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On behalf of the
American Geriatrics Society/Louisiana Geriatrics Society

Chairman and Members of the Committee:

Thank you for convening this hearing and for allowing me to testify today on the shortage of geriatricians in the United States. I also want to thank several Committee members – Senators Hutchinson, Lincoln, and Reid -- for their leadership in this important issue.

I am Dr. Charles A. Cefalu, Professor and Director of Geriatric Program Development at the Louisiana State University Health Sciences Center (LSUHSC) in New Orleans, Louisiana.

I am a Board member of the Americans Geriatrics Society (AGS) and an active member of the AGS. I appreciate the opportunity to participate today on behalf of the AGS, an organization of over 6,000 geriatrics and other health care professionals dedicated to the care of older adults as well as the Louisiana Geriatrics Society, a relatively young organization of over 100 geriatric health care professionals.

After a short tenure in rural private practice in Southeast Louisiana, I received my formal Geriatric Medicine training in North Carolina. At that time, geriatrics training was unavailable in Louisiana and it still is today. Since then, I have worked at the LSUHSC to develop a model Geriatric Service and Training Program for medical students, residents, and geriatric medicine fellows to practice in the state. Currently, the program is slated to receive state funding through LSU in New Orleans and the Medical Center of Louisiana. However, as explained later in my testimony, numerous obstacles to the development and success of this program exist. Solutions to these problems are outlined at the end of this testimony.

I applaud the Senate Special Committee on Aging for convening this hearing to highlight the national shortage of geriatrics-trained health professionals. As reports from the Department of Health and Human Services and Institute of Medicine (IOM) have concluded, and my colleagues and I will note today, the need for adequately trained health care providers to identify and manage older persons' health care needs is urgent.

My testimony today will:

Explain the history of geriatric medicine;
Describe the changing needs of our nation's elderly population;
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 geriatricans; and
Suggest recommendations to increase the numbers of geriatrics trained health care professionals in order to improve the quality of health care services provided to our Medicare beneficiaries.

History of Geriatrics

Geriatrics is a relatively new field. Geriatricians are physicians who are experts in caring for older persons and in gerontology, the study of the aging process itself. Medical science has learned a lot about aging and age related disease and how to prevent and manage such disease and associated chronic disability. Unfortunately, research and knowledge in geriatric medicine is not being transferred fully to the health care workforce, both because of the shortage of geriatricians, and the newness of the field.

Geriatric medicine promotes wellness and preventive care, with emphasis on care management and coordination that helps patients maintain functional independence in performing daily activities and improves their overall quality of life. With an interdisciplinary approach to medicine, geriatricians commonly work with a coordinated team of nurses, geriatric psychiatrists, physician assistants, pharmacists, social workers, physical and speech therapists and others. The geriatric team cares for the most complex and frail of the elderly population.

Geriatricians are primary care-oriented physicians who are initially trained in family practice or internal medicine and who are required to complete at least one additional year of fellowship training in geriatrics. Following their training, a geriatrician must pass an exam to be certified and then pass a recertifying exam every 10 years.

The Needs of our Aging Population

Our country is aging rapidly. In 1900, there were 3.1 million Americans age 65 and older, and, today, there are roughly 39 million people. By the end of the next decade, we will see an even more dramatic increase in the growth of the older population, 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 are the fastest growing segment of the entire population, with expected growth from 4 million people today to 19 million by 2050. It is this group – the old, old – who are the heaviest consumers of health care. The implications of this "demographic imperative" are dramatic. We simply are not prepared for the burdens this will place on our health care and financing systems.

In addition to longer life spans among our citizens as a result of public health measures and advances in medicine, the nature of illness is changing. Americans are not dying typically from acute diseases as they did in previous generations. Now chronic diseases such as diabetes and heart disease are the major cause of illness, disability, and death in this country, accounting currently for 75 percent of all deaths and 80 percent of all health resources use. People are now living longer with disabling chronic conditions. On average, by age 75, older adults have between 2 to 3 chronic medical conditions and some have 10 or 12 conditions.

