



University of Pittsburgh

INSTITUTE ON AGING

In partnership with University of Pittsburgh Medical Center

Testimony to the U.S. House Subcommittee on Civil Service and Agency Organization

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Introduction

As a geriatrician, I have been asked to focus on issues relevant to the concerns of the roughly half million older retirees in the Federal Employee Health Benefit Program. This is an entirely appropriate request from a committee focused on chronic care because the prevalence of chronic diseases in the elderly is approximately twice as common as in younger individuals. In addition, chronic conditions in older individuals also pose many more challenges. Having devoted my career to caring for such patients—and to searching for the causes of their diseases and to optimal approaches to their care—it is a privilege to be asked to share some thoughts with those who may be able to effect change.

Statement of the Problem

It may be important to put the issue in context. It is now widely realized that the number of older Americans is rapidly increasing and will double in the next 25 years. What's less well appreciated is that chronic disease is the dominant issue in such people, that several features of chronic disease differ in older adults compared with younger adults, that few physicians are trained to deal with these conditions in the elderly, that the number of such physicians is declining, and that many features of the health system—which is largely optimized for acute care—ill suit the needs of older adults with chronic conditions.

Differences in Chronic Disease Among the Elderly

For several reasons, the challenge posed by chronic disease in the elderly differs from that in younger patients. First, older patients with chronic disease generally suffer from more than one concurrently, making detection, diagnosis, and treatment of the new one more difficult. Second, the generally-used approach to a given condition may be contraindicated by these other conditions or by the multiple medications the patient is taking to treat them. Third, while scientific evidence for chronic disease management is limited, it is far more limited for chronic disease in older adults, and this has impeded development of appropriate guidelines. Fourth, chronic disease in older adults often occurs in patients who also have mental impairment and/or depression, and the impact of these is further exacerbated by the fact that many older adults do not have a spouse or other advocate; these factors hinder the physician's ability to complete an adequate evaluation and ensure adherence to therapy.

Fifth, older patients have much shorter life expectancies than do younger patients, which requires putting risks and side effects in a very different perspective. Sixth, owing to the issues just mentioned, as well as to ageism, older adults often have different values and goals. When coupled with the multiple possible combinations of coexisting chronic conditions in the older person, it is easy to understand that application of the type of disease management models being developed at present will be difficult at best.

Lack of Physician Training for the Complexity of Chronic Disease in the Elderly

Despite the complexity of chronic disease in older adults, and the rapidly increasing number of such individuals, few physicians have received even an hour of geriatric education.

The lack of physicians with geriatrics training reflects several factors. Most physicians were educated before geriatrics was offered in medical schools. And for a variety of reasons, acquiring training in geriatrics once they are in practice is difficult. First, there are few geriatricians to teach them since less than 1% of American physicians have geriatric certification. Second, there is little incentive for a practicing physician to seek such training. In addition to the tuition they would pay and the practice revenue they would forfeit during training, reimbursement for geriatric care is low and is no better for those who have received additional training. In addition, caring for older adults requires dealing with a disproportionate amount of paperwork, documentation, and regulations; these not only decrease productivity but also are viewed in many cases as counterproductive to optimal patient care. This view is underscored by the fact that physicians receive no payment at all for services they often provide free for older patients such as counseling for preventive care, telephone management, care coordination, advance care planning, family meetings, anticoagulation management, and pharmacy oversight, among others. Finally, owing to inadequate reimbursement, physicians who agree to care for older patients have to see them in a briefer amount of time, despite the fact that their problems are the most complex. Physicians find such practice frustrating and even dangerous.

Nor is the number of physicians trained in geriatrics likely to increase soon. Only 3% of today's medical students receive geriatrics training. In part this is because geriatrics is only offered at a little more than half of the nation's medical schools and required in less than 10%. And in part it is because there are so few geriatricians to teach them; less than one half of 1% of academic faculty are geriatricians. Although geriatricians report high rates of satisfaction in caring for older adults, the fact that virtually every geriatric division loses money on patient care results in geriatric faculty receiving relatively low salaries and having low job security. It should not be a surprise, then, that while the number of older adults is increasing, the number of geriatricians is actually decreasing. Nor should it be a surprise that students, whose average educational debt exceeds \$100,000, are not flocking to the field.

Additional Impediments to Geriatric Care

Access to appropriate care for older patients with chronic disease reflects more than just the paucity of appropriately trained physicians. Hospitals may seek to avoid admissions of such patients, especially those who are frail, since these patients have a higher risk of complications, longer stays, and non-reimbursed readmissions. Reimbursement issues lead many nursing homes to try to avoid admitting patients who cannot pay privately. Home care

programs are closing. Insurers are eliminating their HMO Medicare programs. And in the current fee for service environment, there is little ability or incentive to coordinate care. The resulting fragmentation and competing incentives increase the difficulty in managing chronic care, particularly for older adults who have the most chronic conditions and the least ability to survive inadequate care.

