously is required to benchmark the actual need.

The shortage of health care professionals to care for older adults today and tomorrow is quite serious. The GECs and faculty fellowships that we have had a significant impact. They are indeed national leaders in geriatric education. Yet the projected need continues to outweigh the resources of these programs. The approach to geriatric competency among the health professionals of today and tomorrow is a larger issue than any one profession, association, State or national Government agency can resolve alone. We must work in collaboration and cooperation among all key stakeholders to attain the future that we would like.

There is so much more to say, but I will stop now.

[The prepared statement of Dr. Klein follows:]

**UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING
FORUM:**

**LIVING LONGER, GROWING STRONGER:
THE VITAL ROLE OF GERIATRIC MEDICINE**

May 20, 1998

Presentation by Susan M. Klein
Health Resources and Services Administration

Mr. Chairman and members of the Committee, my name is Susan Klein and I represent the Bureau of Health Professions at the Health Resources and Services Administration, an agency within the Department of Health and Human Services.

We, too, heard the roar of 76 million baby boomers charging toward the next century and advanced age. We began what the editor of the American Society on Aging's newsletter called the "Human Genome Project to lay the coming labor shortages in healthcare before the country, proffer recommendations on what needs to be done and take action to remedy the shortfalls." We call it the Geriatric Education Futures Project (GEFP). What I would like to discuss with you today are the GEFP, two significant challenges in geriatric education successfully being met and one sleeping giant that we must awake.

The impetus for the Futures Project came from precipitously changing demographics in the country. Seven national studies within a five year period highlighted 3 major problems:

- (1) few clinicians with even minimal geriatrics training,
- (2) a severe shortage in the numbers of health care faculty capable of teaching geriatrics, and most importantly,
- (3) the absence of an Agenda for Action to respond to the geriatric education requirements necessary in a radically changed health care environment.

So, the goal of the Geriatric Education Futures Project was to promote and improve geriatric education in the health professions and thereby respond to a national health care need.

Under the creative leadership of Ms. Bernice A. Parlak, Chief of the Geriatric Initiatives Branch, the Geriatric Education Futures Project began. The GEFP is a 3-phase on-going living event, not a series of reports that gathers dust. Nor is it a project that "the government" does. All stakeholders in geriatric education have a role to play in its implementation.

- The first phase of the Futures Project was development of the *A National Agenda for Geriatric Education: White Papers*. Sixty recognized leaders in geriatrics and related fields submitted eleven papers representing diverse and sometimes opposing positions. Their task was to come to consensus on where the field was in geriatric education, where it needed to be and what realistic actions could be taken to get there. Five cross-cutting topics germane to all health professionals and six discipline specific issues were the focus of the Papers:

- ▶ managed care,

- ▶ long term care,
- ▶ case management,
- ▶ interdisciplinary education, and
- ▶ ethnogeriatrics [the nexus of health, aging and ethnicity],

The White Papers are "action-oriented." Each one (1) presented a critical review of the state of the art of geriatric education in its topic area, (2) projected a future responsive to societal need [a vision to meet the projected need]; and (3) provided specific policy recommendations to achieve the preferred future. Each recommendation listed required actions, responsible agents (Such as. associations, agencies, and organizations) and *measurable*, expected outcomes.

- Phase two, the invitational National Forum on Geriatric Education and Training, was held in the Spring of 1995. Over 100 experts in geriatric education, funding agents, providers, consumers, health professions educators and policy makers came together to explore the parameters that define the needs in geriatric education. They assessed the outcomes of programmatic approaches to date, examined funding strategies and identified the factors that limit or enhance the education and training of health care professionals in geriatrics and gerontology. The results were gratifying:
 - ▶ Over 3,000 copies of the *National Agenda for Geriatric Education: White Papers* have been distributed in the U.S. and other countries. Several associations, including the American Public Health Association and the Association for Gerontology in Higher Education have officially adopted its recommendations as their organization's educational goals in geriatrics.
 - ▶ The 1997 publication supported by AARP Andrus Foundation and other foundations, *Aging Education and Training: Priorities for Grantmaking Foundations*, extensively quotes the *National Agenda* and its findings to grantmaking foundations to increase their commitment to aging education and training.
 - ▶ All HRSA funded Geriatric Education Centers [presently there are 30 of the 41 GECs nation-wide] have acknowledged that *White Papers* are the standard of geriatric education for health care professionals.
 - ▶ Perhaps, most important, the White Papers expressed a consensus among various geriatric organizations. You will note today that Dr. Murphy's testimony here represents a unified body of opinions among the experts. I am proud to say that our efforts have contributed to this unity of opinion.

- Phase three of the Geriatric Education Futures Initiative developed national innovative educational collaboratives and continues catalytic activities directed toward the implementation of a national agenda for action in geriatric education.
- ▶ One collaborative, in process, is a second generation initiative. It follows the HRSA, PEW and Institute of Health Care Improvement (IHI) project to develop a model Interdisciplinary Professional Education Collaborative.

This second generation collaborative is among three Divisions within the BHPr responsible from five different sections of the Public Health Service Act, and IHI. It's purpose is to find effective educational methods to prepare new health care professionals with quality improvement knowledge, skills, and competencies for integrated professional work aimed at meeting and improving individual and community health needs and making services more cost effective. A good example is the Oregon GEC which is improving the health and health care services to the population age 65+ by increasing the number of immunizations for influenza and pneumonia. According to local statistics, there is a 19% rate of immunization rate for influenza. Death rate for community pneumonia is high; one estimate is 14%. Students are involved in the design and conduct of the intervention, so that they can learn Quality Improvement techniques and learn about preventive care of the elderly. This project is expected to significantly impact public health. This and one other GEC, are participants in the Community-based Quality Improvement Education Program for the Health Professions sponsored by the Bureau of Health Professions (BHPr) and the Institute for Healthcare Improvement.

Other examples of collaboratives include:

Iowa GEC Consortium

A state wide consortium to enhance interdisciplinary geriatric education and explore collaborative opportunities such as conferences, curriculum development, and grant initiatives was developed utilizing the White Papers. This consortium successfully submitted an application for GEC funding.

Best Practices Sourcebook

An interdisciplinary collaborative effort:

- University of Maryland School of Social Work
- Association for Gerontology Education in Social Work
- National Association of Social Work
- Council on Social Work Education
- California GEC
- National Coalition on Mental Health and Aging

- West Los Angeles Veterans Affairs Medical Center, Geriatric Research, Education and Clinical Center
- Western Maryland Area Health Education Center
- Bureau of Health Professions, HRSA

The collaborative will compile, review, synthesize, write and disseminate a Sourcebook of best practices of models and strategies for gerontological interdisciplinary teams with guidelines for incorporation into professional education programs. The Sourcebook's contents will include best practice models, strategies, outcomes of four focus groups, literature and Internet searches, and letters to key personnel conducting federally funded geriatric team training programs.

Interdisciplinary Training Programs for Professionals Caring for People with Disabilities

Partners include:

- Office of Disability, Aging, and Long-Term Care Policy, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services
- George Washington University Health Policy Center

This is an exploratory study to review the literature on interdisciplinary training and a description of several training programs which are focusing on the elderly and is in response to the Interdisciplinary Education White Paper.

Planning Grant on Interdisciplinary Geriatric Team Training

Partners include:

- University of Colorado Schools of Dentistry, Medicine, Nursing
- UCHSC Center on Aging
- Aura Regional Medical Clinic
- University of Denver School of Social Work
- Total Long Term Care
- Senior Life
- Colorado Access

This planning grant is the implementation of the Interdisciplinary White Paper recommendations. The grant was one of only three Hartford Foundation grants awarded. Numerous GECs have used the White Papers as the basis for GITT applications.

Development of Joint DDS/MSG Program

Partners include:

- School of Dentistry, University of Southern California
- School of Gerontology, University of Southern California

These two schools have joined together in developing a degree program which will result in the awarding of joint doctorate of dentistry and masters in gerontology degrees. This is believed to be the first joint DDS/MSG degree program in the U.S.

National Agenda on Geriatric Education: Interdisciplinary Education,

□ Half-day Institute. 23rd Annual Meeting, Association for Gerontology in Higher Education, Boston, MA - February 20, 1997.

□ Monograph: *A National Agenda for Geriatric Education: Interdisciplinary Education White Paper - The AGHE Institute Response and Strategies*

A GEFP collaborative sponsored by the AGHE Education Committee, the Bureau of Health Professions, HRSA and the Oklahoma GEC. One of the largest attendance pre-workshop institutes held by AGHE.

Why are these collaborative efforts so important? Because they represent joint efforts among disciplines which have never worked together in the past. These participants have risen above the petty turf battles which so often stymie collaborative approaches among the various health professions. HRSA has been able to use relatively low levels of funding in an incredibly cost-effective manner because of this unity. We have been able to bring these groups together to form partnerships which will grow and bear fruit in the future with minimal levels of funding.

Challenges and Giants

The two challenges being addressed and the sleeping giant that must be awakened are:

1. The aging population is becoming culturally more diverse. As many as one in four older adults will be a member of a minority ethnic group by the year 2030. "Both between and within each of the major ethnic categories, including those classified as white, vast differences are found in factors which affect the health and health care of older adults. Differences include patterns of health beliefs and health care utilization, health risks, patterns of interdependence with family members, ethical decision making priorities, and in some cases, response to treatment (Ethnogeriatrics White Paper)." Cross-cultural competency in geriatric care must be incorporated into all levels of health care education. The nexus of the fields of aging, health and ethnicity is known as ethnogeriatrics. Ethnogeriatrics has emerged from the GECs as a most significant contribution to the field of geriatrics.

The Ethnogeriatric Collaborative is a collaborative of 41 Geriatric Education Centers whose goals are to develop a Core Model Curriculum in Ethnogeriatrics for Geriatric Education Centers and a data base of GEC produced and other ethnogeriatric curriculum. Already the Stanford GEC has a resource base of over 3,000 resources for training in ethnogeriatrics. It is anticipated that following the completion of these goals the core curriculum will be applied to specific ethnic subgroups.

2. Geriatric health care of the old-old is by nature interdisciplinary. Multiple chronic health problems, interacting with social, emotional and environmental concerns complicate acute, episodic health problems so that only an interdisciplinary team can adequately address the complex nature of the problems. Interdisciplinary geriatric education and training must be required for health care professionals. The IHI collaborative mentioned above and the activities of the GECs are prime examples of such training.

The Sleeping Giant

The accompanying chart shows that 6.7 million health care professionals do not have geriatric education or training and the proposed targets for education and training for GECs next year. The GECs have done a yeoman's job in reducing the number down from over 7 million in the past 14 years. The GECs are recognized as the national resource for geriatric education in the country. However, the rapidly growing numbers of older adults precipitate the need for these 6.7 million. This number includes 15,000 faculty of all disciplines, 3,750 of which are minority faculty, to receive sufficient education and training to incorporate geriatrics into the curriculum of health professions schools.

The "unmet need" numbers are extrapolated from varied and inconsistent figures. The sleeping giant is the actual number of clinicians, faculty and minority faculty who do not have geriatric education or training. There is no workforce data base that has adequate geriatric education information. Medicine and nursing are the only professions that have some reliable figures. These datum are limited and reliant on individual interest and available research funds. This means that over 200 allied and associated health professions have no data available.

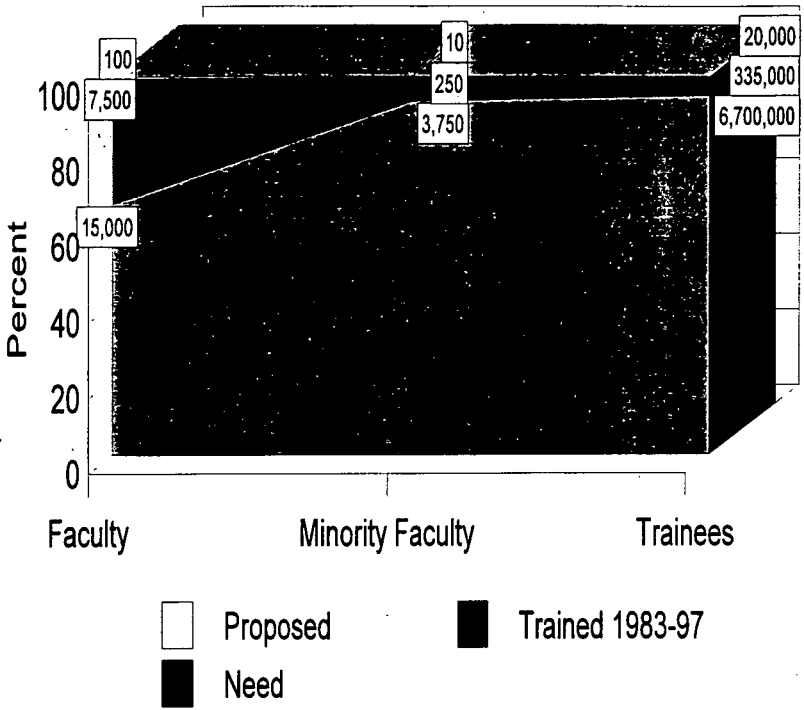
A workforce analysis of the need for geriatric education for health professions faculty, clinicians and researchers is required to benchmark the actual need. The demographic imperative of a rapidly aging population, the attendance at GEC educational activities, the opinion of leading experts in the field and the growing anecdotal data of iatrogenic health problems due to health care providers' lack of geriatric expertise are indeed strong evidence for the need. However, in an era rightfully demanding accountability, benchmarks and performance outcome measures, the lack of hard data is disturbing. There is an urgent need to wake this giant of health care professionals to the important and unique characteristics of geriatric care and to be able to determine the size of this giant so that as a nation we are prepared to provide it with adequate education and training.

Summary

The shortage of health care professionals to care for the older adults of today and tomorrow is quite serious. The Geriatric Education Centers and Faculty Fellowships in Geriatric Medicine, Psychiatry and Dentistry have had a significant impact upon the need. They are indeed, national leaders in geriatric education. Yet, the projected need continues to outweigh the resources of these programs. The approach to geriatric competency among the health professionals of today and tomorrow is a larger issue than any one profession, association, state, or national

government agency can resolve. Only through collaboration and cooperation among all key stakeholders can we hope to attain a future of caring, cost effective, efficient health care of older adults that will allow them to " live longer and grow stronger." *A National Agenda for Geriatric Education* has been that vehicle. The seeds of cooperation have been planted and are beginning to blossom. Their fruit will nourish the awakened giant and equip it to deal with the dragons of disease, dementia and death.

GERIATRIC EDUCATION CENTERS - UNMET NEED



Dr. TAKAMURA. Thank you very much. I think this topic certainly does lend itself to much more discussion, but in order to remain within the constraints of our time limit, what I am going to do is to turn immediately to panel two, introduce them to you, ask you to go ahead and write your questions down. We will in that process be collecting them from you, and following the testimonies of all of the panel two witnesses, what we will do is then open this up to a question-and-answer period.

Very quickly, then, in panel two is Dr. Steven Phillips, who has worked throughout the entire continuum of care for older Americans. He has held appointments within the fields of academic and clinical geriatrics, including positions with the Veterans Home of California and the Martinez VA Medical Center at the University of California-Davis. Dr. Phillips has most recently been involved with the development of fully integrated delivery models of care intended to make the transition from Medicare fee-for-service to managed care. He is currently the medical director for Senior Dimensions Extended Care, which is a Medicare Social HMO.

Dr. Neeraj Kanwal is currently the medical director of Government Programs for Anthem Blue Cross/Blue Shield in Ohio, Kentucky, and Indiana. Among the programs with which he is involved is Anthem's Senior Advantage, a Medicare HMO which has 61,000 members. In the past, Dr. Kanwal has also served as a group practice administrator, HMO medical director, and hospital executive. His university affiliations include George Washington University and Jefferson Medical College.

Our third witness is Mr. Steve Anderson, who joins us as the executive director-elect of the Donald W. Reynolds Foundation, a philanthropic entity which makes capital grants to the States of Arkansas, Oklahoma, and Nevada. Mr. Anderson works to award the foundation's \$1.3 billion to entities working in areas such as aging and cardiovascular research. In 1995, Mr. Anderson was named the chairman of the foundation's Committee on Aging and Quality of Life. Under his leadership, the committee was responsible for developing the program that resulted in a \$28.5 million grant to establish the Donald W. Reynolds Department of Geriatrics at the University of Arkansas for Medical Sciences.

Our final witness is William L. Minnix, who is associated, and has been, with Wesley Woods for 25 years. Dr. Larry Minnix now serves as the president and CEO of this comprehensive long-term care housing, outpatient, and acute-care program for the elders of Georgia. Dr. Minnix has been involved with the training of professionals in geriatrics through his affiliation with Wesley Woods and Emory University. Active in long-term care issues at both the State level and nationally, he currently serves on the board of directors of the National Chronic Care Consortium, the American Association of Homes and Services for the Aging, and is also a member of the State of Georgia's Long-Term Care Commission.

With that, I would like to welcome Dr. Phillips and invite him to present his testimony.

**STATEMENT OF STEVEN L. PHILLIPS, M.D., C.M.D., SENIOR
DIMENSIONS, RENO, NV**

Dr. PHILLIPS. Thank you, Dr. Takamura.

As a geriatrician who is actively involved in both the clinical and administrative roles of health care for older Americans, I am truly honored to have this opportunity to address what I see as the geriatric imperative.

America is in the midst of an unprecedented demographic shift due to people living longer and the promotion of baby boomers into their seventh and eighth decades of life. We have yet to realize the consequences of this transition within our society and the overall implications for various social institutions, families, and individuals.

The field of geriatrics focuses on the whole person by dealing with multiple, complex, and interrelated conditions that can ultimately result in functional decline and, therefore, the loss of independence. The World Health Organization stated over three decades ago that "Health in the elderly is best measured in terms of function" and that "the degree of fitness rather than the extent of pathology or disease may be used as a measure of the amount of services the aged will require from the community." In other words, the cost of health care for an aging society can be viewed as being inversely proportional to functional status.

The current health care delivery model of organ-specific disease management does not begin to address the basic issues of functionality. How we as a Nation care for this population is dependent upon the efforts of medical and other professional schools, academic training programs, national geriatric and gerontologic organizations, and health care delivery organizations.

