

Training Physicians in Geriatric Care: Responding to Critical Need

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As the nation's older population grows, the U.S. will require a well-trained workforce of health care providers with expert knowledge in geriatric medicine. Compared with younger adults, older Americans use a disproportionately larger share of health care services provided by physicians, nurses, pharmacists, physical therapists, and other practitioners. While people over age 65 represent 12 percent of the U.S. population, this group consumes one-third of healthcare services and occupies one-half of all physician time. Unfortunately, only a small share of the 650,000 medical doctors in practice today—including specialists whose patients are disproportionately elderly—receive the necessary training and education in geriatrics to provide older Americans with the best possible care.

Only three of the nation's 145 medical schools have a full-scale department of geriatrics that requires a mandatory rotation in geriatrics for students and residents, and less than 3 percent of all medical students take even one course in geriatrics. In contrast, every medical school in Great Britain and 19 of Japan's 88 medical schools have such a department (ILC, 2001). A mandatory geriatrics rotation in all U.S. medical schools would be welcomed, but it would not solve the problem. Indeed, even if all of the 16,000 medical students who graduate each year started to receive geriatrics training today, it would take more than 40 years before the entire U.S. physician workforce would be adequately prepared to address the complex and distinctive needs of their elderly patients.

The U.S. cannot afford to wait that long. In less than 10 years, the baby boomers will start turning 65. Although schools of medicine, nursing, and social work are beginning to take steps to attract new students to the field of geriatrics, it's imperative that the existing health care workforce—practicing physicians, nurses, therapists, pharmacists, and social workers—receive the training and education necessary to address the needs of their expanding pool of older patients.

Older Adults' Use of Services

Older patients tend to use health care services more than younger adults. Patients 65 and older visit physicians an average of 11.4 times a year, compared with 7.2 visits for the population between the ages of 45 and 65. The oldest old—those at least 85—average 15

physician visits each year (see Figure 1).

As a result, though adults 65 and older made up only 12 percent of the population in 2000, they made 24.3 percent of all office visits that year—about 200.3 million visits, according to the National Center for Health Statistics. About 45 percent of all visits were made to primary care physicians (see Figure 2).

For most medical specialists, the elderly represent a disproportionate share of their practices (see Table 1). For family practitioners, 20.4 percent of their total patient visits in 2000 were made by people age 65 and older, and for internists, older adults made 39 percent of total visits. The percentages climbed higher for cardiologists (59.7 percent), urologists (53.1 percent), and ophthalmologists (51.5 percent).

Figure 1 Average Number of Physician Visits Among Older Adults, 1999



Source: Department of Health and Human Services

The Unique Healthcare Needs of Older Adults

Older patients often have several chronic conditions, take multiple medications, and respond to treatments and medications differently than do younger persons. For these reasons, diagnosis and treatment can often be difficult. Few physicians are trained to recognize or address the unique and complex needs of the elderly, nor are they able to perform an effective geriatric assessment. As a result, physicians often consider conditions like memory loss or incontinence to be the expected side effects of aging, though appropriate interventions can improve these conditions. In many cases, physicians hesitate to prescribe exercise regimens or cholesterol lowering strategies, even though patients

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could benefit. Depression, which physicians often confuse with the onset of cognitive impairment, is often undiagnosed in older adults. In addition, many physicians are not trained to consider the social, environmental, and psychological factors such as retirement and isolation that can compound the effects of a patient's illness.

The Role of Geriatric-Care Professionals

Health care professionals who are trained in geriatrics can help to maintain the health and quality of life of older patients. The complex needs of older patients often require a team of health care providers with aging-related expertise to work together to assess the patient's physical and mental well being and to coordinate care in a variety of settings—the patient's home, the physician's office, the hospital, and the nursing home. Geriatric-care teams also work cooperatively with caregivers, such as family and friends, who play a crucial role in helping the older patient maintain health and independence.

Older patients who receive specialized geriatric care tend to do better than those who receive usual care. In one study, patients who received inpatient and outpatient care in geriatric units experienced large reductions in functional decline and improvements in mental health at no additional cost (Cohen, 2002). In another study, older patients cared for by nurses trained in geriatrics had fewer readmissions to the hospital and were less likely to be transferred from nursing facilities to a hospital for inappropriate reasons (Kovner et al., 2002).

Specialty health care professionals could also benefit from training in geriatrics. A cardiologist, for example, might be more likely to look for signs of depression, which often worsens conditions like hypertension and heart disease. Family doctors and

internists would be more likely to help frail patients prevent fall-related injuries by reviewing medications and checking vision.