The result is that a common scenario for older adults is to be referred to one physician after another, each of whom adds a test and/or a medication which in turn engenders another symptom so that the cycle continues until the patient's status deteriorates and results in an acute event. The patient is sent by ambulance to an emergency department and hospitalized. The hospitalization is generally longer than for younger patients, more often includes complications, and is more often followed by the need for intensive care or subacute and/or chronic care. The final result is an increased likelihood of an outcome that neither the patient nor the physician is happy with and at a cost that neither the patient nor society can afford.

Potential Solutions

The situation is far from hopeless. Studies show that students begin medical school attracted to caring for older adults and that geriatricians are among the most satisfied of medical specialists. Moreover, while the high complication rates among older adults generate high utilization, neither is inevitable. In addition, not only are many of the solutions to improving geriatric care relatively inexpensive, but implementing them could decrease the number of emergency department visits, the number and length of hospitalizations, and the number of medications, which in turn may make these interventions at least revenue neutral if not cost saving.

What are some potential strategies? In the short term, a task force could be created that comprises experts in geriatric care and health care policy. The task force could work with the FEBHS to identify the current regulations that function more as impediments than enhancements to care. One example is the rule that patients must be admitted to an acute care hospital for at least 3 days to qualify for nursing home admission, even if they have no acute care need. The task force could also identify policies that might be inadvertently driving up costs by being "penny wise but pound foolish." The task force might also model potential outcomes of paying more for proactive management of chronic conditions, for instance by paying for routine chronic care planning visits that might prevent the far costlier visit to an emergency room and/or hospital admission. The task force also could consider other potential short-term interventions to improve the training of clinicians and the incentives most apt to accomplish this. To assist in this regard, the Task Force could review inroads being made by the twenty recently-funded Reynolds Centers since many of them are developing innovative ways to educate physicians in geriatric care. Finally, the Task Force could develop a list of interventions and prioritize them.

At the same time, it would be worth considering the funding of one or more demonstration projects. Our own work suggests that one promising solution to the scarcity of appropriately trained physicians is to re-engineer care of the older adult to make it feasible for a primary care physician to deliver, attractive enough that the PCP would want to, and feasible enough to allow it. We are working on a model that is proactive, preventive, and led by the PCP, who

is supported by a team of appropriately trained specialists, as well as an infrastructure of case managers, care managers, information technology, and pharmacy oversight. Several features make this approach especially feasible. First, it does not require a long lead time to train a large number of geriatricians; training is designed to be streamlined and focused. Second, the approach relies on developing strategies that any physician can use. This is particularly appealing since care of the older adult requires input from virtually every type of physician other than a pediatrician. Third, it relies on adapting and integrating approaches that for many of its components have already shown promise but which have never before been deployed as a comprehensive and integrated model. Fourth, while the approach invests more funding up front, it is focused on paying for things like preventive management of chronic disease, advance care planning, identifying patients' values and goals, and care management. The vast majority of the health care dollar for geriatric care currently is devoted to medications, ambulance rides, emergency room visits, and hospitalization, so if such an approach could reduce these costs by only a small amount it would not only be able to pay for itself but it would result in better care as well.

Of course, since the model just described is so different from the current model of care, and since the stakes are so high, such a model must be tested. Fortunately, for several reasons, this could be accomplished relatively quickly and efficiently in a system such as our own. The University of Pittsburgh Medical Center system is situated in what is demographically the oldest region of the country; Allegheny County today has roughly the same proportion of older adults that the country will have in 25 years. Second, the University of Pittsburgh has one of the nation's largest number of clinical geriatricians. Third, its expertise in geriatric research is one of the nation's largest and most diverse, with nationally-recognized experts in virtually every area relevant to designing, implementing, and evaluating such an intervention. Fourth, UPMC has one of the nation's largest integrated health care delivery and financing systems, which also spans the entire health care continuum. Finally, UPMC's system includes an insurance company which could design and deliver the product as well as collect data on the actual costs and outcomes of care.

Conclusion

In conclusion, the need is great. The number of older retirees within the FEHBP is roughly 500,000 and growing quickly. And the impact is even greater than the numbers alone suggest, since the costs are growing more rapidly than the number of retirees and may soon eclipse the ability of the FEHBP or its employees to afford. In addition, the lack of appropriate chronic care impinges on the productivity of current workers who must take time off to help their parents deal with this.

Furthermore, your goal is laudable: to not only deal with the plight of these individuals but in the process to attempt to develop solutions that could serve as a model for the US health system as a whole. I hope that I have been able to provide some perspective on how the needs of your older retirees who suffer from chronic illness differ from those of your younger enrollees. I hope you also share my optimism that much can be done. But it will require creative planning, more research, and changing regulations to reduce barriers to care.