Caring for an Aging America: Are We Prepared?

Older age is the time of life when we are most likely to need high-quality medical care. It's also when we are least likely to get it.

BY SALLY POBOJEWSKI

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Gabriel Solomon, M.D., sits in front of a computer in the Turner Geriatric Clinic staff room scanning medical records for patients he'll see this afternoon. There's been a last-minute addition to his schedule — a retired teacher who often shows up at the U-M Geriatrics Center without an appointment. When Mrs. Smith (not her real name) wants to see a doctor, she comes to the Geriatrics Center, because she says other doctors just see her for a few minutes and then say everything's normal.

Mrs. Smith came to the clinic today because she's worried about a swollen, painful knee that makes it hard for her to walk and do housework. She also wants to know if she should keep using an inhaler (prescribed by another physician) and whether she should switch her Medicare Part D insurance to Blue Cross Blue Shield.

Solomon is unfazed. A soft-spoken father of two and former social worker at a homeless shelter, Solomon has lots of patience and never seems to be in a hurry. He listens carefully and answers every question. Not only does he give Mrs. Smith verbal instructions; he writes everything down, and arranges to have a Turner Clinic social worker call to answer her insurance question.

A graduate of Wayne State University Medical School, Solomon is one of six physicians in the U-M's geriatric medicine fellowship training program. One of the first of its kind in the country, the program provides specialized training for physicians who want to become geriatricians — doctors who specialize in geriatric medicine. After a three-year residency in either internal or family medicine, fellows spend one or two years conducting research and working with elderly patients at Geriatrics Center clinics, University Hospital and area nursing homes.

After examining Mrs. Smith's knee, Solomon brings in his attending physician, Jocelyn Wiggins, an assistant professor of internal medicine who received her medical degree in her native England. Wiggins is a warm, outgoing woman who completed a U-M geriatric medicine fellowship in 1997. Wiggins tells Mrs. Smith to stop the inhaler, reassures her it's OK to take Tylenol every day for her knee pain, and reminds her how important it is to take her daily blood pressure medication.

After Mrs. Smith, Solomon moves on to his next patient. This time, it's Mrs. Jones (also not her real name), a woman with advanced dementia who arrives with her daughter for a check-up. Multiple strokes have destroyed her ability to speak or understand, but she greets Solomon with a radiant smile and a hearty punch in the arm.

"She seems happy," Solomon says with a grin, as he checks her blood pressure.

As he does with every patient, Solomon makes it a point to ask if the family has a problem paying for Mrs. Jones' medicine. He works with a Turner Clinic pharmacist to help patients cut costs by switching to generics or, whenever possible, stopping some medications.

"A lot of geriatrics is just trying to simplify a patient's complex medication regimen," Solomon says. It not only saves money and improves compliance, it also reduces the risk of adverse drug interactions, which can be a big problem for seniors whose bodies don't process drugs as efficiently as younger people.

Mrs. Jones' daughter mentions that her mother has had several episodes of decreased responsiveness lasting 20 or 30 minutes. After these episodes she seems fine. Solomon thinks seizures might be a possibility. The question is what's causing them and how aggressively should they be treated.

Solomon and Wiggins don't want to prescribe an expensive, anti-seizure medication that has side effects without knowing what's causing the problem, but Mrs. Jones doesn't have much tolerance for diagnostic tests. It's a fight just to get blood drawn and lying still for an EEG or brain scan is out of the question.

After much discussion, everyone agrees to wait and see if the seizures continue. In geriatric medicine, less is often more.

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Retooling health care

Living to a ripe old age has its rewards, but it also comes with a price. The older we get, the more likely we are to get sick. Nearly 80 percent of Americans age 65 and older have at least one chronic medical condition such as arthritis, diabetes, hypertension, Alzheimer's or heart disease, and 20 percent have three or more.