I will address the area of managed care and older Americans. As of May 1997, a total of 4.6 million persons were enrolled in risk contracts, which represented an increase of 1 million in a single year. In April 1993, there were 118 health plans with Medicare risk contracts. In May 1997, there were a total of 280. Medicare risk contracting allows for the creation of a global budget for Medicare services and contrasts the payment for individual services under traditional fee-for-service Medicare.

In 1992, a report identified six objectives of successful geriatric program: (1) identifying high-risk patients; (2) assessing multi-problem patients; (3) treating multi-problem patients; (4) rehabilitating patients following acute events; (5) reducing medication problems; and, (6) providing long-term care and home care.

Unfortunately, throughout these HMOs, not every center, every site of an HMO had these services. The reason, these authors felt, was due to the fact that there are few trained practitioners in the field of geriatrics, and they felt that it was necessary to design demonstration programs that would evaluate the benefits and costs of more integrated geriatric services and then refine these programs based on evaluation findings.

I am happy to say that just such a demonstration is occurring presently in the State of Nevada, Senator Harry Reid's State, through the Health Plan of Nevada Senior Dimensions Medicare risk HMO. The SHMO-II, as it is known, Social Health Maintenance Organization, is a designated Health Care Financing Admin-

istration demonstration project that is funded through a risk-adjusted payment mechanism. The intent of SHMO-II is to address medical, psychological, functional, and social needs of seniors in a coordinated manner. There are three key components of the Social HMO II model:

Care coordination—screening for risk, assessment of those identified to be at risk, and developing a comprehensive plan of care in an interdisciplinary team model.

Second, extended care benefits. These benefits include counseling for situational disorders, nutritional services, transportation, personal care, emergency response systems. They are made available through care coordination. They are not an entitlement; rather, they are determined by established criteria and are intended to augment community services that already exist.

Third, geriatric resource team. We call it our GRT. It provides intervention recommendations and assists the primary care providers with reassessment and evaluation as needed. It serves as the ultimate educational piece for the HMO.

SHMO-II demonstration is supporting the development of an integrated delivery system that is based upon enhancing the role of primary care physicians, and until recently, there has been little motivation for HMOs to change their delivery model in order to more appropriately meet the needs of an older and more functionally impaired patient population. Critical factors include the willingness of an HMO to change, primary care physicians committed to a better way of caring for their elderly patients, and a core group of geriatricians to develop and assist in the implementation of change.

I thank you.

[The prepared statement of Dr. PHILLIPS. follows:]

"LIVING LONGER, LIVING STRONGER...."

Testimony before the
Senate Special Committee on Aging

Official Forum

May 20, 1998

Washington, D.C.

Presented by

Steven L. Phillips, MD, CMD

Vice President of Integrated Services

Gerimed of America, Inc.

Senator Reid and other members of this senate forum, I am Steven L. Phillips, Medical Director of Senior Dimensions Medicare-risk HMO out of Las Vegas, Nevada which is a HCFA designated Social Health Maintenance Organization II (SHMOII). As a geriatrician who is actively involved in both the clinical and administrative roles of health care for older Americans I am truly honored to have this opportunity to address the Geriatric Imperative.

The American population is aging and with this comes new challenges regarding the nations ability to appropriately care for its elderly. At the beginning of the 20th century those over 65 accounted for 4% of the total population. They now account for 12% and are consuming 33% of all health-care dollars and by 2030 will represent 20% of all Americans and require nearly half of all health-care dollars. Needless to say America is in the midst of an unprecedented demographic shift due to people living longer and the promotion of Baby Boomers into their seventh and eighth decades of life. We have yet to realize the consequences of this transition within our society and the overall implications for various social institutions, families and individuals. From a healthcare perspective the prevention of disease and loss of ability to function in daily activities and provision of treatments to reduce the effects of disease upon medical, psychological, functional and social domains represents the Geriatric Imperative of the 21st century. Physicians and other healthcare professionals who understand the medical, psychological, functional and social aspects of aging will be better prepared to meet the current and future challenges facing our nation. The potential for harm and incurring unnecessary expense to an already strained health-care system is what can occur when a diagnosis is missed or unnecessary treatment or intervention rendered. The field of Geriatrics focuses on the whole person by dealing with multiple, complex and interrelated conditions that can ultimately result in functional decline and therefore the loss of independence. The World Health Organization stated over three decades ago that "Health in the elderly is best measured in terms of function" and that "the degree of fitness rather than the extent of pathology may be used as a measure of the amount of services the aged will require from the community." In other words the cost

of health-care for an aging society can be viewed as being inversely proportional to functional status. The current health-care delivery model of organ-specific disease management does not begin to address the basic issues of functionality. Physicians and other health-care professionals must shift their focus towards the identification and restoration of function. How we as a nation care for this population is dependent upon the efforts of medical and other professional schools, academic training programs, national geriatric and gerontologic organizations, and health-care delivery organizations.

The role of medical and other professional schools is to increase the number of teachers in order to provide meaningful educational curriculum to their respective students and graduates for both primary-care and specialty practices. Reuben et al determined through a survey process that the current deficit of geriatrics faculty members was severe and would likely get worse unless substantial increases in geriatrics fellowship positions and mid-career training positions occurred. These deficits existed in medical and non-medical faculty positions across the board. The same scenario exists with physician equivalents and geriatricians required to provide for the growing elderly population between 2000 and 2030. Without adequate numbers of medical and non-medical faculty with expertise in the field of geriatrics the likelihood of meeting the projected manpower needs within clinical geriatrics is poor. The proceedings of a conference on geriatrics curriculum development was published in 1994 in the American Journal of Medicine and identifies the core elements required at the undergraduate, graduate and post-graduate levels. The problems that exist now and into the future have been recognized with regards to the shortage of a geriatric workforce. The limiting factor is an adequate funding source to bring about the expansion of current programs and the reformation of the curriculum being taught at the undergraduate, graduate and post-graduate levels of most institutions for higher learning.

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

Another party actively involved in the Geriatric Imperative are the managed care organizations. With an increasing number of elderly joining Medicare-risk health

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

Care Coordination is based upon the elements of:

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations for Geriatric Policy:

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

Dr. TAKAMURA. Thank you very much, Dr. Phillips I appreciate your observing the time limitations that we have.

I would like to now invite Dr. Kanwal to present his testimony.

STATEMENT OF NEERAJ KANWAL, M.D., EXECUTIVE MEDICAL DIRECTOR, GOVERNMENT PROGRAMS, ANTHEM BLUE CROSS AND BLUE SHIELD, MASON, OH

Dr. KANWAL. Thank you. Good morning. I am Dr. Neeraj Kanwal. I am medical director for Anthem Blue Cross and Blue Shield. I am speaking on behalf of the Blue Cross/Blue Shield Association to tell you about the National Blue Initiative for Quality Senior Care.

The project is an alliance between the Blue Cross/Blue Shield Association, various member plans of the association, and the American Geriatrics Society. In my role in being responsible for delivering high-quality care for our members, we established this group to really make a difference in helping physicians do a better job of taking care of the elderly.

As you heard this morning, the new few years will be critical in preparing for the rapid demographic shifts in our country.

In many respects, we are not prepared for this. I think the term of the day is "the slumbering giant." Just as the Medicare population increases, our availability of practitioners will be dropping. Moreover, in our networks of care, the physicians who are taking care of our members are primarily experienced in taking care of younger patients, the working population in our commercial HMOs and networks. Most of our primary care physicians are not geriatricians, and, in fact, many of them who are geriatricians don't tell us about it.

In order to improve the quality of the care of the people that we serve and to integrate the services, we felt that some further interventions were necessary, and we believe that health care providers must be more attentive to these needs. We are trying to meet the essence of geriatric medicine. This is the reason why Anthem Blue Cross and Blue Shield joined with the Blue Cross and Blue Shield Association and the American Geriatrics Society to really to make an intervention to make a difference. This initiative known as the National Blue Initiative for Quality Senior Care—and I have brought a demo—provides primary care physicians with expertise and the latest clinical knowledge on geriatrics. The program represents an alliance which is unprecedented, but also a way to reach the broadest networks of physicians in Blue Cross plans across the country to work with the leading organization of geriatric medicine. More than 30 Blue Cross and Blue Shield plans are using this program to enhance their relationships with their providers and to improve the care that is being given.

As the older population grows, it is essential that primary care physicians have the resources they need to better understand the complex, multifaceted health issues of older adults. Our goal is to help these physicians implement this expertise and make it practical for day-to-day use.

The initial project was a textbook, "Modules in Clinical Geriatrics," which summarizes key components of clinical geriatrics into

six modules of study. The modules are available to physicians in our Blue networks.

The key aspect of the modules is its emphasis on wellness, prevention, and an integrated approach to providing health care for seniors. The curriculum covers general principles of aging and approaches to older patients, geriatric psychiatry, and geriatric syndromes such as malnutrition, dementia, falls, pain management, and other conditions.

Anthem Blue Cross and Blue Shield is distributing these modules to approximately 1,000 physicians with significant senior patient populations. Anthem's local health care managers personally deliver these to physicians' offices in Ohio, Indiana, Kentucky, and Connecticut.

The program provides physicians practical resources and tools they can use daily in their offices, including charting aids, clinical guidelines, and pocket reminders. Upon completion of the self-study portion of the book, physicians can earn continuing medical education granted by the American Geriatrics Society.

I would like to emphasize that the program is not just a study book. It includes practical materials that physicians can review with their office staff on being more sensitive to seniors, and there are work sheets that can be photocopied and used for all of their patients, including documentation for when patients enter nursing homes.

The initiative answers several needs that we have at Anthem and that we are hearing from our physicians. Physicians have requested information and assistance. We think the National Blue Initiative will help our physicians stay abreast of emerging issues, and we are receiving positive feedback for this program.

Let me just read a very brief quote from a physician. "When I first started in practice, I had very few older patients. But with the development of Medicare HMOs, I have seen a tremendous influx; now I average two to three new senior patients per week. Studying the first module really changed my perspective. It is a whole new world when an 85-year-old comes into your office for the first time. But now I feel more comfortable treating those patients, and I have the reference material to look back on."

The National Blue Initiative represents just one example of how Blue Cross and Blue Shield plans and the American Geriatrics Society work to improve the care of our members.

In summary, this new program demonstrates that we can work together, collaborate, and try to increase the effectiveness of primary care physicians throughout our networks of care.

[The prepared statement of Dr. Kanwal follows:]

**Statement of the Blue Cross and Blue Shield Association
on the Vital Role of Geriatric Medicine
Presented by
Neeraj Kanwal, MD, MHSA
Executive Medical Director, Senior Markets
Anthem Blue Cross and Blue Shield**

Good morning. I am Neeraj Kanwal, MD, MHSA, Executive Medical Director of Anthem Blue Cross and Blue Shield Senior Markets. I am pleased to be here today to represent the Blue Cross and Blue Shield Association to discuss the National Blue Initiative for Quality Senior Care.

The Blue Cross and Blue Shield Association is a federation of 55 independent, community-based Blue Cross and Blue Shield Plans. Blue Plans offer older Americans a complete selection of Medicare coverage options, from traditional "Medigap" supplement policies to Medicare Select PPOs to Medicare HMOs. Collectively, Blue Plans provide Medicare HMO coverage to more than three-quarters of a million Medicare beneficiaries, making the Blue System the second largest Medicare HMO provider in the country.

Anthem Blue Cross and Blue Shield provides group and individual health care benefit plans to over 4 million people in Ohio, Kentucky, Indiana and Connecticut. Anthem provides Medicare HMO coverage to 61 thousand Medicare beneficiaries in these four states.

Why Geriatric Training is Needed

As you have heard this morning, the next few years will be critical in preparing for the rapid demographic shift in the U.S. population. By the year 2030, one in five Americans will be age 65 or older. These older Americans will live longer and, in many cases, healthier lives than their parents or grandparents.

But, in respects, the U.S. health care system is not prepared to care for this growing population of seniors. Ironically, the number of geriatricians specially trained in understanding seniors' unique health care needs is expected to decline just as the Medicare population grows, since many current practitioners will retire during the next few years. Moreover, most practicing physicians who see older people today have had little or no training in geriatric medicine. Most of our primary care physicians are not geriatricians, and, in fact, have younger patients. A key reason for this is that the elderly have not familiarized themselves with primary care physicians, as much as they have with specialists.

In the traditional Medicare fee-for-service program, older patients are often referred from one specialist to another, with no one coordinating the different services and prescription drug regimens. The Medicare physician fee schedule provides payments for hundreds of separate procedures, but generally does not pay for care management and health education services. As a result, patients are often hospitalized even when it would be more appropriate if the treatment took place at home or in a nursing home.

We are working to improve the quality, integration and effectiveness of the various health care services actually delivered to Medicare HMO beneficiaries. We believe the scope of health services delivered to older persons should be expanded -- to focus not only on the effective treatment of chronic disease, but also on the unique aspects of wellness and risk screening for

older adults. Additionally, we believe health care providers must concentrate increased attention on helping older people maintain their ability to function in activities of daily living for as long as possible. This is the essence of geriatric medicine.

The National Blue Initiative for Quality Senior Care

This is why Anthem Blue Cross and Blue Shield joined the Blue Cross and Blue Shield Association and the American Geriatrics Society (AGS) late last year to help improve health care for older patients. This unique initiative - known as the National Blue Initiative for Quality Senior Care -- provides primary care physicians with expertise and the latest clinical knowledge in geriatric medicine. This program represents an unprecedented alliance between the nation's largest health insurer and the leading society of physicians specializing in the care of older adults. More than 30 Blue Cross and Blue Shield Plans across the country are now using this program to improve care delivery and enhance their relationships with participating physicians.

As the older population grows, it is essential that primary care physicians have the resources they need to better understand the complex, multifaceted health issues older adults. Our goal is to help primary care physicians implement this expertise in their day-to-day practices so they can improve the quality of care they provide to older adults.

Through the National Blue Initiative for Quality Senior Care, BCBSA and AGS have produced a textbook of "Modules in Clinical Geriatrics". This self-study curriculum summarizes the key components of clinical geriatrics into six modules of study for primary care physicians. The modules are available to physicians in Blue networks across the country.

The key aspect of the "Modules in Clinical Geriatrics" curriculum is that it emphasizes wellness, prevention and an integrated approach to providing care to seniors. It is medically unsound to treat older persons simply by caring for one disease or health issue at a time. We are working to focus on coordinating and managing a broad spectrum of care that includes wellness and prevention programs, special interventions for high-risk patients, and interdisciplinary teams of health care providers.

In six modules, the curriculum covers topics including the general principles of aging and approaches to older patients; geriatric psychiatry; and geriatric syndromes such as malnutrition, dementia, falls, pain management, sleep disorders, osteoporosis, urinary incontinence, and delirium.

Anthem Blue Cross and Blue Shield is now distributing the modules to approximately 1,000 primary care physicians with significant senior patient populations. Anthem's local health care managers are personally delivering the educational materials to physicians in our Medicare HMO service areas in Ohio, Indiana, Kentucky and Connecticut.

The program provides physicians practical resources and tools that they can use daily in their offices. These tools include workbooks, charting aids, clinical guidelines and pocket reminder guides. Upon completion of the self-study curriculum, physicians earn continuing medical education (CME) credits.

I like to emphasize that the program is not just a study book. It includes practical materials that physicians can review with their office staff on being sensitive to seniors. There are worksheets that can be photocopied for medical records on doing functional assessments, or intake documentation

for a nursing home. In addition, the program includes a quality improvement tool to help doctors evaluate how well they are taking care of older people and where they could improve. Pocket guides are also offered on commonly requested materials. The program is valuable because it is a way to say to physicians, learn and use these practical tools to make your practice more effective.

This initiative answers several needs that we at Anthem have been hearing from our physician community. Physicians in our network have requested information and education on caring for older adults. Moreover, this initiative demonstrates to participating physicians that we are committed to becoming their partners to improve the care -- and the doctor/patient relationship -- that members experience.

The National Blue Initiative will help our physicians stay abreast of emerging issues in elder care. For example, physicians treating healthy older people sometimes fail to remember that they need a different spectrum of immunizations, tests and screening than their younger counterparts. To make our participating physicians more aware of the unique health care needs of our elderly members, we will provide them with tables summarizing the important vaccinations and other preventive services that people over age 65 should receive.

This educational program also helps physicians make better decisions about when and where to treat older people's health problems. For instance, at least 50 percent of people age 65 and over will undergo surgery during their remaining years. However, many physicians are reluctant to pursue surgical treatment for elderly patients solely because of their advanced age. As a result, some beneficial surgeries are not being performed. In addition, the unnecessary denial of routine surgery can lead to a need for high risk emergency procedures later on. To prevent these complications, our education program offers physicians information on how to better assess surgical risks and when to pursue surgical treatment.

While this educational program is a new initiative, we are already receiving positive feedback from our participating physicians. The physicians find the prevention, geriatric assessment and behavioral symptoms sections to be very helpful in the diagnosis and management of geriatric conditions. Some of our physicians have already reported that they have made changes in their practice as a direct result of the information we and the AGS have provided.

Let me read you an excerpt from a letter from one of our participating physicians: "When I first started in practice, I had very few older patients. But with the development of Medicare HMOs, I've seen a tremendous influx; now I average two to three new senior patients per week. Studying the first module really changed my perspective. It's a whole new world when an 85-year-old comes into your office for the first time. But now I feel more comfortable treating those patients, and I have the reference material to look back on."

The National Blue Initiative for Quality Senior Care represents just one example of how Blue Cross and Blue Shield plans continually work to improve the care of our members. By supporting our participating physicians with tools and information about geriatric medicine, we can help them improve the care they provide to Medicare beneficiaries. Evaluating the impact this program has on physician practice patterns and patient outcomes will allow us to refine our systems of care -- so we can continue to meet our members' individual health needs.

This exciting new program demonstrates that managed care plans, when organized appropriately, have enormous potential to create innovative solutions that work to improve health care quality for older Americans.

Dr. TAKAMURA. Thank you very much, Dr. Kanwal.

Let me also remind all of you who are here today that we will be, in fact, entertaining your questions and that cards have been circulated. If you have a card with a question on it, if you just hold it up, we will be sure to have some staff come by and pick them up.