In addition to the special needs associated with chronic illness, older persons in general have unique characteristics that differentiate them from younger populations. But the vast majority of physicians and health care practitioners with older patients have not been trained in geriatrics and the special needs of the elderly because this training has until recently been a low priority for medical schools. As a result, some practitioners may treat an 85-year old patient the same way they would a patient of 50 years – yet there are remarkable differences just as there are between children and middle aged adults.

Thus, special training is needed to evaluate and treat most effectively frail, older persons. 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 differently than younger patients. Indeed, Mr. Chairman, you convened an Aging Committee hearing last year on the marketing of fraudulent aging products to older Americans. Geriatricians are uniquely positioned to help guard against this intolerable practice. All of these situations potentially could translate into suffering by patients, concern from their caregivers and unnecessary costs to Medicare related to inappropriate hospitalizations, multiple visits to specialists who may order conflicting regimens of treatment and needless nursing home admissions.

Training in geriatric medicine can help save or improve the lives of people who still have much to give by providing health care professionals with the skills and knowledge necessary to recognize special health characteristics of older patients and distinguish disease states from the normal physiological changes associated with aging. Geriatricians focus on maintaining and improving functional status, providing early intervention and continuity of care, identifying and managing co-morbidities, fostering optimal outcomes, and maximizing patient comfort and dignity. Because of this, geriatricians are also better able to assist in developing cost-effective strategies to enhance the quality of life for older people and for their caregivers. Geriatricians possess the skills needed to help health care institutions and other providers of services to best meet the growing needs of this segment of our population.

Although nearly all practitioners will be called on to deliver care to the majority of the elderly, many experts agree that a sufficiently large core of geriatricians will be needed to provide care for the roughly 10 percent of the elderly who are the oldest, most frail, and most likely to have functional limitations. Geriatricians also will need to advise and train the physicians and other health care practitioners who have had little or no geriatric training but who treat large numbers of elderly patients. Such programs have been recently initiated; the need for additional programs is considerable.

The following problems must be solved if we are going to cope effectively with the aging of our population.

1. Shortage of geriatricians – physicians who specialize in caring for older adults. 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 to function as:

- Academic Geriatricians. Increases in geriatricians in medical schools are essential to train geriatricians and other primary care and specialist physicians to diagnose and treat problems common in older persons. They are also needed to lead clinical research activities in developing new and better treatments and prevention for the diseases that affect this population. Unfortunately, the situation for geriatricians in academic settings is getting worse. Geriatricians are busy clinically, in part because caring for the elderly is labor intensive and time consuming. This translates into less time dedicated to their teaching and research.

- Clinicians. Geriatricians are needed as consultants to other generalist physicians and to serve as direct primary care providers to the most frail, chronically ill, and functionally impaired Medicare beneficiaries. Trained geriatricians can be effective primary care providers for frail older persons with functional and chronic health care problems. For these patients, geriatricians are often able to manage their care in the least resource intensive settings such as in a patient's house, obviating the need for more costly hospitalizations and nursing home placements.

Here at home, Louisiana has one of the most critical shortages of geriatricians in the nation. Figures for 2000 indicate that only about 44 physicians in Louisiana held certification in Geriatric Medicine. Furthermore, neither the LSU School of Medicine in New Orleans or Shreveport has an established accredited geriatric medicine fellowship program. Physicians interested in seeking formal training must leave the state for their training and very often never return because of the tremendous numbers of opportunities elsewhere. As discussed later in this testimony, one of the major obstacles to development of a Louisiana training program is the Medicare GME cap imposed on hospitals for purposes of training slots.

Ensuring that more geriatricians are trained is especially critical in view of the rapidly aging population. In Louisiana, the U.S. Census Bureau projects that from 1993 to 2020 the number of people age 65 years or older will increase by 50% to 75%.

2. Lack of training in schools for all professionals: All health care professionals – physicians and non-physician providers – need adequate training in geriatrics. As our population ages, almost all health care professionals, except those caring for children and pregnant women, will be caring for growing numbers of older people.

