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Policy for an Aging Society

A Review of Systems

Christine K. Cassel, MD

MEDICAL STUDENTS AND RESIDENTS ARE TAUGHT to perform a complete review of systems in a thorough patient workup. Through this process, patients may report less prominent concerns that may be meaningful to the physician's evaluation. As a complement to the new series, *Care of the Aging Patient: From Evidence to Action*, in this issue of *JAMA*, a Commentary will provide a forum for discussion of a policy review of systems for the care of older adults.

In the first article, Reuben¹ brings into sharp relief the need for greater expertise and new approaches to caring for older patients as they face physical decline and advanced illness. Using the case of Mr Z, Reuben examines the patient-care encounter and the analytical and interpersonal processes that the physician must undertake. For most US physicians, both specialists and generalists, this story is likely unfamiliar, and physicians may hardly be able to imagine themselves or colleagues conducting the kind of extensive evaluation described. Patients would flock to this comprehensive yet individualized care.

Although this approach is at the core of training in geriatric medicine, such specialists are rare, and fewer students are seeking careers in geriatrics or primary care. In each year from 2007 to 2009 fewer than 100 US medical graduates pursued postdoctoral training in geriatrics.² The crisis represented by this shortage is made clear by imagining an alternate scenario: usual care rather than best case.

In the usual care scenario, Mr Z would have been considered a healthy older man. His falls would not have been explored and his concerns would have been referred to specialists. He ultimately could have sustained a major fracture, requiring surgical intervention. During that hospitalization, he most likely would have become weak and had iatrogenic complications, such that even a very prolonged rehabilitation would not return him to his prior function. During this time, someone most likely would have discovered that his wife at home had Alzheimer disease and was unable to care for herself. Hopefully, a capable social worker would have helped husband and wife to be admitted to the same long-term care facility, but they might have been sepa-

rated since he would be in rehabilitation and she in custodial care. Their complex health care could lead not only to poor patient care but to costly overuse of technologies^{3,4} and most importantly loss of the function, dignity, and personal values they would have chosen.

Reuben's careful analysis suggests that anticipating and addressing patients' evolving short-term, midterm, and long-term issues provides better care in all metrics: quality, fewer errors, and reduced overuse of health care services. Everyone is better off. Why don't patients have more access to this kind of care and what will it take to provide it?

The 6 characteristics of optimal quality of care for a patient facing frailty are: (1) extensive knowledge of the aging process, of prognostic indicators, and the multiple geriatrics syndromes; (2) proactive and anticipatory care that is longitudinal; (3) a well-functioning practice structure with a multidisciplinary team or network, in which care is coordinated efficiently and effectively and linked to community resources; (4) personal interaction with the relationship grounded in good communication skills and a clear sense of the patient's values, goals, and preferences; (5) practices that manage care across diverse settings to ensure safe transitions and continuity; and (6) health care institutions, especially hospitals, that incorporate acute care of the elderly units, early mobilization, careful attention to drug interactions, and other best practices to reduce the grave risk they currently pose to frail, older individuals.

Several current US policy initiatives may have the potential to improve the situation.

First, workforce support for primary care should always include explicit attention to geriatric medicine. Most geriatric specialists begin postgraduate training in family medicine or general internal medicine, the 2 largest and most-threatened primary care specialties. Geriatric medicine is at even greater risk—less widely sought than primary care. As initiatives to reallocate residency positions under the graduate medical education (GME) limits are considered,^{5,6} geriatric medicine should be foremost on that list—a core discipline for Medicare and Medicare GME payment priorities. Incentives such as loan forgiveness or repayment may help bridge the gap until effective payment reform occurs.

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See also pp 2686 and 2703.

Second, for all Medicare-supported training, Medicare could require core content in geriatrics related to every specialty. Medicare is beginning to evaluate how to make public money and the public good it supports in medical training accountable for the products of that training.⁷

Third, payment reform and incentives should be developed to promote geriatrics careers and best practices. Innovative approaches to physician prepayment or salary models should be strengthened within Medicare—especially those that link Medicare and Medicaid across hospital, nursing home, and home care patients. The acute care of the elderly program shows that comprehensive payment approaches allow clinicians and interdisciplinary teams to achieve better outcomes at less cost.⁸ In the private sector, the “concierge model” demonstrates the feasibility of paying a monthly fee to a physician for responsibility and accountability for coordinating care of the patient. A similar model could be tested in Medicare—a modest “retainer” to physicians willing to assume responsibility for managing and coordinating a patient’s care. This model may emerge through the Centers for Medicare & Medicaid Services–sponsored patient-centered medical home demonstration program.⁹ If so, specific parameters outlined by the geriatric evaluations described by Reuben¹ would allow meaningful risk adjustment and focus on the medical home for the patients whose illness complexity and frailty risk require more intensive coordination of services. The expertise of geriatric medicine should be available to every “medical home.”

Moreover, current proposals to reduce or eliminate payments for hospital readmission in Medicare could stimulate the development of acute care for the elderly units, but these patients are not always readmitted; they may lose function and require home care or nursing home care. Linking hospitals and nursing homes more closely would create greater accountability for the transitions and interactions among multiple sites of care.

In addition to innovative new care delivery and payment models, geriatricians and geriatrics-trained primary care physicians need to be compensated commensurate with their subspecialty training and in parity with other specialties to draw students to these specialties.

Fourth, expanded support of comparative effectiveness research should reflect the magnitude of Medicare expenditures. The emphasis on comparative effectiveness research evidenced by the Institute of Medicine’s report⁴ could advance health policy for the geriatric population. A critical missing piece in the evidence base is the application of any medical procedure or even a clinical guideline or quality measure for patients in their 80s and 90s. Pay-for-reporting (or for-performance) programs, such as the Centers for Medicare & Medicaid Services’ physician quality reporting initiative, should not be based on data that only apply to a small number of atypical Medicare patients. Comparative effectiveness research can provide greater advances for new forms of value-based purchasing.

Fifth, full integration of health information technology should be adopted in geriatric care. The US government could call for ways to define *meaningful use*, the legislated criterion for incentive payments related to electronic medical record adoption that improve care for older patients, given the significant investment being made and the urgent need to improve care in this area. For example, health information technology might facilitate clinical practice such as prognostication and provision of appropriate evaluation tools (Table 1, Reuben¹) or documentation of advance directives in real time on the desktop. Policy makers also need to support local efforts to develop and implement physician orders for life-sustaining treatment (POLST).¹⁰ This should include requiring medical record sharing among specialists and acute and long-term care facilities. At least 13 states currently allow orders to withhold life-sustaining treatment when requested by patients to be transferred from nursing home to emergency medical technicians, emergency departments, or hospitals.

This moment presents an extraordinary opportunity for the United States to redesign Medicare and Medicaid to truly reflect the most efficient and effective care for the patients for whom it is most important. These patients are the invisible consumers in the US health care system. It is time to build a system of personalized care based on evidence that works for the legions of patients like Mr Z, so that patients and health care teams can together develop care plans that incorporate not only medical conditions but respect the patient’s desire to remain able to care for a spouse or partner, reduce the risk of injury, optimize function, and maintain independence and dignity as long as possible.

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