Let me now introduce and welcome Mr. Anderson.

**STATEMENT OF STEVE L. ANDERSON, EXECUTIVE DIRECTOR,
DONALD W. REYNOLDS FOUNDATION, FORT SMITH, AR**

Mr. ANDERSON. Thank you, Dr. Takamura. I would like to begin my comments by giving you a brief explanation of what the Donald W. Reynolds Foundation is. First of all, we are not tobacco, and we are not aluminum. [Laughter.]

Donald W. Reynolds was an entrepreneur, son of a door-to-door salesman, and truly a pioneer in the American communications industry. His career began at the age of 10 when he sold newspapers on the street in Oklahoma City. He pocketed a half-cent for each newspaper he sold. By the age of 21, he had used his life savings to purchase his first newspaper.

The Donald W. Reynolds Foundation was created in 1954 by Mr. Reynolds. After his death in 1993, the foundation received from his estate a substantial bequest, which positions the foundation as one of the 30 largest independent foundations in the Nation. The trustees organized the structure of the foundation to have a 50-year limited life to ensure that the foundation resources would be used in accordance with Mr. Reynolds' intentions.

At a planning retreat in 1995, the trustees invited representatives from other philanthropies, business, health care, and education to discuss opportunities for potential new giving programs. The trustees unanimously adopted one new area of focus: aging and quality of life of the elderly.

A trustee committee was established for this new initiative. I chaired the Committee on Aging and Quality of Life. Our first task was to retain Dr. Robert Butler, the president and CEO of the International Longevity Center and professor of geriatrics at Mount Sinai Medical Center in New York, to assist us in developing our plans. Dr. Butler identified many funding possibilities; however, for many of the same reasons that you have heard this morning, we felt the most pressing need seemed to be the problem of too few health care providers that were trained in the special needs of the elderly. Our trustees determined that geriatric education was an appropriate niche for the Donald W. Reynolds Foundation to fill.

Our committee developed a list of broad-based goals and objectives in establishing the geriatric education initiative. The goals included the following: (1) increasing the number of physicians trained and certified in geriatrics; (2) providing an increased number of fellowship positions in geriatrics to help develop a critical mass of geriatricians to meet the educational mandate; (3) assuring that every medical student and primary care physician has training in geriatrics and is well schooled in the unique problems of older persons; and, finally, providing opportunities for practicing primary care physicians to retrain in the field of geriatrics.

With the help of Dr. Butler and based upon the model he had developed in establishing the first and only department of geriatrics in the United States at Mount Sinai Medical Center, we developed a request for proposal to establish a new department of geriatrics. Because of a limited staff and logistical constraints, we began our search with medical schools in the States of Arkansas, Oklahoma, and Nevada where we were already making capital grants. By invitation, we asked the three medical schools to submit proposals. As a result of the proposals that were submitted and site interviews at each school, we selected the University of Arkansas for Medical Sciences as the first site for a Donald W. Reynolds Department of Geriatrics.

Initially, the grant to UAMS provided 15 million to construct a facility that would provide clinical, research, educational, and office space for the Department of Geriatrics and the Center on Aging. In addition, a grant of 10.5 million was provided over a 5-year period to fund the program development of the Department of Geriatrics. This past year, the construction portion of the grant was increased to 18.5 million.

Concurrent with the grant to UAMS, the foundation announced a \$250,000 grant to help establish a chair in geriatrics at the University of Oklahoma. That grant was matched by their State legislature, and this year, the University of Oklahoma has announced the establishment of the third Department of Geriatrics in the United States. Later this month, we are going to begin dialog with the University of Oklahoma that could lead to a major funding commitment by the foundation to help develop their program.

To date, the Donald W. Reynolds Department of Geriatrics has met or exceeded all the milestones presented in its original proposal. I have provided handouts that describe the goals and objectives and list the milestones for the first 5 years of development. The major emphasis during this present year has been the preparation for the mandatory 4-week junior clerkship in geriatrics that will become a curriculum requirement in July.

Identifying prospective faculty members and obtaining commitments to join the staff has been a monumental undertaking but is apparently progressing on schedule. Student interest in the program has been overwhelming.

To date, we believe that the Donald W. Reynolds Department of Geriatrics has been an overwhelming success, and it has met all of our expectations.

Under the leadership of Dr. David Lipschitz, we believe that the Donald W. Reynolds Department of Geriatrics at the University of Arkansas for Medical Sciences could become a model for the development of other similar programs across the country. The institution is perfectly positioned as the only medical school in a State that ranks fourth in the percentage of its population that is over the age of 65. Because of clustering of older persons, numerous communities in the State of Arkansas already mimic the way the United States will be in the year 2020. In these communities, the percentage of the population over the age of 65 already approaches 20 percent.

When care is delivered, it is costly and acute care crisis type care. It follows that Arkansas offers a unique opportunity to design

and test models of health care delivery that can prepare the Nation for the dramatic increase in our older population that will occur early in the next century.

I appreciate this opportunity to be a part of this panel, and I thank you for inviting me.

[The prepared statement of Mr. Anderson follows:]

Presentation
Before
The Senate Special Committee on Aging
"Living Longer, Growing Stronger: The Vital Role of Geriatric Medicine"

By Steve Anderson
Executive Director
Donald W. Reynolds Foundation

Washington, D.C.
May 20, 1998

• **History of the Donald W. Reynolds Foundation**

Donald W. Reynolds was an entrepreneur, son of a door-to-door salesman and truly a pioneer in the American communications industry. His career began at the age of 10 when he sold newspapers on the street in Oklahoma City, pocketing a half-cent for each newspaper he sold. At the age of 21 he used his life savings to purchase his first newspaper. He spent the rest of his life reporting the news and pursuing media properties. At the time of his death the Donrey Media Group consisted of 52 daily newspapers, 10 outdoor advertising companies, five cable television companies, and one television station serving more than eight million people each day and operating in 17 states.

The Donald W. Reynolds Foundation was created in 1954 by Mr. Reynolds to provide grants to non-profit civic, charitable, cultural, educational and health organizations. After his death in 1993, the Foundation received from his estate a substantial bequest, which positions the Foundation as one of the 30 largest independent foundations in the nation. The ten Trustees of the Foundation board bring a diverse background of experiences and expertise together with only one commonality. That one common point is their relationship, either business or personal, with the Founder. The Trustees organized the structure of the Foundation to have a 50-year limited life to ensure that the Foundation resources would be used in accordance with Mr. Reynolds' intentions. As a result of this limited life expectancy, the Trustees are not attempting to restrict giving in order to maintain an endowment fund in perpetuity. As programs and opportunities for funding arise, the Trustees are free to decide on appropriate use of Foundation resources.

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- **Funding Programs for the Donald W. Reynolds Foundation**

Under the Foundation's original funding program, the Capital Grants Program, the Foundation makes annual awards for construction of buildings to institutions in the states of Arkansas, Oklahoma and Nevada. The Trustees soon realized that other organized programs would need to be established in order to meet even the most conservative projections of average annual giving required to exhaust the corpus of the funds in 50 years. At a planning retreat in 1995 the Trustees invited representatives from other philanthropies, business, healthcare and education to discuss opportunities for potential new giving programs. The Trustees unanimously adopted one new area of focus-Aging and Quality of Life of the Elderly.

A Trustee committee was established for the new initiative. I chaired the committee on Aging and Quality of Life. We retained Dr. Robert Butler, the President and CEO of the International Longevity Center and Professor of Geriatrics at Henry L. Schwartz Department of Geriatrics Mount Sinai Medical Center, New York City to assist us in developing our plans. Dr. Butler identified many funding possibilities however, for many of the same reasons that have been identified again this morning the most pressing need seemed to be the problem of too few healthcare providers that were trained in the special needs of the elderly. With the exception of the John A. Hartford Foundation in New York City very few private Foundations were making grants for education in geriatrics. Over the past three years the Hartford Foundation has made grants annually ranging from \$5 million to \$8 million for geriatric education. Our trustees determined that geriatric education was an appropriate niche for the Donald W. Reynolds Foundation to fill.

- **The Goals for Developing a Geriatric Education Program**

Our committee developed a list of broad-based goals and objectives in establishing the geriatric education initiative. The goals included:

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- Increasing the number of physicians trained and certified in geriatrics,
- Providing an increased number of fellowship positions in geriatrics to help develop a critical mass of geriatricians to meet the education mandate,
- Assuring that every medical student and primary care physician has training in geriatrics and is well schooled in the unique problems of older persons
- Providing opportunities for practicing primary care physicians to retrain in the field of geriatrics.

With the help of Dr. Butler and based upon the model he had developed in establishing the first and only department of geriatrics in the United States at Mount Sinai Medical Center, we developed a request for proposal to establish a new department of geriatrics. Because of a limited staff and logistical constraints, we began our search with the medical schools in the states of Arkansas, Oklahoma and Nevada where we were already making capital grants. By invitation we asked the three medical schools to submit proposals. As a result of the proposals that were submitted and site interviews at each school we selected the University of Arkansas for Medical Sciences (UAMS) as the first site for a Donald W. Reynolds Department of Geriatrics.

- **The Donald W. Reynolds Department of Geriatrics Grant**

Initially the grant to UAMS provided \$15 million to construct a facility that would provide clinical, research, educational and office space for the Department of Geriatrics and the Center on Aging. In addition, a grant of \$10.5 million was provided over a five-year period to fund the program development of the Department of Geriatrics. This past year, the construction portion of the grant was increased to \$18.5 million.

Concurrent with the grant to UAMS the Foundation announced a \$250,000 grant to help establish a chair in geriatrics at the University of Oklahoma. That grant was matched by the state legislature, and this year, the University of Oklahoma has announced the establishment of the third Department of Geriatrics in the United States.

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Later this month we are going to begin dialogue with the University of Oklahoma that could lead to a major funding commitment by the Foundation to help develop their program.

- **National Advisory Panel**

In addition to providing funding for the Department of Geriatrics at UAMS, the Foundation has established a national advisory panel to assist the Foundation and UAMS in assuring that the original goals are met and remain relevant to the initiative. That panel consists of Dr. Robert Butler, Dr. Harvey Cohen, the Director of the Study of Aging and Human Development and Chief of the Division of Geriatric Medicine at Duke University, and Dr. David Reuben, the Director of the UCLA Multi-Campus Program in Geriatric Medicine and Chief of the Division of Geriatrics at UCLA Center for Health Sciences.

- **Progress in the Development of the Department of Geriatrics**

To date the Donald W. Reynolds Department of Geriatrics has met or exceeded all the milestones presented in its original proposal. I have provided handouts that describe the goals and objectives and list the milestones for the first five years of development of the Department of Geriatrics. Also included in handout form is the first progress report presented to the Foundation in October of 1997. The major emphasis during this present year has been the preparation for the mandatory four-week junior clerkship in geriatrics that will become a curriculum requirement in July of 1998.

Identifying prospective faculty members and obtaining commitments to join the staff has been a monumental undertaking but is apparently progressing on schedule. Student interest in the program has been overwhelming. In October of last year there had already been received 25 application requests for the 1998-fellowship year and firm commitments from three internal medicine residents to begin their fellowship in July of this year.

To date we believe that the Donald W. Reynolds Department of Geriatrics at UAMS has been an overwhelming success and met or exceeded all of our

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expectations. We realize however, that the development of the educational program this year is critical to the overall development and success of the program.

- **Leverage of Resources in the Development of the Department of Geriatrics**

As a result of our grant and the development of the Donald W. Reynolds Department of Geriatrics many additional funding opportunities have become available to UAMS. This year, David Banks CEO of Beverly Enterprises has announced a \$1 million commitment by his company to the endowment campaign. In addition Mr. Banks has agreed to head the campaign. A private Arkansas Foundation has agreed to fund the development of a satellite facility in Northwest Arkansas, a commitment that could exceed \$7 million. The Hartford Foundation has named UAMS as a Center of Excellence in geriatrics. By using the recruitment funding that was a part of the budget for the first three years of the grant, UAMS has been able to attract nationally-known research talent such as Dr. Bill Evans who heads the Nutrition, Exercise and Metabolism program. Another nationally known individual is considering a position in the developing Public Policy Institute.

- **A National Model For the Development of Departments of Geriatrics**

Under the leadership of Dr. David Lipschitz we believe that the Donald W. Reynolds Department of Geriatrics at the University of Arkansas for Medical Sciences could become a model for the development of other similar programs across the country. The institution is perfectly positioned as the only medical school in a state that ranks fourth in the percentage of its population that is over the age of 65. Because of clustering of older persons, numerous communities in the state of Arkansas already mimic the way the United States will be in the year 2020. In these communities the percentage of the population over the age of 65 already approaches 20%. In some counties the majority are retirees and middle class. In others the older population is significantly disadvantaged with a large fraction living below the poverty line. Overall studies have shown that Arkansas ranks first in the nation in the percentage of its older persons who live in poverty. The overall health of older Arkansans ranks at the bottom of the nation

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but at the top in per capita medicare costs. This is largely due to the lack of access of older Arkansans to health care, the lack of education and the lack of health promotion and disease prevention. When care is delivered it is costly acute crisis care. It follows that Arkansas offers a unique opportunity to design and test models of health care delivery that can prepare the nation for the dramatic increase in our older population that will occur early in the next century.

- **The Donald W. Reynolds Foundation Commitment to Geriatric Education**

Quoting from the presentation that Dr. Butler recently made to The National Bipartisan Commission on the Future of Medicare "Today, as the population ages and as we move away from institutionalization and hospitals, and more and more into the community, we need different systems of care. Geriatric physicians are the pioneers of comprehensive assessment and care coordination that help maintain the functional independence of their patients. Unfortunately, we still have very few geriatricians in the United States. Despite the fact that Medicare Graduate Medical Education funds are considerable-\$6.8 billion-little of it has been spent on geriatrics, but we must have at least 20 full-time equivalent academic geriatricians within all 140 allopathic and osteopathic medical schools to ensure the integration of knowledge about geriatrics in undergraduate and postgraduate medical training. This cadre would be the teachers, leaders, role models and innovators. Every doctor in primary care and specialty medicine should be fully knowledgeable about the many diseases and disabilities of old age, and understand the techniques of maintaining function in older patients. To provide this necessary academic, teaching leadership, we need only a small but vital number, about 3,000 out of 650,000 doctors." The Donald W. Reynolds Foundation is committed to that goal as we consider additional support for our currently-funded programs and possible new initiatives in the area of aging. We also urge the federal government to step up and take the lead in a major faculty development initiative under the Graduate Medical Education of Medicare. By redirecting funds that are already available the need as stated by Dr. Butler could be met with a modest investment. By working together in the public

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and private sector we can make a difference and we can meet the needs of the aging Baby Boomer generation as its oldest members reach 65 years of age.

Attached is an excerpt from the status report prepared by the Donald W. Reynolds Department of Geriatrics for the Advisory Panel site visit on October 23, 1997.

Steven L. Anderson
Executive Director-Elect
Donald W. Reynolds Foundation

May 14, 1998

Steve Anderson received his Bachelor of Arts and Bachelor of Architecture degrees from the University of Arkansas in 1976. From 1984 through 1997 his firm provided architectural design, construction management and consulting services to the Donrey Media Group, the Media Empire owned and operated by Donald W. Reynolds.

Upon the death of Mr. Reynolds in 1994 the Donald W. Reynolds Foundation was endowed with the bulk of his estate making it one of the 30 largest private foundations in the country. Mr. Anderson was named to serve as a trustee on the Board at that time.

In 1995 Mr. Anderson was named chairman of the Foundation's Committee on Aging and Quality of Life. Under his leadership the Committee was responsible for developing the program that resulted in a \$28.5 million grant to establish the Donald W. Reynolds Department of Geriatrics at the University of Arkansas for Medical Sciences.

In October of 1997 the Board of Trustees appointed him to replace Don Pray as Executive Director of the Foundation. Mr. Pray will retire December 31, 1998. In April of this year Mr. Anderson resigned his position on the Board of Trustees and joined the staff of the Foundation as Executive Director-Elect.

In his current role as Executive Director-Elect, Mr. Anderson is responsible for the construction of the Foundation's new headquarters building in Las Vegas. With the completion of the building, which is scheduled for January 1, 1999, and the retirement of Mr. Pray the Foundation will move its offices from Tulsa, Oklahoma to Las Vegas. Mr. Anderson will assume the role of Executive Director at that time.

The current endowment of the Donald W. Reynolds Foundation is in excess of \$1.3 billion. The Foundation makes capital grants in the states of Arkansas, Oklahoma and Nevada. It also makes grants in the areas of Aging and Cardiovascular Research. In 1997 the trustees approved grants in excess of \$93 million.

Dr. TAKAMURA. Thank you, Mr. Anderson. I appreciate your comments as well.

Our final witness on the second panel is Mr. William Minnix, who says that we should call him Larry. I haven't figured that one out. Larry, if you would proceed?

STATEMENT OF WILLIAM L. MINNIX, JR., D.MIN., PRESIDENT AND CHIEF EXECUTIVE OFFICER, WESLEY WOODS CENTER ON AGING, EMORY UNIVERSITY, ATLANTA, GA, ON BEHALF OF THE AMERICAN ASSOCIATION OF MEDICAL COLLEGES

Mr. MINNIX. Thank you. I think the question about what I should be called is the fact that I am a clergy person representing the Association of American Medical Colleges. Figure that one out. But I am pleased to do so. I think I was asked to do that because we at Wesley Woods at Emory have developed with success in attracting, retaining, and expanding the influence of geriatric physician practice in our area.

The centerpiece of our program was a Wesley Woods geriatric teaching and research hospital that opened 11 years ago. It was at the time—and still is in many ways—a unique facility designed to attract the critical mass of patients, students, faculty to make geriatrics a priority at Emory. That relationship has led to the formal merger of Wesley Woods with Emory this summer. We will become the aging and chronic care arm of Emory Health Care.

We serve somewhere in the neighborhood of 30,000 people a year in our various programs. About half of those would fall into the category of frail. As a former medical director said, we get patients that nobody else wants, but they are not sure they want you to have them either. About a third of them suffer from some form of dementia.