However, medical and other professional schools have just recently begun to teach geriatrics. Thus, current levels of training are inadequate to prepare the country to care for the exploding numbers of older persons. This lack of training has been documented by many studies, including those sponsored by the Institute of Medicine and the Department of Health and Human Services. For example, a 1998-1999 study found that more than 40 percent of medical students felt that their medical school's geriatric medicine curriculum time was inadequate.

Major 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, given their patient caseload. The Institute of Medicine and a recent MedPAC report identified low Medicare reimbursement levels as a major reason for inadequate recruitment into geriatrics. In short, because of the complexity of care needed and the time required to deliver quality care, Medicare currently provides a disincentive for physicians to care for Medicare beneficiaries who are frail and chronically ill.

First, the physician payment system does not provide coverage for the cornerstone of geriatric

care -- assessments and the coordination and management of care --except in limited circumstances, and does not support an interdisciplinary team of health care professionals. Care management includes services such as telephone consultations with family members, medication management, and patient self management services. Geriatricians spend considerably more time performing care management services than other providers.

Second, the Medicare physician reimbursement system bases payment levels on the time and effort required to see an "average" patient, and assumes that a physician's caseload will average out with patients who require longer to be seen and patients who require shorter times to be seen 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; the average age of the patient caseload is often over age 80.

These patients not only have a greater number of chronic medical conditions than younger patients but also have impairments of hearing, vision, and function that increase both the time and effort required for their care. A "typical" frail, elderly patient cannot fill out forms for the office staff, requires assistance to get to the exam room, needs help with disrobing, requires assistance to climb up on the exam table, cannot hear the physician ask questions, and sometimes cannot understand the physician's instructions. These patients are more time consuming and require more costly care. As a result, a geriatrician typically has fewer patients in his/her practice, provides fewer visits than other primary care physicians and, thus, has lower revenue.

This is particularly problematic for health care facilities in Louisiana such as the Medical Center of Louisiana that is affiliated with Tulane and the LSU School of Medicine, which primarily serves a huge indigent elderly patient population.

Further exacerbating inadequate payments is the 2002 Medicare fee decrease of 5.4% imposed on all Medicare providers. This accounts for the largest physician fee decrease since the Medicare fee schedule was implemented a decade ago.

Clearly, long-term Medicare reimbursement problems have resulted in increasing difficulty in managing and maintaining a geriatric practice. The AGS has collected several stories about geriatricians who left or are leaving private practice because of the inability to run a self-sustaining practice. I will submit our collection for the record but a few of the stories are worth describing here.

One case study is from a physician in Alabama. He's chosen to discontinue care of any nursing home patients (a problem growing increasingly familiar in the United States) and to limit the number of Medicare patients he accepts because of ongoing inadequate Medicare reimbursement and new payment policies.

Another case study is from a fellowship trained geriatrician in Oregon; he is quoted directly below. "My experience with private practice was that it was not financially viable. It was very popular with patients. I had a 2 month waiting list for new patient appointments. However, I was specializing in medicine at a substantial discount. When the (local) Health System purchased my practice, within a year they were advising me that I needed to either double the number of

patients I saw, or take a cut in pay. They hired a consultant to come in and talk with all the doctors about their pay issues. When I explained to the consultant what a geriatrician was and the impact of that on my practice volume, the advice of the consultant to me was to abandon geriatric medicine and represent myself as a general internist."

Another important cause for insufficient recruitment into geriatrics is the system disincentive in Medicare graduate medical education (GME) payments included in the Balanced Budget Act. The limit for hospitals on the number of hospital trainees eligible to receive Medicare GME funds means that newer training fields, such as geriatrics, are unable to get GME support, even for physicians who want to get grained in geriatrics. When given a choice, hospital administrators are more likely to opt to fund training positions for a trainee that generates more revenue than a geriatrician.

Finally, as a new specialty struggling to survive in an era of tight budgets and federally mandated training limits, geriatrics cannot grow in the same manner as other longstanding, well-developed, and more highly compensated specialties.

Recommendations to Increase the Number of Geriatrics Trained Health Professionals

Through Medicare, Medicaid and the Department of Veterans Affairs (VA) medical system, the Federal Government is financing the vast majority of health care services to older Americans. 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.