Older patients' medical needs often are overlooked or ignored by a health care system that emphasizes efficiency and cost containment. When you have more than one chronic disease, it's difficult to cover everything in a 15-minute office visit. If you have trouble hearing or remembering, it's easy to be confused by changes in your medication schedule. And for older people who live alone, recovering from surgery or an injury can be a daunting challenge.

According to a 2008 Institute of Medicine report, "Retooling for an Aging America," our current health care system doesn't work well for many older people, especially those with multiple chronic diseases and the very oldest — frail patients over age 85.

A major part of the problem is a shortage of physicians, nurses, social workers and other health care providers who have been trained to handle the complex medical, economic and social problems that often accompany aging.

With life expectancies increasing and 78 million baby boomers moving into their senior years, experts say the problem will only get worse, unless we find better ways to keep older Americans healthier longer and manage their medical care more effectively.

Gabe Solomon likes being around older people. "They're fun to talk to and always have interesting stories to tell," he says. "They are more realistic about limitations on what we can do than younger patients, and realize that quality of life is more important than anything else."

Unfortunately for the American health care system, there were only 7,128 certified geriatricians working in the United States in 2007, according to the IOM report — compared, for example, to 12,024 gastroenterologists. Most major medical schools offer geriatric training programs, but they can't find enough physicians to fill them. Solomon completed his internal medicine residency along with 29 others at the U-M, but he was the only one who chose to specialize in geriatrics.

The shortage of geriatricians is part of a 20-year decline in all fields of primary care, says Jeffrey Halter, M.D., a professor of internal medicine and director of the U-M Geriatrics Center and Institute of Gerontology. Several factors — including low salaries, social attitudes toward aging and the complexity of the work — make it difficult to attract new physicians to a career in geriatric medicine.

"I think we are doing a much better job of teaching our students the value of older people to society and the importance of doing a good job of taking care of them," Halter says. "But there are stereotypes out there, in part because treating older people can be a little more challenging."

"There is a small stigma attached to working with older people," agrees Solomon, after pausing to think about his answer. "Some people think geriatric patients complain and are difficult to work with. I think it's that people just don't know how to deal with all the problems that come with aging. There are so many medical issues, and Medicare won't reimburse you for the time it takes to deal with them."

When it comes to geriatric medicine, Medicare is the 800-pound gorilla in the room. The $480-billion federal health insurance program covers part of the costs of medical care for Americans over age 65, as well as younger people with certain medical conditions. Because it determines which procedures, tests and services will be covered by insurance, Medicare has a major influence on how geriatric medicine is delivered in the United States.

Medicare and most private insurance plans reimburse individual health care providers for specific services provided. Individual hospitals and physicians receive a flat fee for each procedure, hospitalization or office visit. The problem is that geriatric medicine requires a team-based approach to health care — an approach that isn't covered under the current Medicare system — and many of the services geriatricians provide fall in the category of uncompensated care.

As a result, the IOM report indicates that geriatricians' salaries tend to be lower than those of other primary care providers, even though geriatricians are required to complete one year of additional training. The inability to see more patients because of longer individual appointment times, hours spent coordinating care and counseling family members, and consultation time in team-based health care delivery all reduce a geriatrician's earning power.

"You can earn three times the salary if you become a specialist like a dermatologist, cardiologist or gastroenterologist," says Halter. Many new physicians who graduate from medical school with huge student loans to repay can't afford to make the financial sacrifice.

But Halter says money isn't the only factor responsible for the shortage of geriatricians. Geriatric medicine as a sub-specialty is inherently more complicated than other types of primary care, because elderly patients often have several long-standing medical conditions. Treating one disease can make the others worse.

"If I'm a nephrologist, I can focus on the kidney and spend all my time thinking about the kidney," Halter explains. "But in an older person, kidney disease is different. It's kidney disease in someone who also has diabetes and heart disease."

Since no one can know everything about every disease, geriatricians are more likely to need help from specialists in other disciplines. According to Halter, the team-oriented approach in geriatric medicine makes some physicians uncomfortable. "We're not trained in medical school to ask for help," he says.