We have our Ms. Cosgrove stories which can be repeated over and over again, but through a recent Medicaid demonstration project called Source, the State permitted us to combine the expertise of geriatric medical care, which we offer, with home and community-based services in the community, through an enhanced case management model. I looked at some statistics yesterday. We have bona fide nursing home patients—because of good geriatric medical care and case management and the ability to broker those services, that we are taking care of people in their homes for in some cases less than \$10 to \$15 a day, when they could be in nursing homes for several times that expense.

Our most dramatic Ms. Cosgrove story is a Medicaid-Medicare-SSI patient who was on 52 medicines, 12 inhalers. We were able to reduce her inhalers down to one pill a day. Taxpayers are paying for those medications and the doctor visits. This shows an example of good geriatrics.

The key to our success is the recruitment of good geriatricians, and so I will broker for you today what they tell me as to what makes a successful program work and what the problems are.

We have seven full-time geriatricians, four full-time gero-psychiatrists, several neurologists that rotate through for various movement disorders, memory disorders, and we have two gero-physiatrists that are based with us full-time. All of these physicians have been recruited from the country's best programs.

What makes our program work: first, it is mission-driven from the top. Emory University is committed to geriatrics, aging, and chronic care as a major priority. Without that, geriatrics programs are subject to changes in personalities of departments and do not receive support they deserve.

Second, we are committed to an interdisciplinary structure. We are moving toward establishment of a Center on Aging not just to integrate medical disciplines, but, other disciplines of nursing, theology, business, and law. We have made progress. The CEO of all of those activities would be myself, and I report to the Executive Vice President of Emory Health Care. The dean of the medical school reports to him as well. So you have the power at the top to make things happen and to get beyond the inevitable bureaucratic turf that you face in the delivery of health care today.

Third, comprehensive and integrated care is crucial. Our geriatricians appreciate the fact that we have created an integrated delivery system. We are making it work through baling wire, rubber bands, paper clips, because the bureaucracy we face externally is horrendous. Getting "meal-on-wheels" across a county line almost requires an act of Congress. Many of you professionals have experienced similar problems.

Fourth, philanthropic support. It takes 2 to 3 million each year to do what we do. Our geriatricians generally are considered to be "money losers," but because this enterprise is mission-driven and not bottom-line driven, we have been successful through foundation support. The Robert W. Woodruff Foundation has been particularly helpful to us. The Lettie Pate Whitehead Foundation, The Jesse Parker Williams Foundation, and United Methodists help us with our charitable and unreimbursed care.

Research funding which needs to continue is another major driver. Having talented and highly motivated colleagues around is also very attractive.

The barriers, you have heard them: bureaucracy, bureaucracy, bureaucracy. It is internal within academic medical centers and health care systems, and external through Medicare, Medicaid, and HCFA. Care for the elderly has to be re-engineered. You cannot attract and retain geriatricians unless somebody addresses the bureaucracy.

I appreciate this opportunity to bring you those comments.

[The prepared statement of Mr. Minnix follows:]

STATEMENT OF THE



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

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on

Increasing the Supply of Geriatricians

Presented to the

Senate Special Committee on Aging
United States Senate

by

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May 20, 1998

Mr. Chairman and distinguished members of the committee, I am William L. Minnix, Jr., D. Min., President and Chief Executive Officer of the Wesley Woods Geriatric Center of Emory University. I am accompanied by Michael Whitcomb, M.D., Senior Vice President for Medical Education at the Association of American Medical Colleges (AAMC). The AAMC welcomes the opportunity to testify and participate in a discussion on how we can encourage the education and training of more geriatric physicians. The Association represents all of the nation's 125 medical schools, approximately 400 major teaching hospitals, including 75 Veterans Affairs medical centers, 88,000 faculty of these institutions represented by 86 constituent academic and professional societies, and more than 160,000 men and women in medical education as students and residents.

As educators of tomorrow's doctors and as providers of health care services, medical schools and teaching hospitals are very aware of how society's needs are changing. The nation's population is aging. Older Americans are now living healthier, better quality lives as we have become more adept at forestalling the onset of disease through scientific interventions. With increased life expectancy, the number of those age 85 and over is growing rapidly. However, there are identifiable groups of older persons who are frail and more vulnerable and require significant resources or even lack access to services. Aware of these demographic changes and concerned about the long-term financial viability of the Medicare program confronting an aging "baby boom" generation, Congress created the National Bipartisan Commission on the Future of Medicare in the Balanced Budget Act of 1997 to make recommendations on a comprehensive approach to preserve the Medicare program.

At the same time, the health care system is undergoing a number of decisive paradigm shifts that affect the provision of health care services and the way we educate and train physicians. These sweeping changes demand new educational imperatives and redesign of the way we educate and train all types of physicians, including geriatricians, and other health care givers. Health care is shifting from:

- its historic orientation toward the individual patient to concern about the health status of defined populations as well as the well-being of individuals;
- physician-centered and specialist-oriented patterns of care to integrated teams of health professionals centered on primary care;
- a preoccupation with episodes of illness to a more balanced emphasis across the spectrum from health maintenance to disease prevention to diagnosis and treatment;
- hospital-centered systems of care to broad-based, integrated systems using accessible and affordable ambulatory care, community sites and home care as well as hospitals; and
- patient management strategies that seek every available benefit, however marginal or costly to strategies that value effectiveness and parsimony in the use of clinical resources

and that weigh evidence over convention in clinical decision making.

The need for practicing geriatricians and clinicians trained in the care of the elderly has been well-documented by the presenters in the previous panel. We appear before you today to explain what medical schools and teaching hospitals are doing to encourage the training of physicians who care for the elderly and to offer suggested strategies for those responsible for medical education and recommendations for Congress to improve the supply of geriatricians and other physicians who care for the elderly. Medical education is a complex and long process. There are no "quick-fix" solutions to shifting the medical education paradigm, but medical educators are taking steps to ensure that newly trained physicians are well-schooled in providing high quality health care for our senior Americans.

Before explaining how medical educators are enhancing geriatric education, it is useful to review the medical education process. Medical education takes place along a continuum, starting with four years of undergraduate medical education. In these years of medical school, students learn content, that is the knowledge, skills, values and attitudes needed for the practice of medicine and are exposed to clinical practice. They graduate as "undifferentiated" physicians. Medical school generally is followed by three to seven years of graduate medical education (GME) in a clinical setting. In their residency years, new physicians apply the content of undergraduate medical school to patients in clinical settings and specialize in their chosen discipline. As practitioners, physicians evolve their style of practice based on clinical experience and ongoing formal and informal education. Physicians are keenly aware of the need for continued learning, and participate in programs of continuing medical education (CME). The concepts of independent lifelong learning and continuous adaptation of new knowledge and techniques to medical practice define what it means to be a physician.

Opportunities to integrate learning about the care of older people abound along the entire medical education continuum and geriatricians play key roles in this teaching. Medical schools, teaching hospitals and a variety of other organizations have been devising and implementing new methods and approaches to change and improve the medical education process at the undergraduate, graduate, and continuing medical education levels.

Undergraduate Medical Education

Over fifteen years ago, the AAMC took the position that this country's changing demography demanded that all physicians should be trained to treat the elderly patient. With sponsorship from the National Institute on Aging and the Pew Memorial Trust, an advisory committee developed a report on the preparation for improved geriatric care in the undergraduate medical education curriculum. Five responsibilities of medical schools to accomplish the goal of better undergraduate preparation for the treatment of the elderly patient were outlined and schools were encouraged to:

- provide a focus for change in the educational and training programs to increase attention

to the aging process and elderly patients;

- seek support to expand research in aging to improve clinical care, to stimulate medical student interest in the fields of gerontology and geriatrics, and to foster interactions with other specialties and disciplines;
- offer a variety of clinical settings and patient encounters, including ambulatory, long term institution, and home care experiences, through which students can learn special arrangements for the care, diagnosis and treatment of the elderly;
- arrange for students to interact with healthy, independent elderly persons; and develop geriatric educational material within all disciplines; and
- urge scientific disciplines and medical specialty societies to develop and disseminate geriatric education material in their fields.

At the time of the AAMC's geriatric report in 1982, only 15 U.S. medical schools had identifiable departments, sections, divisions or units in geriatrics or gerontology. For academic year 1998-99, preliminary data show that 50 medical schools have identifiable units, including 4 separate centers or units at the departmental level. Most schools have sections or divisions of geriatrics or gerontology in the departments of internal medicine or family practice.

For 100 years, medical schools in this country have undergone national oversight and review by the practicing profession, represented by the American Medical Association, and medical educators, represented by the AAMC. As the arbiter and standard setter for medical education, the Liaison Committee on Medical Education (LCME) conducts an annual review of all accredited medical schools, including a survey of medical education programs, to assess medical schools' compliance, in specific terms, in courses of instruction and their place in the curriculum. The annual inventory of geriatrics training, like that of other disciplines needing greater prominence in the curriculum, examines how schools are complying with standards such as the following for geriatrics and related areas:

- The faculty must introduce current advances in the basic and clinical sciences, including therapy and technology, changes in the understanding of disease, and the effect of social needs on demands for medical care;
- Clinical instruction...must include the important aspects of acute, chronic, continuing, preventive, and rehabilitative care;
- Students must have opportunities to gain knowledge in those content areas that incorporate several disciplines in providing medical care, for example, emergency medicine and the care of the elderly and disabled; and

- All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effect on their health of social and cultural circumstances.

The LCME's annual survey asks medical schools how they comply with the standards from an operational perspective. As medical schools are organized in many different ways, so is the variation in medical school curricula. However, nearly every medical school requires the teaching of geriatrics. The vast majority (92 percent) teach students about geriatrics as part of a required course. While ten percent cover the topic as a separate required course, most schools offer separate elective courses in addition to the geriatrics taught as part of a required course. Medical school graduates have indicated general satisfaction with the amount of curricular time being devoted to instruction in geriatrics. In 1997, two-thirds of medical school graduates responding to the AAMC's annual Graduation Questionnaire (GQ) stated that "appropriate" curricular time was devoted to instruction in geriatrics. While these attitudes would indicate overall satisfaction, it should be pointed out that one-third of the 1997 medical school graduates thought there was inadequate time devoted to geriatrics education.

Nearly three-quarters of graduating medical students indicated that "appropriate" curricular time was devoted to death and dying issues. The vast majority of medical schools teach students about death and dying as part of a required course. In addition, students may take additional elective courses on the subject. However, a recent report by the General Accounting Office (GAO) on suicide prevention and efforts to increase research and education in palliative care noted that instruction in palliative care topics in medical schools and residencies varied greatly. Many schools reported a need to change their curriculum in this area. The AAMC is undertaking a project designed to enhance doctor-patient communication issues and to suggest strategies that medical schools and residency programs can employ in providing communications skills during end-of-life care.

There are several points during the four years of medical school when students gain experience with caring for the elderly. In the preclinical phase of medical school, typically the first two years, basic scientists discuss issues of aging and senescence as these concepts apply to physiology and pharmacology for example. Also in the preclinical years, many schools are incorporating small group tutorial curricula emphasizing problem solving and taught around cases, often involving elderly patients. Students use these cases to learn not only history-taking and diagnosis skills, but also doctor-patient communications and case management skills. For example, more than 80 percent of medical schools provide training in identifying and treating elder abuse and neglect.

Most schools also introduce students to clinical medicine early in the preclinical phase of study. These introductions to patient programs often provide ongoing interactions with the same patients, providing opportunities for the bio-psycho-social learning that is so important in understanding issues of aging. Students are assigned patients, frequently elderly, and are expected to obtain their histories and in consultation with their supervisors, devise a treatment plan. These clerkships or community preceptorships (periods of instruction) are based primarily on experiential learning. In the teaching hospital, where roughly one-quarter to one-third of all

inpatient cases are Medicare enrollees, students routinely encounter elderly patients in their clinical education. Early exposure to clinical experience in a particular specialty and encounters with faculty who serve as role models and mentors during these clinical experiences are often important factors in students' career choices.

As health care shifts from hospital inpatient-centered care to integrated managed care systems utilizing a variety of ambulatory care settings, medical educators are shifting much clinical education to diverse outpatient settings. Nearly all medical schools offer student clerkships in ambulatory care settings. The system of care for the elderly must particularly be viewed as a large system of health and social services that are likely to be delivered in a variety of settings, ranging from the tertiary teaching hospital to the home. For example, nearly all medical schools provide educational opportunities in home health care as part of a required course or other educational experiences in home health. The challenges of providing a sufficient number of sites where students can learn from appropriate faculty are formidable. It is difficult to assure uniform quality of teaching from different clinical faculty in a wide variety of settings and to assess student learning.

Graduate Medical Education

Graduate medical education (GME) is recognized and accepted as an essential phase of medical education. Its principal goals are to prepare proficient practitioners of medicine and to equip them for continued professional development. Each specialty has a formally organized board that establishes the minimum length of time to be spent in training and the other criteria a resident must fulfill to be eligible for certification. While undergraduate medical education is university-based and molded by the academic traditions of higher education, GME has historically been hospital-based and developed from a tradition of "on-the-job" experiential training. Many of the same concerns about providing appropriate teachers and nonhospital teaching sites also are prevalent among educators of residents.

GME training programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME). In practice, programs are required to submit information about their curricula to the appropriate Residency Review Committee (RRC) which evaluates the data during the accreditation process. For example, program requirements for residency education in internal medicine have a geriatric component:

Resident experience must include formal teaching and regular, supervised clinical activities in geriatric medicine. Assignments to geriatric services must be offered, and are defined as specifically designated geriatric inpatient units, geriatric consultation services, nursing homes, geriatric ambulatory care clinics, and/or home care. (*Graduate Medical Education Directory 1997-98*).

Geriatrics as a defined specialty is relatively new. It was recognized by the American Board of Medical Specialties (ABMS) in 1985 as a subspecialty of internal medicine and family practice.

The first examination for which a physician could become a board-certified geriatrician was offered in 1988. Thus, the specialty has not had a very long time to mature and is still developing. Residency training opportunities in internal medicine and family practice geriatrics have increased dramatically since 1989. In 1989-90, there were 50 training programs in internal medicine and family practice geriatrics approved by the Accreditation Council on Graduate Medical Education (ACGME). In 1997-98, there were 103 approved training programs.

Obstacles and Constraints to the Development of Academic Geriatrics

Increasing the visibility of geriatrics in medical schools is difficult given the current shortage of academic geriatric faculty. Faculty can serve as important role models for medical students and they can influence students' career choice. Data from the AAMC's faculty roster database show that there are only 558 faculty reporting geriatrics (either internal medicine or family practice geriatrics) as a medical specialty among the 125 allopathic medical schools. This compares with 121 faculty in June 1991 and 468 faculty in June 1995. While the number of geriatric faculty has increased more than four times since 1991, most geriatric leaders believe current numbers are inadequate.

A broad spectrum of clinical training sites where the elderly are served, from nursing homes and day care centers to physicians' offices and home care, are needed to expose medical students to elderly people with varying health status. Simply seeing elderly patients in the hospital during geriatric assessment rounds does not provide the full learning experience necessary for career choice. Patients must be evaluated in social and various care settings. However, most medical educators lament the paucity of appropriate clinical training sites at both the graduate and undergraduate education levels. Finding training sites of uniform quality and faculty who are willing to teach in these sites, particularly practitioners who must generate clinical income in a cost-conscious environment, is challenging. Establishing and maintaining high-quality educational sites is costly.

Increasing emphasis on multi-disciplinary and integrative teaching is well-suited to enhanced geriatrics education and educators are developing innovative programs. However, this demands the time and attention of a limited number of trained educators who face the demands of many competing responsibilities. Medicine is an increasingly complex field, and many worthy courses compete for students' time. Like other integrative subjects that require multi-disciplinary approaches, geriatrics needs to be well-integrated into the curriculum.

Recruitment of students into geriatrics is difficult. While the number of residency training programs in internal medicine and family practice geriatrics has increased substantially since 1989, many geriatric training positions are not being filled. In 1996, the latest year for which data are available, only 144 of 222 geriatric training positions offered were filled.

Clearly, geriatrics has not yet enjoyed a high degree of popularity with students and residents. This patient population requires particular tact and understanding. For example, patients with

impaired mental capacity may not recognize their own physician. The key to more geriatricians is making the specialty more attractive to students as a career choice. The AAMC has invested significant effort to learn as much as possible about medical student specialty choice by asking graduating seniors about factors influencing specialty choice. The results—and they haven't changed materially from year-to-year—tell us that medical students are influenced by their educational experiences. These include positive clerkship experiences and physician role models. Students also pick specialties that interest and challenge them intellectually and that are consistent with their altruistic values and personalities. With more role models and the opportunity to see the elderly in ambulatory settings, students should develop increased interest in this career.

A significant constraint in attracting more medical students to train in geriatrics is the comparatively low level of payment for primary care and evaluation and management services under the Medicare Fee Schedule and other third party payment systems. The vast majority of geriatricians' services provided to Medicare beneficiaries are visits and consultations. While certain provisions in the Balanced Budget Act of 1997, in particular the transition to a single dollar conversion factor and the implementation of a resource-based practice expense system, will boost payments to primary care physicians, the aggregate gains in payment have not been as high as originally anticipated when the Medicare physician fee schedule system was proposed.

Exacerbating the problem of comparatively low compensation levels is that academic physicians, including academic geriatricians, must devote a large percentage of their time—up to 50 to 60 percent—to teaching and research activities. Time spent in these activities reduces the time available for providing billable patient care services that contribute to the department's total operating revenue. In addition to paying general departmental expenses, a significant portion of this revenue derived from patient care services helps maintain competitive compensation levels of the clinical faculty and supports the general medical education and research programs of the medical school.

AAMC Activity Related to Improvements in Medical Education

The AAMC and its members are fully aware and sensitive to the perception that the graduates of our current medical education system may be misaligned with what society wants and needs from the medical education community. Society now recognizes the need for a broader view of health care and wants doctors who can and will attend equally well to all aspects of health care.