Thus, we urge Congress to consider the following options:

- Provide for an exception to the overall GME cap for geriatricians. The 1997 Balanced Budget Act instituted a per-hospital overall cap on the number of GME slots that will be supported by the Medicare program. The Geriatric Care Act, S. 775, introduced this year by Senators Lincoln (D-AR) and Reid (D-NV), would provide for a limited exception of 3 geriatrics trainees per hospital under the cap. The Advancement in Geriatric Education Act, S. 1362, introduced by Senator Hutchinson (R-AR) and Senator Craig (R-ID), Ranking Minority Member, would provide for a limited exception of 5 geriatrics trainees per hospital under the cap

- Provide for two years of GME funding for fellowship programs, and allow for the maximum of GME funding under the geriatrics GME exception. In short, continue to allow programs training geriatric fellows to receive full funding for an additional period of two years of fellowship training as allowed under current statute. Only in this way can the number of teachers and researchers in geriatrics be increased significantly. S. 1362 would reinstate this practice.

- Institute loan repayments for fellows in geriatric medicine. S. 1630, introduced last Congress by Senators Reid and former Chairman of the Aging Committee Senator Grassley (R-IA), would forgive $20,000 of educational debt incurred by some medical

students who go on to become geriatrics fellows. Physicians who have an interest in pursuing geriatric fellowships are often discouraged because of their large education debt and the relatively low compensation after training. Senator Reid plans to reintroduce this measure shortly.

- Provide adequate funding for Title VII geriatrics programs. Title VII provides for three types of geriatric health profession's programs: geriatric academic development awards, geriatric education centers, and primary care training programs that emphasize geriatric curriculum. The fiscal year (FY) 2003 budget did not fund these programs. However, Congress dramatically increased the funding level for this program in FY 2002 from $12 million to 20 million.

Congress should fund these programs again this year at $30 million as recommended by the Health Professions and Nursing Education Coalition (HPNEC) and continue to increase appropriation levels. In prior years, Senator Reed (D-RI) has led the effort in the Senate to maintain financing for this important program.

- Maintain and expand the geriatrics academic development award authorization. This program creates junior faculty awards and has received tremendous commendations from current recipients. The community based linkages section of Title VII of the Public Health Service Act authorizes this program. S. 1362 would expand the current number of GACA awards and make technical changes to the existing program. It would also increase the authorization level for all three geriatric health profession's programs: GACA awards, the geriatric education center program, and geriatric primary care fellowship programs.

- Revise the current Medicare payment system to promote care management services for chronically ill beneficiaries. The geriatrician shortage will continue until the Medicare fee schedule is updated. The fee-for-service system must be revised to allow the physician of frail, chronically ill patients to provide geriatric assessment and coordination and management services, often by using an interdisciplinary team. Revamping the fee schedule may help attract physicians and other appropriate non-physician professionals to a career in geriatrics. S. 775 would provide for Medicare reimbursement for these services.

- Revise the Medicare fee schedule to adequately compensate for high cost, complex Medicare patients. The Medicare payment system should compensate physician and appropriate non-physician providers who spend extra time with frail, older, functionally impaired patients whose care is often time consuming and complex. S. 1589, the Medicare Chronic Care Improvement Act, introduced by Senator Rockefeller (D-WV), includes a provision to develop such a payment update.

- Institute incentives for medical schools, as well as professional schools, to incorporate geriatrics into training programs. All health care professional schools, at all levels, must immediately incorporate and highlight geriatrics into their curricula.

- Immediately halt the Medicare physician fee schedule 5.4% payment decrease. Senators Breaux (D-LA) and Jeffords (I-VT) have introduced S. 1707, the Medicare Physician Payment Fairness Act, which would accomplish this goal.

We would like to work with this Committee and the Congress to legislate these important changes. Changes such as these should be considered as the Congress debates how to modernize the Medicare system. Failure to act in this area is likely to result in diminishing quality care for frail, older persons and, potentially, the decline of the geriatrics profession.