"Team care is very important in geriatric medicine," says Robert Hogikyan, M.D., an associate professor of internal medicine and program director for the geriatric medicine fellowship. He says U-M's geriatric medicine fellows learn to work closely with nurse practitioners, physician assistants, direct care workers and administrators and medical directors of nursing homes.

Then there's the issue of cure vs. care. Most diseases of old age cannot be cured; although they often can be managed and sometimes even prevented. Physicians who get their greatest satisfaction from curing patients are unlikely to choose geriatric medicine.

"You are not going to have quick, easy fixes," says Hogikyan. "You assist patients in making small gains — the focus being on quality of life."

Needed: more training, clinical guidelines

Like most medical schools, the U-M has incorporated geriatrics into its curriculum and residency programs for general medicine and family practice physicians. If all physicians receive training in geriatrics, is additional specialized training really necessary to treat older patients? U-M geriatricians respond to this question with an emphatic "yes."

Treating elderly patients means dealing with issues that aren't covered well in standard general medicine training. Challenges like physical and mental changes that affect an older person's ability to function independently, behavioral problems associated with Alzheimer's disease, depression and anxiety — all of which are common in older people.

Geriatricians also are more likely to deal with financial and family issues than other physicians. Even with Medicare, older people have high out-of-pocket costs for health care, especially for prescription drugs. Nearly half of all Medicare beneficiaries have annual incomes below $20,800 for individuals and $28,000 for couples, so they often can't afford the medications they need to stay healthy.

Unlike physicians who treat younger adults, geriatricians usually don't have the benefit of established clinical care guidelines to determine what treatment works best. In many cases, studies to determine the best way to treat older patients with multiple diseases have not been done. And guidelines developed for younger patients with diabetes, for example, may not be applicable to older patients with diabetes and heart disease.

"Currently, there are few quality of care indicators that specifically address common clinical problems in people over 75," explains Caroline Blaum, M.D., a U-M geriatrician and associate professor of internal medicine. Blaum works with several national organizations, such as the American Geriatrics Society and the American Medical Association Physician Consortium for Quality Improvement, to develop evidence-based medicine guidelines to help geriatricians treat their elderly patients more effectively.

"Quality measures are disease-specific. They evaluate treatment for one disease at a time," she says. "Guidelines are determined based on results from controlled clinical studies, which generally are open to patients with just one disease and exclude anyone over age 75."

Blaum directs the Health System's Medicare Demonstration Project, which focuses on how physicians and hospitals can provide quality care for Medicare patients while reducing costs. One of the most successful aspects of the project involves managing transitional care — creating a systemized way to follow up with patients after discharge from the hospital to their home or to a nursing home. Elderly patients who had a follow-up appointment within one week after discharge were less likely to show up in the emergency room and need repeat hospitalizations.

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Blaum says the two important things we can do to improve the quality of care for older Americans is first, start reimbursing health care institutions and physicians for the additional costs of providing team-based care, and second, train more professionals in geriatric medicine.

Hogikyan emphasizes the importance of providing more geriatrics training for internal medicine specialists and family practitioners. He doubts that U.S. medical schools will be able to supply large numbers of geriatricians in the future. "My sense is that geriatricians will focus on patients with multiple, complex co-morbidities," he says. "Primary care physicians will need to be more skilled at working with most older adults."

While experts may differ on the best way to improve medical care for America's rapidly aging population, everyone agrees that it will require fundamental changes in how our society provides and pays for health care. The question is can we afford it?

Jeff Halter doesn't have much patience with this question.

"We're the richest country in the world and we can't afford to do this?" he asks incredulously. "It seems to me that thoughtful people ought to be able to figure out how to provide good quality health care for everyone in America. So we don't have to send our older people packing off to the wilderness when they hit 75, and say goodbye and good luck." [M]

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