As part of a major initiative to address societal concerns the AAMC embarked on a project to assist medical schools in their efforts to create a better alignment between the training of new doctors and society's expectations of physicians. Called the Medical School Objective Project (MSOP), this effort is not directed specifically at geriatrics education, but applies to all medical education. In recognizing new expectations, the MSOP panel reached consensus on a set of four overarching attributes that characterize the qualities all physicians must possess: they must be altruistic, knowledgeable, skillful and dutiful. The panel also set forth learning objectives for the medical student curriculum derived from those attributes. The attributes and objectives apply

equally to the education of geriatricians as they would any other medical career choice.

In January 1998, the AAMC issued the first report which sets forth the objectives that can guide medical schools in developing goals that reflect an understanding of the implications for medical practice and medical education of evolving societal needs, practice patterns, and scientific developments. Among them is that medical school graduates must demonstrate an understanding of, and respect for, the roles of other health care professionals, and the need to collaborate with others in caring for individual patients and in promoting the health of defined populations. Physicians must feel obliged to collaborate with other health professionals and to use systematic approaches for promoting, maintaining and improving the health of individuals and populations.

Emphasis on interdisciplinary learning as the health system shifts from physician-oriented systems of care to systems utilizing teams of health care professionals is critical, particularly in geriatrics. Interdisciplinary teams, in which health professionals from multiple disciplines apply their special skills, knowledge and values to achieve common goals, can enhance innovation, improve the quality of patient care, and strengthen academic-clinical ties and partnerships among institutions and settings. While the challenges of changing behavior and cultures are great, the benefits from interdisciplinary education have huge potential.

The MSOP report also notes that in caring for individual patients, physicians must apply the principles of evidence-based medicine and cost effectiveness in making decisions about the utilization of limited medical resources. They must be committed to working collaboratively with other physicians; other health care professionals, and individuals representing a wide variety of community agencies. As members of a team addressing individual or population-based health care issues, they must be willing both to provide leadership when appropriate and defer to the leadership of others when indicated. They must acknowledge and respect the roles of other health professionals in providing needed services to individual patients, populations or communities.

As part of the MSOP project, the AAMC convened a panel to provide guidance on educational objectives related to population health, and how medical schools might design and implement educational strategies to achieve the MSOP panel's recommended objectives. A draft report outlines the educational objectives for imbuing a population health perspective in medical students and makes recommendations for change, including examples of suggested educational activities. One barrier to change has been that population health instruction is cross-disciplinary, with no one department having responsibility for the competencies. As a result, medical schools, serving as the accountable organizational entity, must clearly delineate the expected outcomes of training in population health so that they can be met explicitly. Additionally, the report calls for faculty development by identifying positive teachers and mentors who are well-versed in the elements of managed care.

The report has been endorsed by the American Association of Health Plans (AAHP). The AAHP appointed a team of medical educators to review the report. The reviewers made some editorial clarifications to the document. After the team's review, the document was approved as submitted

by the AAHP's Quality Committee and then by the governing body of the AAHP.

Already medical schools are using the MSOP guidelines to evaluate and, if necessary modify, their curricula. Twenty-four schools have formed a consortium that will play an active role in implementing the next phases of the project.

Suggested Strategies for Schools of Medicine

In addition to revising constantly physician education due to advancements in scientific and medical knowledge and changes in treatment patterns, medical schools may wish to adopt several strategies to attract medical students to geriatrics. In 1992, the AAMC issued a report on the generalist physician that recommended an action agenda to increase the attractiveness of primary care medical careers. Many of these strategies, repeated from the report on the generalist physician in boldface type below, have been successfully employed to increase the number of students choosing careers in primary care specialties. They also can be utilized to increase the number of students choosing careers in generalist specialties from which geriatricians tend to obtain their residency training.

Schools of medicine should establish administrative units for the generalist specialties. Medical schools should establish administrative units for geriatrics where the responsibility for leadership and management of its educational effort can be focused to assure adequate support. Such units need not be formal departments or even divisions within departments, but should have sufficient administrative authority to be effective champions for the care of the elderly. Having a separate department does not necessarily mean that students will be exposed to geriatric patients. A variety of educational experiences in diverse settings such as nursing homes, home care and other nonhospital settings will expose the student to the broad spectrum of the elderly population. Every doctor in primary care and specialty medicine should be fully knowledgeable about the many diseases and disabilities of old age, and understand the techniques of maintaining function in older patients.

To recruit and advance faculty, medical schools should provide appropriate academic recognition for scholarship, teaching and role modeling among faculty in the generalist specialties. The contributions and special skills of geriatric faculty should be recognized and rewarded. Faculty from geriatrics should serve on key administrative and planning committees in the institution. The current traditional system of rewards may limit the prestige of geriatrics as a discipline, impairing the school's ability to attract and sustain adequate faculty. Retraining of existing mid-level faculty also should be considered.

Medical schools should foster research opportunities in the generalist fields among faculty, residents and students. With the explosion in scientific discovery, there are many unanswered, urgent questions about aging. Geriatrics is poised to play an important role in meaningful research efforts to help better understand aging and disability.

Medical schools should require that all medical students have meaningful curricular experiences in the generalist specialties. This includes clinical experiences in nonhospital settings and the opportunity to encounter role models among the faculty who teach geriatrics. Most medical students make their specialty choice before the end of the third year of medical school. The early introduction of positive experiences in clerkships, preceptorships or other educational activities related to the elderly population in nursing home or home care settings, for example, will ensure that students have an appropriate base for making career decisions. Effective role models are likely to raise student interest in geriatrics.

It also is important for medical schools to partner with a variety of public and private entities. Medical schools and teaching hospitals should seek relationships that enable them to develop teaching chronic care systems for senior care. For example, a rural hospital may want to develop a senior care system, partnering for referrals of the sickest patients and sending physicians to the academic center for "in-career" internships during which the physician works alongside academic geriatricians for a limited period of time. Private money may need to be raised to support such efforts. Institutions could also develop systems that break down bureaucratic barriers to care coordination. Medicare, Medicaid and Title III are not well-integrated and pulling together agencies that deal with these programs could be beneficial.

Recommendations for Congress

The AAMC also recognizes that the federal government can support an increase in the number of geriatricians trained through a variety of mechanisms:

Provide adequate support for existing federally-sponsored student loan re-payment programs. Students who show interest in geriatrics may hesitate to choose the specialty due to high levels of educational debt because they cannot afford to study geriatrics for two additional years. The AAMC believes that if monetary incentives are provided, they should be directed at individuals. A variety of federally-sponsored student loan programs, such as the National Health Service Corps program, already exist.

Provide adequate funding support for Title VII geriatrics programs. Increased funding is needed to support multi-disciplinary geriatric education centers (GECs) and geriatric training programs (GTPs). Both types of programs are effective in providing opportunities for health care personnel to develop skills for providing better, more cost effective care for older Americans.

Affiliated with educational institutions, hospitals, nursing homes, community-based centers for the aged, and veterans' hospitals, GECs include short-term faculty training, curriculum, and other educational resource development, and technical assistance and outreach. GTPs provide fellowships for medical and dental faculty and provide for curriculum development, the hiring of faculty, and the first three months of fellowship training.

Establish a new career development program for academic geriatricians. The Health

Professions Education Partnership Act of 1998 (S. 1754) would require the Secretary to establish a program to provide Geriatric Academic Career Awards to junior faculty to promote careers in academic geriatrics. The amount of a five-year award would be \$50,000 in FY 1998 and would be adjusted for inflation in subsequent years. Individuals who received awards would be required to provide training in clinical geriatrics, including the training of interdisciplinary teams of health care professionals. Such a program would provide critical faculty support as faculty are under pressure to generate clinical revenue in an increasingly price-sensitive health care system.

Provide adequate support for the Geriatric Research, Education and Clinical Center (GRECC) program in the Department of Veterans Affairs. Established in 1975, the GRECC program increases the basic knowledge of the aging process, shares the knowledge with other health care providers, and improves the overall quality of health care received by elderly veterans. The 16 GRECCs established by the VA are at the forefront of the fields of gerontology and geriatrics. A 1997 audit by the Inspector General (IG) of the VA noted that "the GRECC's integration of research, education, and clinical care activities at major research facilities was an effective method for addressing the health needs of the elderly." The IG recommended the development of a method for implementing GRECC-developed treatment models and educational programs at more VA facilities. It should be noted that the VA maintains many programs for older veterans, including 121 geriatric evaluation management (GEM) programs across its system. Aimed at keeping the frail elderly out of nursing homes, these GEMs provide comprehensive health care assessments and other services to veterans with multiple medical problems and those with geriatric problems.

Consider allowing the Secretary of Health and Human Services to engage in a thoughtful process for determining whether the Medicare program should pay for residents in shortage specialties beyond the hospital-specific resident limits. The Balanced Budget Act of 1997 placed an overall limit on the number of full-time equivalent residents for which the Medicare program would make direct GME and indirect medical education (IME) payments to each hospital. The Congress may wish to allow the Secretary to consider establishment of an exceptions process for the training of types of physicians in short supply.

The Medicare Physician Fee Schedule should pay for physician case management services, CPT codes 99361 - 99373, and preventive medicine services, CPT code 99387. Physician case management as well as preventive medicine services are currently not listed for separate payment among the covered services in the 1998 Medicare Fee Schedule system. Instead, these activities are "bundled" into other services. As a result, a significant amount of physician work extended to coordinate and to assure that the Medicare beneficiary is provided continuity of care across delivery settings by a multi-disciplinary team of care providers, is not a separate billable service. Further, periodic patient evaluations to identify potential risk factors and to discover the onset of a disease in its early stages also are not separately billed to Medicare, although they are now typically covered by managed care plans and other third party payors that have recognized the significant cost and quality benefits of preventive medicine services.

While primary care physicians may see a significantly higher percentage of complex patients that merit billing a visit or consultation service at a level 4 or 5, government and institutional concerns over fraud and abuse are so intimidating that many physicians are reluctant to code at the higher level for fear of their inability to document adequately to substantiate the higher charge. This fear must be assuaged by the Health Care Financing Administration in the future.

Conclusion

As revolutions continue in biomedical science and health care services, revolutionary forces also are being exerted on medical education. Medical educators are transforming our educational paradigm by adopting a broader focus incorporating responsibility for the life-long learning that physicians will need to maintain relevant knowledge and skills in a rapidly changing profession. The AAMC recognizes that increasing the number of geriatric physicians calls for action on at least two fronts: voluntary efforts by private sector organizations and government action to eliminate barriers that prevent us from meeting the need. Medical schools, teaching hospitals and other private organizations should work with governmental bodies to find and craft solutions for increasing the number of geriatricians.

Dr. TAKAMURA. Thank you very much. I would actually like to thank all of the witnesses on panels one and two, and just remind you that this is really now your opportunity to have some of your questions answered.

What I would like to do then is to begin with a question that was directed to Dr. Murphy, and I would like to ask Dr. Murphy if he can offer his analysis and his comments.

It has been mentioned very frequently that there is a need to mandate curricular changes. This is a very controversial area for Congress. How can this be addressed? What would your suggestions be?

Dr. MURPHY. I am not sure mandating is the way to go. I think that incentivizing is a much preferable approach, and I think that there can be initiatives designed to foster the development of educational programs in health professional schools based on funding priorities and initiatives set at the Federal level.

With Title VII dollars in the mid-1980's, my program was able to use funding and seed money to start geriatric education programs for residents and family medicine and internal medicine, and that was a battle that I wouldn't have been able to have won if I didn't have those initial dollars. The hospital system I work for now continues to pay for the geriatric nurse specialist and geriatric social worker who are on our faculty and teach residents in training and medical students in training on a daily basis. But the initial getting over the hump with the Federal dollars made a huge difference. So I think incentives are the way to go.

Dr. TAKAMURA. OK. Let me ask a question that is somewhat related to the question that I asked you, but ask this one of Dr. Klein, if I can.

Let me just ask: What is the need for academic geriatricians? How would you say that their number can be increased when current, I guess, requirements support only 1-year fellowships that don't allow much time for research training?

Dr. KLEIN. In the White Paper on Medicine, it gives the exact figures. There is a tremendous need for academic geriatricians, and, of course, if you don't have the academic geriatric faculty, geriatrics is not going to be incorporated into the curriculum and health care professionals will not learn geriatrics in their basic training.

The question as to how can we get more of them, that is something that we have done with the geriatric faculty fellowships in medicine, psychiatry, and dentistry, which is very helpful as it is a 2-year fellowship. There have been changes—and the others can speak to this—that now require only one year of training to receive the Certificate of added Qualification in geriatric medicine. That is good for a clinician, but faculty need a minimum of 2 years, and the field keeps reminding us that every 2 years is not enough to have a strong research base to continue to stay in geriatrics as a faculty member.

So the answer, in quick form, is to have enough faculty fellowships that are funded so that you can attract junior or mid-career faculty. It has always been a problem that junior faculty have such tremendous debt after graduation that they cannot afford to enter a 2-year fellowship and be able to eat. Minimal stipends for the

mid-career fellows results in the same hesitancy of physician educators to become fellows.

So the availability of faculty fellowships and the availability of adequate stipends is critical.

Dr. TAKAMURA. You know, I remember that one pretty well. Thank you.

Dr. Phillips, a question for you. Your organizations, many of these organizations are doing well with the non-institutionalized elderly. How do you provide for the residents of nursing homes? Are you having any impact? Can you tell us a little bit about that?

Dr. PHILLIPS. Yes. We formed a Department of Geriatrics almost a year ago within the HMO, and it has two roles: one is consultative for the ambulatory care setting, creating primary care teams for internists and family physicians to learn how to be team players, if you will; but for those in nursing facilities, in group homes, assisted living, as far as we are concerned, they are best cared for by geriatricians and geriatric nurse practitioners. So the Department of Geriatrics actually has responsibility for those plan members that are in those levels of care, if you will, and it has been extremely successful.

We have also created through education of our primary care providers, when they identify someone who they think needs a higher level of care, we do a geriatric assessment. Currently, 85 percent of those members referred to us for a higher level of care placement are still in the community using community-based services and our expanded benefits.

Dr. TAKAMURA. Thank you.

Dr. Kanwal, can physicians in your programs afford to spend the kind of time Ms. Cosgrove said was required to provide the care that she needed? That is, how do you reconcile efficacy with efficiency?

Dr. KANWAL. There is no simple answer for that question. We have different payments mechanisms for physicians throughout, and we have different mechanisms in different areas that we serve. But we feel that it is required that seniors get the kind of time and attention that they need, and we do chart audit and things to make sure that the services are provided.

We really don't have strong incentives or any disincentives to do the right thing.

Dr. TAKAMURA. However, you do them, anyway. Right?

OK. Dr. Klein, I am going to go back to you. The accomplishments of the White Papers are really laudable. How did you initiate this? Was there congressional support?

Dr. KLEIN. There was no congressional support, which is rather uncommon. We essentially run the geriatric education centers and the faculty fellowship that are congressionally mandated. But our task in the Health Resources and Services Administration is to look at geriatric initiatives. Where is the field? Where does it need to go? We saw very clearly that there was no agenda for action and that the field was in dire need of a focused direction. So we developed the Geriatric Education Futures Project with very little funding, no congressional mandate, few staff and the good will of the field.

As you know, people in geriatrics are committed to older adults and will do whatever they can to further geriatric education. So we were able to draw together the leadership with little funds and make the futures project work.

Congressional mandating is a very significant thing. When Congress says you must do something, then it does happen. Without that, if there are individuals who are committed have the time, and are able to do creative financing, then such a project happens. The majority of past reports that we mentioned identifying the need for geriatric education were congressionally mandated. A congressional mandate with attached appropriations would facilitate the continued movement of the futures project.

Dr. TAKAMURA. Thank you very much.

What I would like to do is ask Mr. Anderson, if he would, if he can tell us how an interested entity could go about seeking funding from your organization. A critical question.

Mr. ANDERSON. We do not have a formal application process yet for our aging program. A simple letter to the foundation expressing interest in receiving a grant would be the appropriate method at this time.

Dr. TAKAMURA. OK. Thank you.

For Mr. Minnix, for Larry, I know that you talked about or have in your testimony the recommendation that schools of medicine should establish administrative units for the generalist specialties. Would you just speak a little bit about that?

Mr. MINNIX. I think that the issue there is how to organize geriatrics in medical schools and academic training centers which can be done in a number of ways. There is no one "right way" to do it. However, the organization must be interdisciplinary, or the chances are pretty good it will be diluted or weakened. I think medical schools get hung up on calling such entities departments. I think it is important to call it an administrative entity through which a number of disciplines can come together to focus on aging-related problems. I think that is essential.

Dr. TAKAMURA. OK. Great. Thank you very much.

Dr. Murphy, back to you. In addition to providing better care for geriatric patients, do you feel that sufficient attention to promoting the responsibility of persons in delaying the need for that care has been provided to medical students in their training?

Dr. MURPHY. In some places, yes. A place like Wesley Woods, they clearly get that experience. In other places, no. It is not universal that medical students in their training will have positive experiences in caring for older individuals. As I tried to allude to in my comments, having success or seeing success in the care of older people is essential for individuals to feel fulfilled in fulfilling those roles and to develop the types of attitudes that they need to be able to provide appropriate care when they are out in practice. So in those settings where there are successful interdisciplinary programs with positive educational experiences for students, yes, but that is not by any means seen throughout the country.

Dr. TAKAMURA. Thank you very much.

Dr. Phillips., can you comment on the costs of your respective projects? How are you choosing outcomes? Is this information proprietary, or can it be shared?

Dr. PHILLIPS. Under the Social HMO II, the outcomes have been developed through both HCFA and the participating health plans working with Dr. Bob Kane at the University of Minnesota. These materials are not proprietary. The outcomes are based upon both utilization of services, hospitalization, emergency room, medication usage, as well as improvement in functionality and quality of life and satisfaction measures.

The cost is really dependent upon the size of a health plan. We have approximately 30,000 members in this demonstration right now, and per member, if you spread the cost throughout all membership, we are somewhere around \$15 per member per month to actually provide this form of coordinated care and expanded benefits. We anticipate over time that efficiencies will improve upon that. But we also at the same time feel that expending that money will in the long run improve care and functionality and reduce costs. But it is a long-term investment, and within Medicare HMOs right now, when members can leave rather rapidly, if you will, from one plan to another, not many health plans want to make this kind of investment in coordination of care. We need to come up with creative ways to make that possible.

Dr. TAKAMURA. Thank you, Dr. Phillips.

