

The following written testimony is on behalf of the American Geriatrics Society (AGS), an organization representing geriatricians and other health care professionals dedicated to the care of older adults.

Brief History of Geriatrics

Geriatric medicine promotes 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 other providers such as nurses, pharmacists, social workers, 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, since 1994, 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. There are almost 7,000 geriatricians in the United States.

The Frail Elderly/Chronically Ill Population

Americans are not dying typically from acute diseases as they did in previous generations. The Partnership for Solutions, a Robert Wood Johnson founded initiative of which we are a partner, has found that about 78% of the Medicare population has at least one chronic condition while almost 63% have two or more. Of this group with two or more conditions, almost one-third (20% of the total Medicare population) has five or more chronic conditions, or co-morbidities.

In general, the prevalence of chronic conditions increases with age – 74% of the 65 to 69 year old group have a least one chronic condition, while 86% of the 85 years and older group have at least one chronic condition. Similarly, just 14% of the 65-69 year olds have five or more chronic conditions, but 28% of the 85 years and older group have five or more.

Medicare Reform and the Geriatric Patient: How Does Disease Management Differ from Geriatric Care?

The Medicare program has recently undergone major reforms: the addition of outpatient prescription drug coverage and disease management. Will these new changes address the problems faced by frail older persons and the physicians who treat them?

Little is being done to change the nature of the system from acute episode care to sustained chronic care. As today's hearing notes, the Medicare bill included several new chronic care provisions, including a new study on chronic care, a small scale physician-oriented demonstration

program, and, of relevance today, a larger scale disease management pilot program. Unfortunately, the new disease management program may not adequately address the needs of persons with multiple chronic conditions.

The new disease management pilot program establishes chronic care improvement organizations (CCIOs) under the Medicare fee-for-service program. CCIOs, which may include disease management organizations, health insurers and integrated delivery systems, will be required to improve clinical quality and beneficiary satisfaction and achieve spending targets in Medicare for beneficiaries with certain chronic conditions. CCIOs will be held at full risk for their role in helping beneficiaries manage their health through decision-support tools and the development of a clinical database to track beneficiary health.

Why aren't disease management programs sufficient to transform the system of care for frail older persons?

Disease management covers many different activities influencing individual health status and the use of health care services. Typically, disease management programs treat patients with specific, clearly-defined diseases, such as diabetes, asthma, congestive heart failure or chronic obstructive pulmonary disease where the evidence is clear and management strategies are straightforward. Disease management focuses on patient education and evidence-based self-management strategies as tools to improve care. Disease management relies on improved disease outcomes to improve health and reduce disease-specific health care utilization. Patients who are the best candidates for disease management programs are those who have the motivation and cognitive skills to appreciate their role in illness management and implement self-management strategies.

Geriatric care is another term for coordinated care or care management. Care coordination programs generally enroll patients with multiple chronic conditions. The combinations of conditions puts the patients at high risk of medical and social complications that requires specific interventions tailored to the specific needs of each enrollee. These interventions include an array of services, such as telephone coordination with other physicians, extensive family caregiver support, referrals for social supports, and high levels of medication management.

While disease management is appropriate for certain Medicare beneficiaries with a single chronic condition, such as diabetes, asthma or hypertension, it fails to address key issues for patients that have multiple chronic illnesses and/or dementia. This issue is further explored below.

First, disease management is not typically appropriate for persons with more than one chronic condition. Imagine putting a patient with diabetes, hypertension, dementia, asthma, and COPD into a disease management program for each of these conditions. Most of the people who are most costly to Medicare have multiple conditions and the care for these people can not be segmented into different disease management programs. In fact, many of these individuals with one or more chronic conditions also have Alzheimer's disease or another dementia. Disease management focusing on diabetes without taking dementia into account wouldn't be successful. While some disease management companies suggest that they have taken a new holistic approach to patient care, this evidence remains anecdotal.

Second, when used for patients with multiple co-morbidities, disease management can disrupt a patient's critical relationship with a primary care physician. Some disease management programs utilize specialists that focus only on specific interventions tailored to one condition. The nature of chronic illness requires a comprehensive, care coordination based approach that utilizes a variety of interventions. Disease management programs that lack a physician component do little

to coordinate the care of older persons with multiple illnesses and little to mitigate the safety hazards of fragmented, redundant care delivered by multiple providers. Significantly, a recent, large-scale Mathematica best practices study noted that maintaining and fostering the physician-patient relationship is critical to the success of chronic care delivery.

Third, a major component of disease management involves self-management and patient education. These simply do not work for persons with Alzheimer's disease or a related dementia. Diabetes self management often involves patient education or patient self management which is inappropriate for a beneficiary with Alzheimer's disease or related dementia. Likewise, disease management for asthma and hypertension depends on patient compliance with treatment recommendations; this would not be effective for persons with Alzheimer's disease or related dementia. In comparison, care coordination models rely on engaging family and caregivers and maximizing their involvement.

Fourth, disease management does not always address functional issues that are common in old age or the complications that arise from multiple chronic illnesses.

Fifth, treatment guidelines provide little guidance when multiple chronic illnesses co-exist. Therapeutic decisions are less straightforward, making treatment decisions less amenable to algorithmic self-management protocols.

Finally, disease management programs place little importance on using social support services, a major component of a care coordination approach which relies on a holistic model of patient care.

Additional physician participation and attention to the needs of multiple chronic conditions and especially dementia could improve project outcomes, but the model remains different from the approach of a new fee-for-service care coordination benefit.

Instead, the AGS recommends the legislative authorization of a new Medicare fee-for-service chronic care benefit, which would include a physician assessment and team based care management benefit. This is based on the Geriatric Care Act, legislation introduced in the House by Congressman Gene Green (D-TX) and in the Senate by Senator Blanche Lincoln (D-AR) and the Medicare Chronic Care Improvement Act, legislation introduced in the House by Congressman Pete Stark (D-CA) and in the Senate by Senator John D. Rockefeller IV (D-WVA).

Conclusion

While the introduction of the CCIO program represents a modest step forward in the delivery of chronic care, we remain convinced that a significant portion of our nation's needs will remain unmet without the addition of a related but different physician directed chronic care benefit within the fee-for-service system. We hope to work with the Subcommittee on Health on such a change.