Potential Savings

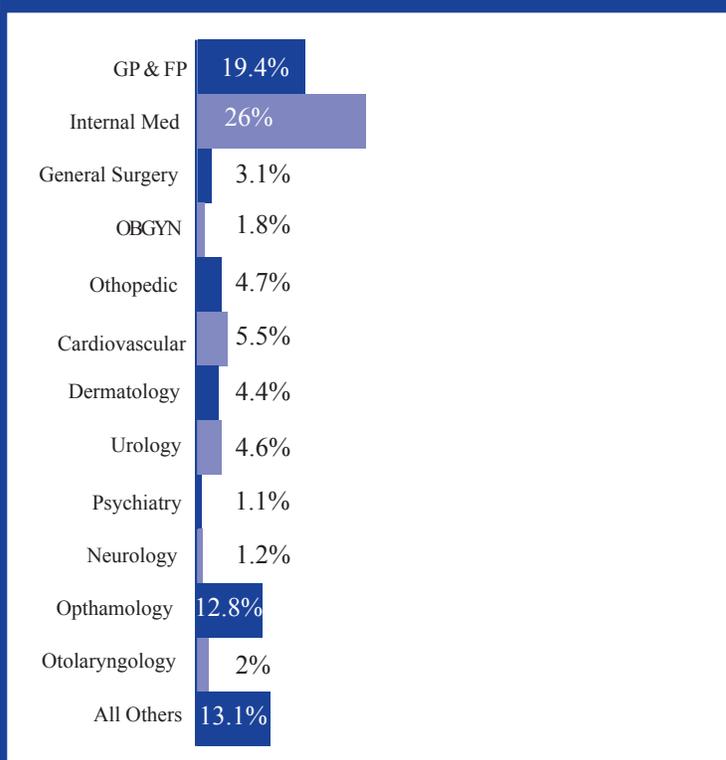
The financial benefits of care provided by physicians and other health care workers trained in geriatrics are potentially enormous. Health care professionals trained in preventive and rehabilitative care, in prompt intervention, and appropriate testing can help reduce costs arising from avoidable hospitalizations and nursing home admissions. The Alliance for Aging Research estimates that proper geriatric care could reduce hospital, nursing home, and home care costs by at least 10 percent a year, saving \$50.4 billion in the year 2000 and \$133.7 billion in 2020. The GAO (GAO, 1995) has estimated that medication-related problems among the elderly, including improper dosing and adverse reactions, costs approximately \$20 billion a year in hospital stays. According to the Centers for Disease Control and Prevention (CDC, 2000), fall-related injuries among

older Americans cost \$20.2 billion in direct medical costs each year. The CDC notes that the number of falls could be reduced substantially through a prevention strategy of exercise, vision correction, medication review, and home modifications, such as bathroom grab rails.

A Growing Crisis

The projected increase in the number of older baby boomers comes alongside another demographic certainty: The decline in the size of the working-age population needed to support rising numbers of elderly. In 2000, there were three workers to support every senior; by 2044, there will be two workers for every senior, according to the Social Security Administration.

Figure 2 Distribution of Office Visits According to Physician Specialty for Adults 65+, 2000



Source: National Ambulatory Medical Care Survey

This projection has profound implications for the health care workforce. The number of trained professionals, most of them baby boomers themselves, may decline as the need for them rises. For example, about half of registered nurses are at least 45 years old, higher than average across occupations. Their retirement will aggravate an already severe nursing shortage. The U.S. Bureau of Labor Statistics estimates that employers will need to find replacements for 331,000 RNs between 1998 and 2008.

Academic institutions are woefully unprepared to address these population trends. Medical schools have yet to make the same commitment to geriatrics that they've made to pediatrics. All U.S. medical schools have a department of pediatrics—a leftover from the early days of the baby boom. In 2000, there were 62,386 pediatricians to treat 59 million children up to age 14 (one pediatrician for every 945 children). In contrast, there were just 9,000 geriatricians to treat about 35 million persons 65 and over (one for every 3,888 older persons). According to the Alliance for Aging Research (2002), the number of geriatricians is expected to fall to less than 6,000 in the next few years, as many leave the lower paid field or retire, while it is estimated that the nation will need 36,000 geriatricians in the next 30 years.

The International Longevity Center (ILC) estimates that a minimum of about 1,450 academic geriatricians are necessary to ensure that no student graduates from medical school, regardless of specialty, without receiving education and training in geriatrics. This modest number would be sufficient to place about 10 academic geriatricians at every medical school to prepare the physician workforce for our aging population. However, there are currently less than 600 faculty members who list geriatrics as their medical specialty.

Legislative Action

There are indications that Congress is trying to promote geriatrics training, although progress is slow. On February 13, 2003, Congress provided a dramatic increase in funding for geriatric programs operated by the Health Resources and Services Administration (HRSA). These programs include the Geriatric Education Centers (GECs), Geriatrics Training Fellowships for Physicians, and the Geriatric Academic Career Award (GACA). These programs received \$12.4 million in 2001, but Congress increased funding to \$20.4 million in 2002 and another increase to \$28 million in 2004. The 2004 appropriation specifically provides \$4.7 million for the GACA, which will help promote the development of a cadre of academic geriatricians to be present at every U.S. medical school.