Ms. Cosgrove, we are not going to let you get away without answering this one. How hard was it for you to locate a geriatrician? And what might have been done to make it easier?

Ms. COSGROVE. Well, in my particular case, my orthopedic surgeon recommended the geriatrician that I went to. I really don't know of any other ones in the area, and I had not heard of her. She had just moved into the area. In fact, she wasn't even in the phone book. I called the hospital to find out how to get in touch with her, and she was a part of the hospital geriatric department. That is why she wasn't in the phone book as such.

But it was worth waiting the 6 weeks to see her, I guarantee it.

Dr. TAKAMURA. That is great. That is a real endorsement.

Let me ask Dr. Kanwal another question, and then I am going to pose three questions to any of the members of this panel following that.

Dr. Kanwal, if Congress required all Medicare+Choice plans to have a certain number of physicians trained in geriatrics, could that help solve the shortage problem?

Dr. KANWAL. It wouldn't work. There simply aren't enough geriatricians out there with enough capacity per patient to do that.

Dr. TAKAMURA. A good, short, very on-point answer.

Now, this question obviously goes to everyone, and I would like to welcome any of the panel members to respond.

There are very many positive aspects to HMO senior care. But what about the problems, such as rationing of care, a preference for less sick patients that is believed among some HMOs? Would anyone like to address that one?

Dr. PHILLIPS. I will start and then pass the mike. I think those are critical issues that we have to address, and I am very much in support that there are standards set, even prescribed, within Federal law, with more detailed requirements provided in regulations to ensure quality of care, reporting of outcomes, but at the same time, if we move in that direction, I think it is necessary to have

rapid monitoring and reporting so that plans can adjust as criteria are developed.

Dr. TAKAMURA. Larry.

Mr. MINNIX. Yes, I think there is no question there is bias in HMO recruiting around well people from whom you can make money. What we are beginning to see, and some of my colleagues in other parts of the country in more mature managed care markets, managed care companies are turning to geriatric programs for help in developing a plan to manage the frail. We have certainly seen that in the Atlanta area, with reimbursement on some kind of sub-capitated basis. I think those kinds of partnerships need to be encouraged, but we have to remember that taking care of frail elderly people takes time, money, and a different approach to care than Medicare currently permits. So things have to change and loosen up, or you will get the same result that you have now.

Dr. TAKAMURA. Thank you.

Again, this is a question to any of the members of either of the panels. Has the consumer played a role in this process? How can we help elders to advocate for themselves?

We will turn to our resident expert.

Ms. COSGROVE. I would say that the consumer should realize they have rights as a patient and should not be turned off as easily as they have been in the past. I would emphasize for the older people to speak up, ask questions, demand to know what is going on and why.

Dr. TAKAMURA. All right.

Dr. Phillips.

Dr. PHILLIPS. Yes, I echo that, but I think one of the problems is, without adequate education, just like we hear there are not physicians who understand how to take care of older Americans, the consumer frequently doesn't have enough information themselves. And when you cannot find in the Yellow Pages geriatricians—and we have already heard with Mrs. Cosgrove that finding someone in a hospital who practices geriatrics. The information highway isn't out there right now. I think we need to improve upon that. I think Division of Aging Services, community organizations need to start getting this information out to seniors so that they can make better choices.

Dr. TAKAMURA. Thank you very much.

Another question, again, to the general members of the two panels. Could any of you speak to some of the mental health needs that older adults have? Oftentimes we pay lots of attention to acute-care and long-term care needs, and their mental health needs go ignored.

Mr. MINNIX. I could speak to that because probably a good 30 percent of the care we render is psychiatric; either behavior problems related to dementia, or depression, which is probably the single biggest undiagnosed and untreated problem in the elderly age group. There are numerous studies that show the real reason that many seniors are in internists' offices is because of untreated depression.

There is a bias against mental illness. It is still seen as a character flaw by some seniors, and there is a bias within professional communities around geriatric psychiatry. However, depression is a

very treatable disease if it is labeled for what it is and treated aggressively. But, there are some reimbursement issues, professional issues, and consumer education issues that get in the way.

Dr. TAKAMURA. Would anyone like to add to that?

Dr. MURPHY. I think that there is no question that mental health issues are rampant in older populations, and a particular group that gets overlooked is individuals with chronic mental illness who were deinstitutionalized in the 1970's, who are a growing older population with multiple problems and clearly need to have the benefit of interdisciplinary teams to provide them the type of care they need to stay in the community and function at their highest possible level.

Dr. TAKAMURA. OK. Thank you very much.

This is a much more specific question, but let me go ahead and ask it and see if any of you might be able to respond. The Department of Veterans Affairs has provided training for more than 50 percent of our geriatric fellows and, additionally, has populated over 75 percent of the leadership in academic geriatric medicine. With ACGME training requirements truncated to 1 year, VA is statutorily prohibited from providing the 2- to 3-year geriatric fellowships that are needed for academic geriatric development.

The main source—that is, the VA—of geriatric leadership training in the United States is threatened. Any ideas for supporting their continuing commitment to geriatric training?

Dr. Klein.

Dr. KLEIN. The question suggests that the reduction to one year is a statutory requirement. Statutory requirements are made and changed only by the Congress. HRSA has no control over this. This concern is an issue that interested people can bring to their representatives.

Dr. TAKAMURA. Thank you.

In general, are the universities with large medical schools at the forefront of establishing geriatric research and training of practitioners? This is from Lee Persons from Minnesota, who is with Close-Up and is here in Washington.

Dr. PHILLIPS. I would have to say no. The majority of medical schools are not in the forefront. We have, one, a dearth, if you will, of academic geriatricians; therefore, we do not have enough clinical geriatricians. And medical schools just are not, for the most part, stepping up and providing in basic curriculum to medical students, residency training programs, as well as fellowships. So I would say, no, we have got—as far as I am concerned, we have an extremely serious situation in our schools—for many good reasons. It is financing. We have certainly heard about that. But we need things to change; otherwise, things are not going to get better.

There actually were more academic geriatricians and clinical geriatricians in 1990, a study done by Dr. David Reuben from University of California-Los Angeles, than there will be in the year 2000, for two reasons: retirement and not enough people being trained. We have known this for 20-some years. We are on a crash course.

Mr. MINNIX. I would like to respond by saying: Yes! I think they are at the forefront! I would say the glass is half-full instead of half-empty. I think that if you look at the statistics, academic med-

ical centers have increased several-fold their faculty committed to geriatrics. Is that enough? No, it isn't. But if you look at the major places where physicians are being trained, research is concentrated. Students are beginning to have role models, and systems especially for frail elders are being developed around academic medical centers. I think that needs to be encouraged and developed though we have a long, long way to go.

I think Congress can help with that through incentives, which is the single biggest key to it, in my view.

Dr. MURPHY. I also would like to make a comment in regard to that, if allowed.

The academic medical centers, we probably do have a half-full glass. But there are other things that can be done, and the balanced budget amendment allows for direct medical education dollars to go to institutions other than hospitals. To the best of my knowledge, the regulations to allow for that have not been promulgated. That is something that would make a difference. Large nursing home chains, other entities, individual residency programs that have an interest in developing innovative programs would be potentially the recipients of those dollars as opposed to hospitals and hospital systems. It has been my experience that oftentimes the DME dollars end of getting siphoned away to inpatient and high-tech training and away from such primary care areas as geriatrics.

Dr. KLEIN. A related issue that we cannot get around is that we do not have new physicians going into geriatrics primarily because they have too great of a debt. What I keep hearing from the field is that the only way to resolve this problem is loan forgiveness, so that when physicians complete their education with \$200,000 or \$300,000 worth of debt, they do not have the luxury to go on for a fellowship or additional training. Loan forgiveness seems to be the only workable option that I am hearing from the field that is going to make a difference.

Dr. TAKAMURA. You know, in the Administration on Aging, we are literally telling everyone that we can possibly get to that in the year 2011 there will be 77 million baby boomers who will join the ranks of our older Americans. It is very clear to us that, as we look at that older adult population, we are really looking at a population that is not a monolith. There are actually several generational cohorts, each of them with very different interests, needs, and wants.

Let me ask the panelists whether they have recognized or whether they are attending to the differential needs of different elders. We have those who reference World War I, those who reference World War II, those who are much younger and are part of what sociologists call the middle or the lost generation.

Any comments? The oldest of the old, do they differ in their interests, needs, wants, as compared to those who are the young old?

Dr. MURPHY. I think that there are different issues for the different generations. The 65- to 70-year-olds, early 70's, frequently will bring their mother to my office. So for them, they are really a sandwiched generation, but no longer with an earnings potential and face an entirely different set of issues than somebody whose parents are deceased.

I think that as the baby-boom generation moves into this age range, we are going to face a very different set of issues, and physi-

cians are very poorly prepared for it. The education level, the tenacity with which patients are going to ask for and require that they get services I think is going to change. I now have my younger seniors coming in having done net searches on diseases and conditions that they have, and it is a challenge for a physician and one that I think we are going to see more and more of in the years to come.

Dr. TAKAMURA. Thank you. Anyone else?

Dr. KLEIN. I think we also have to keep in mind that as the years pass, there are going to be more ethnic minorities, and more poor older adults than there have ever been, and must address these issues also. So the well-educated and those that have the Websites are going to be the loudest, but the ones in greatest need are going to be the poor and minorities, we must keep them in mind.

Dr. TAKAMURA. OK. How can we stimulate geriatric research along lines which will be productive for your organizations? What do we need to change? What do we need to know? What do we need to encourage?

Dr. KLEIN. Again, what I have heard very strongly from the field is that if there is to be geriatric research, there must be geriatric research funding. If funding is available health care professionals who were not previously interested in geriatrics will be attracted into geriatric research because the funds will be available. This has happened for some medical specialties in the past. Funds drive research, research focuses clinical practice and curriculum change.

Dr. PHILLIPS. I would just add to that, as Mr. Minnix has commented, with HMOs coming to academic centers, HMOs, health plans, any organized system taking care of seniors, has a patient population, and there is a lot that can be done in the way of health services research and delivery. I think we need to encourage more of these types of partnerships, whether it is for-profit or not-for-profit. I think the Blues Initiative with the American Geriatrics Society is moving in a direction where one can next, after education, start doing the research because you now have a clinical basis to start working with.

Mr. MINNIX. I would like to respond to that, also. There has been increased NIH-funded research, especially around neurosciences. If you look at emerging chronic diseases, diseases of the brain and central nervous system represent the biggest problems. That needs to continue.

I think we also need to fund research in demonstrating the effectiveness of different types of treatments and health care delivery system. I think there is too little attention given to that. There is a lot of giddyap-whoa played around the use of telemedicine, for example, to help people. Well, if you talk with some people that have done some telemedicine projects, they can be used very effectively. HCFA is afraid of it, and Congress goes back and forth on it. Pretty soon we got to get beyond giddyap-whoa into something that is a little broader and more innovative if we really want to make a difference.

Dr. TAKAMURA. OK. Tied to your last comment, if I could ask the panelists whether any of them have any ideas about or have any

knowledge about efforts to reach rural elders with geriatric health care needs.

Mr. MINNIX. We have just been approached by three organizations—two large nursing home chains and one very good but very rural hospital. The hospital asked if we would consider allowing them to bring a family practice physician to Emory for a month or 2 months to receive on-the-job training to help them do a better job in their rural community. They also asked if we would send a geriatrician and a psychiatrist periodically. We said of course.

This represents a different type of training model. You immediately begin to wonder how to pay for it. It is a different paradigm. But I think that is the kind of change that will help especially in remote rural areas, and within isolated populations in urban settings. Especially minority immigrant populations, they are as isolated as many rural communities.

Dr. KLEIN. I have a comment on that. The Geriatric Education Centers deal a great deal with those populations, Telemedicine and distance learning are critical for rural and isolated populations its use is growing very rapidly. The GECs have been on the cutting edge of telemedicine and distance learning continues to expand. Reaching rural and isolated areas through technology is an important means of access to health care.

Dr. TAKAMURA. I believe within HRSA it is the Office of Rural Health that has done a lot of work in telemedicine.

Dr. KLEIN. Yes, that is very important.

Dr. PHILLIPS. I will just comment. In Nevada, between Las Vegas and Reno, we certainly have rural areas, and what we are starting to do is taking a model that the cardiologists and gastroenterologists incorporated about 7 or 8 years ago, where they have clinics—they go to all the rural areas, Ely, Winnemucca, Elko, Battle Mountain. So we have partnered with these specialists—this isn't just through the health plan; this is also with the school of medicine—on our own rural initiative to start bringing geriatrics out there, and a mobile van. We aren't up to flying like the cardiologists are, but we are going out in a van and bringing geriatrics to rural communities. Then we are also using telemedicine.

We just did a public forum on Monday, the 18, which was actually a follow-up of a field hearing that Dr. Takamura attended in January in Nevada. But this time we had over 300 older Nevadans come to an auditorium to hear about long-term care alternatives: group home, assisted living, you name it, nursing facilities. Then we beamed it to seven rural hospitals and were able to have an interactive exchange with older Nevadans in Ely and Battle Mountain at the same time holding it in an urban setting—Reno.

Dr. TAKAMURA. Do you take the slot machines out with you to rural areas?

Dr. PHILLIPS. No, we don't. [Laughter.]

Dr. TAKAMURA. I am just kidding.

Dr. PHILLIPS. We can't. We have a \$10 limit that you can encourage any health plan member to attend with.

Dr. TAKAMURA. All right. Well, that is good to know.

You know, several of you have mentioned the importance of interdisciplinary work. I guess the question is: Who all is part of this interdisciplinary team? What do you see their roles to be?

Dr. KLEIN. I will speak to that first. The need of the older adult should determine who in the interdisciplinary team will be around the table. Commonly, the physician, nurse, and social worker, are members of the team, team members are determined by the needs of the older adult and therefore can include a variety of other health care professionals. There are over 200 allied health professions who provide services to older adults that are called in, ranging from a physical therapist, occupational therapist, to psychologist, etc. What is important is that the team is interdisciplinary and not multi-disciplinary. Interdisciplinary teams communicate directly with each other and arrive at consensus on an action plan. These meetings have significant impact on the outcomes of care of older adults.

Dr. MURPHY. Just a key point, I think, is that the team needs to be based on the needs of the individuals. There is a core team, and then there needs to be other members that will meet whatever the specific individual needs of a given patient or family are.

Dr. TAKAMURA. OK. Tied to that question, then, would be a question about reimbursement. Are all the members of this team reimbursed?

Mr. MINNIX. No.

Dr. MURPHY. That was one of my points.

Mr. MINNIX. That is part of the problem. Reimbursement is very limited for nurse practitioners who could have a more expanded role in this delivery system. With geriatricians, psychiatrist, and neurologists, in our situation they collect about \$32, \$37 a visit for 20 to 30 minutes of their time. If you assemble all of them around a table taking care of one patient, then you encounter all kinds of problems related to billing according to Medicare guidelines.

You can't have interdisciplinary care until there is interdisciplinary financing. Form follows finance. We all know that. We wish it were different, but it has got to change.

Dr. KLEIN. Which also follows research. If there aren't funded research studies on the effectiveness of interdisciplinary team care then financing of interdisciplinary team care will continue to be non-existent. It is a complex problem.

Dr. PHILLIPS. What we are talking about, really, is traditional fee-for-service Medicare. We are not talking about the HMOs. Out of 5 million members of HMOs, there are another 32 million under traditional fee-for-service in America. There is a form of providing an interdisciplinary team approach under cost-based reimbursement. Well, with the Balanced Budget Act of 1997, that goes away January 1, 1999.

The way this works is a hospital committed to geriatrics is able to set up a department within that hospital, just like an emergency room or radiology department, and they are able through cost-based reimbursement to have social workers, to have nurse practitioners, to have pharmacists, have your core team, as Dr. Murphy is referring to, and provide an interdisciplinary team approach. That is going away January 1 1999.

Dr. TAKAMURA. There is a question that is somewhat related to this last one, and that has to do with where any workforce analysis is being done. And the person who raised this question asks: Should we really permit the health professions to do this kind of

analysis themselves? Isn't there an inherent conflict of interest? Dr. Klein?

Dr. KLEIN. Conflict of interest is an interesting topic. Successful workforce analysis in nursing and Medicare has been congressionally mandated or federally funded primarily through the Health Resources and Services Administration. The potential for conflict of interest is greatly lessened in this way.

However, we must remember that the health professions do have standards of ethics, and we can expect that they would study themselves objectively. However, if there is a cause for concern or if turf issues enter in, it can be useful to have an agency like the Bureau of Health Professions, of HRSA to provide such analysis, as it has done in the past. For example, nursing has a creative demand-based model of analysis that has been well-received.

An agency like HRSA could do the workforce analysis and would not have the same potential problem with conflict of interest as health care professionals may appear to have.

Dr. TAKAMURA. All right. Thank you very much.

Mr. MINNIX. I would like to think there is enough interest to have some potential conflict about it. I think that is where we have been.

Dr. TAKAMURA. That is very good.

Mr. MINNIX. I think if it goes to that point, we have made some progress.

Dr. TAKAMURA. Well, I think one thing is for sure, that there certainly will be enough people to serve. If we look at the 77 million baby boomers plus our existing older-adult population, we are not lacking for patients or customers, if you will.

Let me just ask, you know, as funding improves—and I am sure it will—how do we make sure that the elderly are protected from Medicare fraud and abuse?

Dr. KANWAL. The issue of fraud and abuse is a big issue for Medicare recipients. It is also something that is monitored through intermediaries, through the fiscal intermediaries and through Medicare+Choice plans, a series of audits and checks. One of the things that is a benefit in Medicare+Choice plans is that the selection of providers helps to minimize some of the—really does minimize and thwart any egregious behavior.

It is a continuing problem. I think that there are sufficient safeguards now in the system at the intermediary level, though not enough funding to pursue it, but they are gearing up their systems and their analytics to look for it.

Dr. TAKAMURA. If I can make some promotional statements, there is also a project called Operation Restore Trust, which is dedicated to anti-fraud, waste, and abuse efforts all throughout the country, and this is really an initiative that has been tremendously successful. For every \$1 spent, we are recouping \$23. So it is very successful.

I believe we are about at 11:30. Can I ask one of our members of the panels to talk a little bit about elder abuse as a domestic violence issue and the role of geriatricians in perhaps identification or treatment.

Dr. PHILLIPS. I think elder abuse—we are all within the health care profession mandated reporters, or we should look at ourselves

as mandated reporters. Elder abuse is where child abuse was 25 years ago.

Within our State of Nevada, with our attorney general, Frankie Sue Del Papa, we have created a mandated reporter system that requires all health care professionals to report any suspected elder abuse, with protection if the reporting is done, just like under a child protective agency, with the interest of the potentially abused in mind. I think that it is an area that we will be hearing more and more about and need to really take it upon ourselves to be willing to report any suspected abuse of an older American.

Dr. TAKAMURA. Thank you.

Perhaps the final question from those of you who submitted cards this morning. Is the growing problem of alcoholism among the elderly due to loneliness, grief, loss, et cetera, being addressed by our geriatricians?

Mr. MINNIX. We see some of it in that alcohol is a form of self-treatment. Some of it is chronic alcoholism; people have been having difficulty with it all their lives. Then some of it is situational related to acute depression. Again, it can be treated if recognized in time.

I will give you a bureaucratic barrier. That is a theme of mine. If you have a geriatric-psychiatric program, you have to be careful about taking an alcohol abuse patient because if you are not identified in our State as a substance abuse psychiatric program, you can be accused of treating something that you are not licensed to do. That comes under the heading of, I believe—I call that crazy. So you have to be careful what you call it when somebody comes into your setting.

We see more medication mismanagement and abuse than we see alcohol abuse per se. The alcohol is simply one drug among many that an elderly person might be taking, even inadvertently, that makes them sick. And you have to untangle all that.

Dr. TAKAMURA. Thank you.

Anyone else?

Dr. KLEIN. There was an interesting report from a hearing in the U.S. House of Representatives in 1992 that stated that as many as 50 percent of the admissions of older adults to hospitals were alcohol-related. This is stunning.

Often, the problem is not "do geriatricians look at alcoholism as a potential problem," but that there are so few geriatricians. Does any physician ever ask the question about alcohol? Studies have shown that the answer is no, for the most part. That is the problem, that few physicians even asks the question. Geriatricians are taught to consider alcohol abuse but there are less than 8,000 geriatricians in the country.

Dr. TAKAMURA. I think I would add to that there are oftentimes different cultural expectations about how much one should enjoy one's, you know, drinks, if you will.

Let me at this time thank Senators Grassley, Breaux, Reid, and Reed and their superb staff. They have done a tremendous job of pulling this forum together. I would also like to thank the audience who submitted questions for our panelists to answer.

Thank you all for being in attendance. I think that you know, as we all do, certainly, that the concerns having to do with older

adults are certainly ones that we need to address even more vigorously, and particularly as we head toward the 21st century and begin to welcome our baby boomers into the fold. We will know that the challenges as well as the opportunities will certainly lie ahead.

Thank you very much. [Applause.]

[Whereupon, at 11:31 a.m., the committee was adjourned.]

APPENDIX

**Senate Special Committee on Aging Forum
"Living Longer, Growing Stronger: The Vital Role of
Geriatric Medicine"
May 20, 1998**

**Written Testimony from The John A. Hartford
Foundation, Inc., New York City**

The John A. Hartford Foundation is honored to respond to the invitation of the Senate Special Committee on Aging to provide written testimony regarding our urgent need to address the vital role of geriatric medicine in the well-being of our rapidly expanding population of older Americans.

Despite alerts as early as 20 years ago, the rate of increase in geriatrics training and research capacity in the nation's medical, nursing, and other health professions' schools continues to lag far behind need; indeed the number of geriatricians appears to be diminishing. At every level (undergraduate, graduate, post-graduate) and in every sphere (medicine, nursing, physical/ occupational and other therapies, social work, pharmacology, etc.) of health professions education, the gap between need and supply is widening.

Despite escalating need, the Geriatrics Branch of the Bureau of Health Professions was a victim of structural reorganization, and no longer serves as a geriatric beacon within the Bureau. Funding for interdisciplinary geriatric education, primarily through federally supported Geriatric Education Centers, has failed to keep pace with increasing need.

The outstanding commitment of the Veterans Administration, particularly through its network of Geriatric Research, Education and Clinical Centers (GRECCs) has similarly struggled through budgetary cuts and uncertainties regarding reorganization. The need for geriatric competence among diverse health professionals and their understanding of the dynamics of effective teamwork continues to increase but has been largely unaddressed outside of VA Medical Centers. The same is true with regard to geriatric education for today's practicing professionals, specific to their disciplines and/or

specialties within disciplines. While geriatric medicine is deeply indebted to the VA for its historic commitment, a vastly expanded and sustained effort is needed to address our aging nation's demographic future.

Let us begin with medicine. Fewer than 50 of the nation's medical schools even begin to have adequate geriatric faculty to provide minimal exposure to the discipline to the nation's 60,000+ medical students and nearly equivalent numbers of resident trainees (excluding those who choose pediatrics as a specialty) whose careers will be significantly and often primarily devoted to care of the elderly. It is not necessary that formally trained geriatricians (i.e., those who have completed fellowship training beyond the residency) provide primary care to all Americans above the age of 65. However, such individuals are vitally needed to significantly increase geriatrics teaching and training within the next decade at every American medical school.

No medical student should graduate without required courses and clerkships on geriatrically-relevant primary and secondary prevention, management of chronic disease, an understanding of long-term as well as acute systems, and exposure to care in the home. No resident in an adult primary care residency program should complete training without longitudinal experience with frail elders, those who live in nursing homes and those dwelling in community settings, as well as well-supervised rotations outside of inpatient hospital units. No specialist or subspecialist should acquire certification without demonstration of substantial knowledge and skills in the geriatric aspects of each area, appropriate to the likely diagnostic and therapeutic challenges which lie ahead in their careers as practitioners serving large numbers of elders. Recertification requirements should increasingly emphasize geriatrics as well.

While the professional societies are beginning to address these issues, change is inhibited by the lack of well-prepared faculty. This is where federal support has historically been remarkably effective. Joint training programs (e.g., geriatrically oriented anesthesiology or emergency medicine; geriatric oncology or cardiology) could make a critical difference. This is the only way to create faculty to train others - both at the student or post-graduate level and equally importantly, those professionals

already in practice. With recent reductions in Medicare indirect and direct support for medical education, it is unlikely that new programs will begin without special stimulus.

Further, direction of federal research funding outside of the National Institute of Aging i.e., other components of the National Institutes of Health as well as the Agency for Health Care Policy and Research, to older individuals would enable the nation to advance its knowledge of appropriate treatments for elders, as well as improved systems of care. While the John A. Hartford Foundation has developed pilot programs in most of these areas, its resources can show feasibility and desirability but are insufficient to roll out the national volume of well-prepared faculty needed for the next millenium.

Moving on to nursing, the picture is equally bleak. Most nurses graduate without required courses in geriatrics, despite their extensive exposure to older patients in hospitals. In a recent (1996) national survey of RNs in their first year of practice, 69% named "an older adult," i.e, 65-85 years old as the age group that best describes their patients. Yet only 1800 RNs are prepared to practice as geriatric clinical specialists and 1500 as geriatric nurse practitioners. This represents less than one-half of one percent of the nation's total RN population. A 1997 survey of geriatric content in the nation's 598 state-approved baccalaureate nursing schools was conducted under the auspices of the John A. Hartford Foundation Institute for the Advancement of Geriatric Nursing Practice (located at New York University) found that a majority of respondents had no faculty members possessing the American Nursing Association's certification in geriatrics; only 30% of respondents had geriatric nurse practitioner programs and fewer than 15% reported geriatric nurse clinician programs, with these about equally divided between required and elective.

While nearly two-thirds of programs reported that geriatric content is integrated in one or more courses, slightly over one-third reported stand-alone courses. Over 60% of respondents reported a need to strengthen the geriatric content of their programs. Most nurses are inadequately trained in geriatric patient management and education issues to reduce or delay debilitation from chronic diseases. As with medicine, there are few

geriatrically trained nurses who are dedicated to research to advance understanding of geriatric treatment or nursing management, whether in hospitals, nursing homes, homes or other residential settings.

Other health professions, particularly physical, occupational and other therapies, and pharmacology also require increased attention to geriatric issues. Health-related efforts of social workers are particularly important for effective utilization of scarce medical resources since social and emotional well-being has been shown to be a vital component of successful aging. Yet federal support for geriatric social work has been essentially nonexistent for over a decade. Those who benefited from earlier federal efforts are today's veteran faculty and their heirs are not apparent.

Finally, the issue of training for interdisciplinary team care of elders is largely an afterthought, despite the heroic efforts of the Bureau of Health Professions' Health Resources and Services Administration's Geriatric Education Futures Project. Although teams are the hallmark of outstanding geriatric care, both within hospitals and in community settings, we seem to assume that teamwork is instinctive, rather than a set of skills requiring early learning and continual reinforcement. Through effective teamwork, the lowest cost utilization of services is possible by using the optimal combinations of expertise at each stage of illness or, equally important, to prevent further illness and decline. This issue must be addressed at the highest levels of managed care (both clinical and administrative), at all relevant sites at which care is provided, and at all levels of health professions education and lifelong training.

For over 15 years, the John A. Hartford Foundation has sought to address these challenges with an increasing share of its growing endowment. Since 1983, over \$130 million in awards under the Foundation's Aging and Health Program have been authorized by its Board. Commitments of nearly \$11 million to create 26 Hartford Centers of Excellence in Academic Geriatrics have strengthened research and teaching capacity at the nation's medical schools and attracted increasing numbers of trainees and young faculty to careers involving aging. Some \$6.5 million has been devoted to improving resident training in the primary care specialties of internal and family medicine; \$5.7 million to increase

the geriatric competence of non-medical specialties (e.g., orthopedic surgery and otorhynolaryngology) and medical subspecialties (e.g., endocrinology, nephrology); and some \$7 million to enhance geriatric nursing education, research, and practice (already well under way in hospitals, and soon to reach nursing homes and home settings as well); nearly \$13 million to develop practical demonstrations of interdisciplinary education for health professionals (at a minimum, physicians, nurses and social workers); some \$15 million to attract outstanding medical scientists to projects which extend the frontiers of aging research (in a partnership with other funders representing total commitments of over \$30 million since 1994); nearly \$1 million to increase medical students' exposure to home care for elders, and most recently \$2 million committed to developing models of continuing geriatrics education for practicing physicians. Since 1985, Foundation commitments under its Aging and Health Program total some \$125 million. The Foundation's efforts have yielded excellent results, but they are of the "pump-priming" variety.

A major national roll-out is required to meet our demographic challenges. Larry Minnix, President and CEO of Wesley Woods Center on Aging in Atlanta made several excellent suggestions in his testimony at the May 20th Special Commission on Aging forum, "Living Longer, Growing Stronger: The Vital Role of Geriatric Medicine."* There is also a strong case to be made to extend his recommendations beyond the single discipline of medicine, to all relevant health professions, and in medicine, beyond those who specialize in geriatrics, to all whose practice will consist of a large proportion of elders. Implementation of such recommendations would be an exciting step in achieving the goal exemplified by the title of the Senate forum. The Foundation is prepared to assist in any way possible to achieve this future vision. For further information, please contact Donna I. Regenstreif, Ph.D., Senior Program Officer, 212-832-7788.

The John A. Hartford Foundation, Inc. of New York City is a private philanthropy established in 1929 by John A. Hartford. Mr. Hartford and his brother, George L. Hartford, both former chief executive of the Great Atlantic & Pacific Tea Company, left the bulk of their estates to the Foundation upon their deaths in the 1950s. The majority of the Foundation's current grantmaking relates to

enhancing geriatric research and training, and integrating and improving health-related services to the elderly.

* attached

Larry Minnix
President and CEO
Wesley Woods Center on Aging

Concluding recommendations from testimony at the Special Commission on Aging forum, "Living Longer, Growing Stronger: The Vital Role of Geriatric Medicine,"
-- May 20, 1998

- Provide adequate support for existing federally-sponsored student loan re-payment programs;
- Provide adequate funding support for Title VII geriatrics programs;
- Establish a new career development program for academic geriatricians;
- Provide adequate support for the Geriatric Research, Education and Clinical Center program in the Dept. of Veterans-Affairs;
- Consider allowing HHS Secretary to "engage in a thoughtful process for determining whether the Medicare program should pay for residents in shortage specialties beyond the hospital-specific resident limits";
- Change Fee Schedule system so that Medicare pays for physician case management services and preventive medicine services.



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**Written
Testimony**

**Dr. Russell E. Morgan, Jr.
President
SPRY Foundation
(Setting Priorities for Retirement Years)**

Submitted for the Record to

Senate Special Committee on Aging

Regarding

**Living Longer Growing Stronger:
the Vital Role of Geriatric Medicine**

Setting Priorities for Retirement Years

The Importance of Public Health Professionals in Maintaining the Health of America's Older Adults

The SPRY Foundation (Setting Priorities for Retirement Years) is very pleased to respond to the Senate Committee on Aging's request for insight into the role of public health professionals in the provision of health care services to aging populations. The SPRY foundation is a 501c(3) non-profit corporation whose mission is "to conduct and coordinate research and education efforts that seek ways to assist mature adults both in planning and achieving a healthy, financially secure, and satisfying future." A priority focus of SPRY is "Redefining Retirement As We Enter The 21st Century" which involves helping individuals recognize and plan for their extended lives. SPRY is related to the National Committee to Preserve Social Security and Medicare (NCPSSM), which boasts a membership of more than six million members nationwide.

The majority of the testimony submitted to the Senate Committee regarding health care personnel has focused primarily on the need for increased training of geriatric medical personnel. As the percentage of the population over sixty-five continues to rise, this need will intensify. In addition, the aging of the population will result in an increase in the number of older Americans living in individual communities around the country. This increased presence of senior citizens underscores the need for more public health infrastructure as well to safeguard the health of older Americans.

While traditional medicine focuses on individuals, public health is concerned with the health of populations. An improved emphasis on geriatric issues in traditional medical care only addresses half of the issue. By working in tandem with public health professionals, the medical field can realize the vast potential for increased wellness among senior citizens, and ultimately produce cost savings for Medicare and Social Security. Katherine Gordon, Director of Health Promotion and Disease Prevention at Health Care Financing Administration (HCFA), has enthusiastically supported the collaboration between medicine and public health.

Despite this assessment, little emphasis has been placed upon educating and training future public health practitioners on the unique needs of the elderly. For example, while most schools of public health offer geriatric focused courses, aging issues are not a central focus of the core curricula. However, Allen Rosenfield, Dean of the Columbia University School of Public Health and President of the Association of Schools of Public Health, noted that public health faculty “are gaining a growing appreciation for the importance of aging issues” as a public health problem as the national demographic picture shifts toward an older population.

Conversely, the shortage of geriatric trained physicians and other allied medical personnel has been heavily publicized, albeit with somewhat limited success to date. According to Ronald Merrill of the Bureau of Health Professions, Health Resources Administration (HRSA), “the challenge is to raise the awareness of the public health educational and practice community concerning the growing significance of aging issues.” Nevertheless, the Bureau of Health Professions Geriatric Education Centers, which has a key role to play in promoting this awareness, has seen its funding drop by more than 30% since 1992.

As health care costs continue to rise in the Medicare program, innovations must be developed to ensure that care can be provided in the most cost-effective way. For example, public health efforts represent excellent opportunities for prevention of illness which in turn can save money on expenditures for acute health care services. According to the Association of Schools of Public Health, the national educational accrediting body, public health encompasses the following objectives:

- ◆ Monitor health status to identify community problems
- ◆ Diagnose and investigate health problems and health hazards in the community
- ◆ Inform, educate, and empower people about health issues
- ◆ Mobilize community partnerships to identify and solve health problems

- ◆ Develop policies and plans that support individual and community health efforts
- ◆ Enforce laws and regulations that protect health and ensure safety
- ◆ Link people to needed health services and assure the provision of health care when otherwise unavailable
- ◆ Assure a competent public health and personal health care workforce
- ◆ Evaluate effectiveness, accessibility, and quality of personal and population based health services
- ◆ Research for new insights and innovative solutions to health problems

When these types of public health approaches are combined with high quality medical care, health improvement outcomes can be dramatically elevated. This concept is being recognized now by many major managed care groups. As a result, public health will play an even more important role in the 21st Century. Patricia McInturff, President and CEO of Senior Services of Seattle King County, and a researcher for the Centers for Disease Control and Prevention, recently stated that "aging may be the single biggest public health problem of the 21st century." With this statement as a guidepost, this testimony underscores the importance of increasing the prominence of geriatric issues in public health education by focusing on several examples of how public health can be used with the senior population to improve the overall health of older Americans.

One very important area in which public health has a key role to play is in adult immunizations, particularly for the elderly. In recent years, the need for increased immunization rates has focused primarily on children. However, improvements are also necessary for older adults. In fact, although vaccines for influenza and pneumonia are readily available, they remain the fifth leading cause of death among the elderly, taking as many as 70,000 lives each year and costing Medicare over one billion dollars in hospitalization costs each year. Tragically, it is estimated that as many as 80% of the

deaths resulting from flu could have been prevented with a flu shot. Moreover, both vaccines are covered by Medicare.

Although 58% of the elderly received flu shots in 1995, there is a great deal of variation across different segments of society. For example, immunization rates among African Americans are only about half of the rate for the Caucasian population. To address this problem, HCFA began the Horizons Project which designed and implemented culturally sensitive awareness activities incorporating international public health experiences and applying them at home in the U.S. Local public health departments are an important facet of this project. The project's early success in improving flu vaccination rates highlights the importance of public health in raising awareness of health issues in individual communities.

A similar intervention called the Good Neighbor Flu project is currently underway in Baltimore under the auspices of HCFA and the Baltimore City Health Department. The goal of this project is to increase rates of flu immunizations among African Americans in Baltimore because only 16.7% are immunized, as compared with 37.6% of Caucasians. Only through more efforts like Horizons and Good Neighbor can the flu vaccination goals be met consistently. Public Health practitioners play a pivotal role in these projects both in design and implementation. Moreover, as the percentage of seniors rises from the current level of 12% to 21% by 2030, the importance of a geriatric focus in public health will increase substantially.