Members of Congress have also introduced legislation calling for financial incentives to encourage more physicians to provide more geriatric care. Currently, physicians who specialize in caring for the elderly spend more time with each patient and see fewer patients but are reimbursed less through Medicare's payment schedules based on the "average patient." The *Geriatric Care Act of 2003*

would authorize Medicare coverage of comprehensive geriatric assessment and care coordination services. Because low Medicare reimbursement also discourages physicians-in-training from entering the geriatric care workforce (Medicare Payment Advisory Committee, 1999), the bill also includes financial incentives designed to attract medical students to the field. Specifically, it would amend title XVIII of the Social Security Act to expand the number of residency slots funded by Medicare. Medicare's graduate medical education program (GME) spends about \$6 billion to support

Table 1 Percentage of Total Visits to Various Medical Specialties Made by People Age 65 or Older, 1981, 1991, 2000

Specialty	Percentage of Total Visits in:		
	1981	1991	2000
All Specialties	18.4	23.2	24.3
General/Family Practice	19.3	19.9	20.4
Internal Medicine	34.4	37.7	39.0
Cardiology	46.1	53.4	59.7
Ophthalmology	39.3	55.0	51.5
Urology	37.6	45.8	53.1
General Surgery	20.4	32.2	30.1
Neurology	17.7	19.9	28.5
Dermatology	13.4	27.9	26.3
Otolaryngology	16.9	17.7	22.3
Orthopedic Surgery	13.7	17.9	20.4
Psychiatry	4.6	7.0	6.6
Obstetrics/Gynecology	2.6	4.5	4.7

Source: National Ambulatory Medical Care Survey

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98,000 residencies each year, yet very little of these funds are used to support the training of geriatricians. In fact, in 1999, there were less than 500 individuals in geriatrics fellowships. Ironically, the federal program that finances healthcare for older Americans spends less than 0.5 percent of its dollars on training physicians to care for elderly.

A Call to Action

To prepare for the coming demographic realities, the U.S. must take immediate steps to reform professional health education, equipping future physicians, nurses, and other health workers with skills in geriatrics. Medical schools must create departments of geriatrics. Nursing programs must introduce geriatrics content into their required curriculum. Students in health professional education programs should have required courses concerning the care for older adults.

However, the nation also must ensure that the *current* workforce of health care professionals develop the necessary knowledge and techniques to address the complexity of delivering care to the older population. The immediate goal should be to provide every health care worker today with some education and training in geriatrics. To reach this goal, we propose these steps:

- **Engage physicians, nurses, and other health care professionals in lifelong training in geriatric medicine.** Academic schools of medicine, nursing, and social work must develop continuing education programs in geriatrics for local professionals. Education programs should be geared to professionals who do not have any training in geriatrics and those who need to maintain existing expertise. Academies and boards that represent specialties should work with universities on course development and encourage their members to take these courses.

- **Mandate a specified number of credits in geriatrics as a condition for license renewal.** This would apply to states with requirements for continuing medical education (CME) for the re-licensing of physicians, nurses, pharmacists, and other health care professionals.

- **Base CME for physicians in geriatrics on new models of practicing-physician education.** Research shows that formal CME conferences are not effective (Oxman, 2002). The Practicing Physician Education

Project funded by the John A. Hartford Foundation and the American Geriatrics Society, found that models using small groups, physician leaders in the community, and interactive case studies were able to initiate changes in physician practice. For example, toolkits on memory loss and incontinence help physicians to improve the way in which they evaluate and treat these conditions (Barry, 2002).

- **Require that state regulators, who oversee nursing homes, assisted living facilities, and home health agencies, provide specialized geriatrics training to their paraprofessional staff.** These workers should develop specific skills related to caring for patients with Alzheimer's disease, physical disabilities, and depression.

- **Congress must reconsider its reimbursement policies under Medicare.** The Medicare payment system rewards procedures, tests, and technology-driven care instead of a more patient-centered form of care. Because geriatricians depend heavily on Medicare by virtue of their patient population, low reimbursement for complex, intensive evaluation and management of conditions reduces incentives for providers to seek certification in geriatric practice. The lack of billing codes for comprehensive geriatric assessment makes it difficult to compensate physicians for the time they spend working on care plans and coordinating geriatric-care teams. Congress should pass the *Geriatric Care Act of 2003* (H.R. 102), which would authorize Medicare coverage of geriatric assessment and care coordination services provided to older adults with a serious or disabling condition.

Despite decades of concern from policy leaders, educators and physicians, geriatrics remains only a small part of American medicine. The first White House Conference on Aging in 1961 noted the small number of trained professionals in the field of aging, and the 1971 Conference reported that most of those providing care to older patients had no formal training in the specific needs of this population. With the baby boom closing in on old age, the American medical community is ill-prepared to meet current and future demands for physicians with geriatrics training. The field of aging needs to actively support policy initiatives that are being proposed to remove obstacles that stand in the way of improvements in geriatric care. We need to take steps now to assure that older Americans, particularly those with complex or

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multiple health conditions, receive the care they need in the decades to come.

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