In addition to disease specific interventions, another important function for public health is general outreach into the community. For example, HCFA has started a program in Philadelphia called "Your Medicare Center." This facility, located centrally in the convenient downtown area of the city, offers numerous information services, including materials on health screening efforts. The center provides information on mammography screening, nutrition, and diabetes. These types of programs offer important services to their communities. Specifically, they allow older adults to gather information about how to

remain healthy through prevention. Additionally, local voluntary non-government organizations also represent important links in the "partnership for prevention." Public health has an important role to play in encouraging the use of such centers for outreach efforts. For, in many cases although services may be available, they are not utilized either because people do not know about them or because they are not aware that they should be using them.

This failure to obtain care is caused primarily by a lack of sufficient access for many seniors. This situation has led Bruce Vladeck, former administrator of HCFA, to speak of a "gulf" between coverage and access in health care for older Americans. Mr. Vladeck attributes this gap to many factors including the historic lack of cooperation between HCFA and public health providers. This general inability to work together must be addressed since the goals of public health and HCFA are the same according to Mr. Vladeck. As the ranks of older minorities such as African Americans and Hispanics continue to grow, the well documented access problems will become worse and more difficult to solve.

For example, in the case of mammography screening, there is significant variation among the population. According to recent data, African Americans are only 70% as likely to use mammography screening as compared with the average beneficiary. This disparity can be seen in other vulnerable groups as well, including dual eligible beneficiaries who are eligible for both Medicare and Medicaid and represent a disproportionately high burden on federal and state budgets. As such, there is definite need for monitoring and evaluation of mammography and other types of screening programs in order to increase access to them, and ultimately, to increase their overall effectiveness in decreasing the incidence of disease in the community.

Another important area for intervention is Chronic Obstructive and Pulmonary Disease(COPD). In fact, the National Heart, Lung, and Blood Institute (NHLBI) at the National Institutes of Health (NIH) is currently planning a major outreach campaign to address prevention of COPD. Prevention is urgently needed as statistics from the

American Lung Association indicate that 15 million Americans suffer from COPD with over 100,000 deaths per year. The outreach program will rely heavily on public health efforts to inform people in various communities of the availability preventive health value of the program for older adults. A decrease in the incidence of COPD/achieved through prevention would have a sizable positive impact on health care spending for Medicare and Social Security and serve as another example of the merits of a partnership between medicine and public health. In light of the estimated \$7 billion spent annually on care for individuals with COPD, coupled with additional \$8 billion in lost productivity, these potential cost savings are enormous.

As we enter the twenty-first century, the realities of the United States shifting age demographics are apparent. Recently, a report produced by the New York Academy of Medicine supported by the American Medical Association and the American Public Health Association, "Medicine and Public Health: The Power of Collaboration" highlighted how the two sectors of the health care system are working together to improve health as well as their own effectiveness and economic stability. According to the report, "synergies" between public health and traditional medicine will become increasingly important in the future. Perhaps this assertion applies best to older Americans for whom prevention and outreach efforts represent their best chance to live longer and healthier lives.

This point is further elucidated in the highly acclaimed book, "Successful Aging" Drs. John Rowe and Robert Kahn. The book defines successful aging as "growing old with good health, strength, and vitality. There is a definite emphasis placed on prevention throughout, especially to dispel the myths that once you are older, there is no value in prevention such as smoking cessation, diet modification and exercise. Since the key to preventive medicine is public health outreach programs, the role of public health in a successful aging of the population is undeniable.

Therefore, it is very important that the schools of public health around the country and the American Public Health Association, the national public health professional body,

take an active role in stressing aging issues in training and education for public health practitioners. In order to accomplish this however, the level of funding for such efforts must be increased to promote more research and development with respect to optimizing public health efforts. Moreover, with a concerted effort on the part of medical schools and schools of public health to stress aging issues in their educational programs, the potential for ensuring that the seniors of the twenty-first century can age with good health, strength, and vitality increases substantially.

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* Nobel Laureate

May 28, 1998

Senator Chuck Grassley
Chairman
Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Grassley,

Recently, the Senate Special Committee on Aging held a forum to examine the national shortage of geriatricians. Moderated by Jeanette Takamura, Assistant Secretary of Health and Human Services for Aging, this forum addressed the rising concern among experts in health care that the current number of trained geriatricians in the United States simply is not keeping pace with the growing senior population in this country.

Many of the committee's witnesses echoed what the Alliance for Aging Research has been advocating for years — steps must be taken by public and private agencies to attract individuals into the fields of gerontology and geriatrics to enhance training in the health care professions in the care of older patients. Although Americans over the age of 65, as a group, are the largest users of health care services, they are likely to receive care at the hands of physicians and other health care professionals with little special training in the biological processes of aging.

Doctors with many elderly patients have little systematic training in geriatrics, and U.S. medical schools lack trained faculty. Out of 125 U.S. medical schools, only 13 demand course work in geriatrics or aging, just six require clinical rotations in geriatrics or a nursing home, and less than 4% of physicians-in-training have taken an elective course in geriatrics while in medical school. At the very time the U.S. faces an increasing population of older people needing health care, remarkably few physicians are entering careers as faculty to train other physicians in geriatric medicine and to train researchers in the field of aging-related medical research.

Senator Grassley
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The greatest deterrent, however, to physicians-in-training being exposed to geriatrics -- but correctable by public and private initiatives -- is the shortage of research-based academic leaders and role models among medical school faculty. The Alliance for Aging Research along with the Commonwealth Fund, the John A. Hartford Foundation and the American Federation for Aging Research squarely addressed this problem three years ago by creating the Paul Beeson Physician Faculty Scholars in Aging Research Program. Named after the eminent physician Paul B. Beeson, who chaired the first Institute of Medicine committee to look at geriatric training in the United States, the program exists as the largest privately-funded fellowship in the United States dedicated to training future leaders in geriatric education, research and medicine. To date, private funders have committed in excess of \$30 million to this effort.

The Paul Beeson Physician Faculty Scholars in Aging Research Program provides \$450,000 over a three year period to individual physician-scientists to draw these outstanding individuals into teaching and research in the field of aging. This program also promotes increased training in geriatrics for the physicians who will care for the growing population of people over the age of 65 which is projected to exceed 70 million by the year 2030.

The Beeson Scholars Program began to take shape when a 1991 paper by Thomas Maloney and Barbara Paul of The Commonwealth Fund, titled *Building the Future of Geriatrics*, called for "a consortium of corporate and foundation philanthropy to support faculty development in geriatric medicine in at least 10 medical schools in the U.S." That same year, The Commonwealth Fund called on the Alliance for Aging Research to design and implement a plan for raising sufficient funds to underwrite training a cadre of academic leaders in geriatrics.

In the spring of 1994, The John A. Hartford Foundation proposed the creation a national competition for 10 fellowships a year and pledged \$8.4 million to the effort. Pledges from The Commonwealth Fund and additional pledges from donor friends of the Alliance for Aging Research were added for a total of more than \$14 million, to be expended within three years. Now in its fourth year, this is the largest private sector effort in support of geriatric medicine in U.S. history. That agreement led directly to the creation of the Paul Beeson Physician Faculty Scholars in Aging Research Program in 1995.

The success of the Beeson Scholars Program over the past four years has been the identification and cultivation of 40 outstanding individuals making significant contributions in their careers to the advancement of aging research and teaching of geriatrics. The program will grow to 60 Beeson Scholars by the year 2000. Beeson Scholars are making and publishing important research discoveries about Alzheimer's disease, adult-onset diabetes, osteoporosis, cell senescence, and many other critical aspects of aging research. Many of these scholars have also been given charge of their

Senator Grassley
Page 3

own laboratories and staff in order to further aid their research and teaching efforts.

The program has proven that talented physicians and scientists can be drawn into academic geriatrics in sufficient numbers. Applications for the 10 annual Beeson scholarships have numbered as high as 80 in a given year, and the quality of the applications is outstanding.

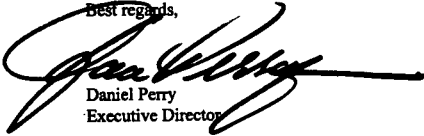
The Beeson Program is identified with individuals who are highly competitive and strongly committed to excellence in geriatrics and aging research. There is mounting evidence that individual Beeson scholars are emerging as recognized leaders in their fields and in their home institutions. Just in the last three years, there have been a number of academic promotions, new and higher levels of grant support from other sources, and recognition of Beeson Scholars both within academia and the medical profession.

Better training of doctors, nurses and other health professionals may be the most effective means of ensuring the best care for older Americans in the years to come. The Beeson Program has already made a notable contribution towards that humane goal and will continue to do so as long as funding exists.

In 1999, when the fifth class of Beeson Scholars has increased the total program to 50, a meeting to assess progress in the field will take place in Washington, DC. Perhaps at that time, the Senate Special Committee on Aging will wish to revisit the issue of geriatric training in medicine and will be able to avail itself of the presence of these emerging leaders in the field.

By sharing this information about the Paul Beeson Physician Faculty Scholars in Aging Research Program, I hope to emphasize the continuing shortage of geriatricians in the United States, but just as important to present a solution to this problem. The Beeson Scholars Program is a prime example of the tremendous accomplishment that can be achieved with the aid of private funding. Also, the Beeson Program points the way to potential future effective collaborations of public and private sectors in preparing for the health care needs of future numbers of older Americans.

Best regards,



Daniel Perry
Executive Director

cc: Ted Totman
Jerry Reed



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Executive Director

Lorraine Tarnow

Please send to Senators Grassley,
Breaux, Reed, + Reid.
Thank you,
Jesse

Tuesday, May 19, 1998

Jeanette C. Takamura, Ph.D.
Assistant Secretary for Aging
c/o United States Special Committee on Aging
Washington, DC 20510-6400

Dear Dr. Takamura:

I am sorry that I will not be able to join you for the Senate Special Committee on Aging Forum on May 20. On behalf of the American Medical Directors Association (AMDA), I would like to provide these relevant comments for your review at the Senate Special Committee on Aging Forum on the National Shortage of Geriatricians "Living Longer, Growing Stronger in America: The Vital Role of Geriatric Medicine." In 1995 you and I worked very hard together on the Advisory Committee for the White House Conference on Aging. AMDA took a very active role for this event, and supported mini-conferences in may states during the 18 months prior to the Conference. We also sent our own delegate and other representatives to the Conference.

Some of the comments in our statement reflected positions we took at the White House Conference on Aging, while others reflect concerns that have arisen since then. I hope that these are helpful to you and Senate Special Aging Committee staff. I wish you great success in your new role as Assistant Secretary for Aging. I look forward to joining you in Minneapolis for this year's AARP meeting. I trust that we will be able to continue our discussion even from the dais at that time.

Sincerely,

Eric Tangalos, MD, CMD



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Lorraine Tarnove

**American Medical Directors Association
Statement to the Senate Special Committee on Aging
Forum on the National Shortage of Geriatricians
Wednesday, May 20, 1998**

The American Medical Directors Association (AMDA) is the national organization representing medical directors and other physicians who practice in long-term care settings, with over 8,000 members from every state. Our members are primary care physicians and the majority have completed training in family practice or internal medicine. Our members are dedicated to improving the quality of care in all long-term care settings.

AMDA participated in the 1995 White House Conference on Aging, where we proposed resolutions on long-term care workforce and planning. We noted that the number of primary care physicians with experience in long-term care medicine was limited and that a number of regulatory and other disincentives existed that discourage primary care physicians from entering into long-term care. We further felt that the number of elderly requiring the expertise and services of such physicians and other health care professionals is and will be increasing and that education, training, knowledge, and motivations are all components to delivering quality medical care. Our resolves found their way into the resolution entitled "Ensuring the Availability of a Broad Spectrum of Services." This language was of such importance that it is also found its way into the resolution on "Preserving the Integrity of the Older Americans Act." The American Medical Directors Association and the White House Conference on Aging felt that Congress should enact legislation to remove barriers and encourage the development primary care physicians with expertise in long-term care medicine. We felt that government policy should be developed to endorse and promote appropriate geriatric and long-term care education for all health care providers, patients/residents, families, and caregivers.

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Finally, we felt that government programs should plan for current and future long-term care provider workforce needs and create a backbone of accountable clinical providers. I hope that today's Forum continues on with these recommendations.

AMDA has been interested in the welfare and quality of patient care since its inception in 1978. OBRA 1987 clearly defined the new role for physicians practicing in long-term care and our Association has done its best to work with consumer groups, the Health Care Financing Administration (HCFA), Congress, and the provider industry for our patients' well-being. Now, with over 8000 members, we more strongly than ever believe in the principles that serve those we serve:

1. Long-term care is part of the continuum of care.
2. Nursing facilities will continue to evolve and take on a variety of roles in providing care in a cost-effective manner.
3. Consumers must have the ability to participate in selecting their individual settings of care and their choice of providers.
4. Physicians and allied professionals who care for our nation's frail elderly must be recognized for their services so that quality care can be delivered by the best people available.

We have and will continue to keep long-term care with all its medical, economic, social, and political ramifications central to future debates on health system reform. From the preamble of the 1995 WHCOA report, conferees declared "As America prepares for the 21st century and the dramatic increase in our aging population, we affirm our commitment

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to all older persons and their families, especially those at risk. Policies that provide security to the elders of our society also enhance the lives of their children and grandchildren and create a bond between generations. Aging is a part of the continuum of life and we recognize the importance of value and interdependence of people regardless of age and declare our commitment to policies that are intergenerational." Greater and greater numbers of the population will require a full spectrum of services. How we creatively address the medical, economic, social, and spiritual well being of our elderly will determine how future generations judge us. How we address the vital role of geriatric medicine as we approach the millenium will determine how future generations of health care professionals weigh career choices in geriatric medicine. Our field should attract the best, the brightest, and those most interested in the humanity of mankind.

Dr. Larry Lawhorne, past AMDA president, in testifying before the Institute of Medicine Committee on Improving Quality in Long-Term Care this past March noted, "More physicians are focusing their practices on nursing facility patients today, resulting in a smaller number of attending physicians but ones who tend to have additional training and experience in geriatrics. We believe that such attending physicians are instrumental in improving patient outcomes. However, physicians who treat large numbers of nursing facility patients find themselves subject to intensive security by carriers and fraud investigators based on their volume of claims. These audits can constitute a disincentive to nursing facility practice." Doctor Lawhorne went on to state that, "The medical director is increasingly becoming the focus of coordinated billing provisions of the balanced Budget Act of 1997. We have heard a few reports of medical directors who were relieved of their duties because they would not simply sign completed orders for durable medical equipment or therapies that were presented to them. Others who work under contract with nursing facilities have simply found that their facility refused to renew their contract in order to find a more compliant medical director." Under the new

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Prospective Payment System for nursing facilities, medical directors and attending physicians are likely to find themselves under pressure to prescribe less expensive drugs and permit fewer therapies. Congress should monitor the implementation of the Medicare Prospective Payment System (PPS) for nursing facilities to ensure that it does not have an adverse impact on access to and quality of care.

In 1991 significant changes occurred regarding the recognition of physician services in long-term care settings. Reimbursement for medical care actually improved. The nursing home reform provisions of OBRA 87 would not have been able to go any further forward without good geriatric medicine. I trust this day's Forum will contain much evidence regarding work force shortages due to inadequate staffing and poor pay at all levels. These same incentives play out in medical school curricula, in residency and fellowship training programs, and the job market. We recommend that such problems be resolved so that the vital role of geriatric medicine will open more doors for future generations.



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

In Reply Refer To:

June 1, 1998

The Honorable Charles Grassley
Chairman, Special Committee on Aging
United States Senate
G31 Dirksen Senate Office Building
Washington, DC 20510

Dear Mr. Chairman:

It would be appreciated if the enclosed information on the Department of Veterans Affairs' (VA) efforts in preparing geriatricians would be added to the public record of the Committee's Forum on "Living Longer, Growing Stronger: The Vital Role of Geriatric Medicine", held May 20, 1998. The VA has for many years been committed to providing advanced education in geriatric medicine to better meet the needs of older veterans, as well as all older Americans. The information on VA's geriatric medicine programs, in conjunction with the excellent testimony given by the participants at the Forum, is intended to provide a broad picture of the current and future need for geriatricians.

Thank you for the opportunity to provide additional information for the record.

Sincerely,

A handwritten signature in black ink, appearing to read "Judith A. Salerno".

Judith A. Salerno, M.D., M.S.
Chief Consultant, Geriatrics and
Extended Care Strategic
Healthcare Group

Enclosure

**Department of Veterans Affairs
Veterans Health Administration
Special Training Programs in Geriatrics
Fact Sheet**

- One of the first physician fellowship programs in geriatric medicine in the United States was established by VA in 1978.
- Between 1978 and 1992, 275 physicians graduated from VA's 2-year geriatric fellowship program.
- VA, having the largest single program of geriatric fellowship-trained physicians in the United States, was credited with playing a significant role in the development and recognition of Geriatric Medicine as a new specialty by the Accreditation Council for Graduate Medical Education (ACGME) in 1988.
- VA has continued to support advanced education in geriatrics through its specialty medical residency training program since FY 1990. The number of resident positions in geriatrics supported by VA continues to grow each year; from 41 in 1991, to 92 in 1995, to the current number of 154 positions.
- Nearly 50 percent of all graduates from VA's advanced training program in geriatric medicine hold academic appointments and therefore have become the educators of future geriatricians.
- Approximately 40 percent of the geriatricians trained in VA's fellowship or specialty resident programs have chosen to remain on the medical staff at VA facilities, either on a part-time or full-time basis. Therefore, VA's geriatric medicine training efforts have impacted on the care of older veterans as well as on the care of all older people in the United States.
- In addition to advanced training in geriatric medicine, VA established a geriatric psychiatry fellowship program and a geriatric neurology fellowship program in 1991 and 1992, respectively. By 1994, VA had graduated 34 geriatric psychiatrists and 3 geriatric neurologists from these special programs. In Academic Year 1997-98, VA supported 23 geriatric psychiatry and 8 geriatric neurology training positions.



ISBN 0-16-057500-1



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