Advancing Geriatrics Research, Education, and Practice: Policy Challenges After the Great Recession

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The series of articles in this JGIM issue provides a number of policy-relevant recommendations for advancing geriatrics research, education and practice. Despite the unprecedented pressure to reduce state and federal spending, policymakers must concurrently address the challenges of a growing population of older individuals with increasingly complex health care problems. Thus, there may be opportunities to advance this agenda in creative ways. For example, without new spending, federal research agencies can make changes to encourage needed new directions in aging research, and the ACA provides new funding opportunities such as the Patient Centered Outcomes Research Institute. States and the federal government have an increasing need for the health professions workforce to have collaborative care skills and geriatrics clinical competencies, and are finding ways to invest in relevant initiatives. On the clinical program side, state and federal governments are initiating programs to promote delivery system changes that improve the care of older adults. Nonetheless, in the face of the policy challenges that have persisted after the “great recession,” academic geriatrics and general internal medicine will need to join forces with public and private interests to secure the resources needed to advance this ambitious agenda for geriatrics research, education and practice.

KEY WORDS: geriatrics; health policy; medical education; health care delivery.

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INTRODUCTION

This series of articles is published at a time of unprecedented challenge to public funding of state and federal programs, especially funding for health care-related research and training. As readers are painfully aware, the “Great Recession” has been associated with very large deficits in the annual federal budget. While the appropriate timing and approach to controlling growth in federal government debt is subject to intense debate, the reality is that increased investments of public funds in new initiatives will be more challenging now than at any other time in the past 40 years.

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Nonetheless, policymakers are also aware of the social implications of the aging US population. As has been widely noted, “an average of 10,000 baby boomers will turn 65 every day for the next 20 years,” leading to an eventual doubling in Medicare program enrollment.¹ Since this population has the highest prevalence of chronic illness and highest per capita health care spending, effective and efficient care of these older adults is seen as critical to controlling future federal spending.² Furthermore, despite advances in health care interventions, the burden of multiple chronic conditions in this population is increasing and anticipated to continue for years to come.³

Important health care and public policy challenges are imposed by this growth in the number of older individuals and in the complexity of their health care problems. Accordingly, these articles identify an ambitious set of research opportunities, health professional training needs and clinical initiatives. We place this agenda in the context of the current public policy climate and offer a pathway for how these important initiatives can be advanced during a time of government austerity.

A GERIATRICS RESEARCH, EDUCATION AND PRACTICE POLICY AGENDA

In Table 1, we summarize the recommendations gleaned from these articles that have implications for state or federal policy. For example, Lindquist et al. discuss a number of policy solutions to encourage aging relevant research such as adding older adults to the list of mandatory reporting populations for federal research grants.⁴ Dr. Wald and colleagues offer an aging-focused research agenda with overlapping interests for general medicine, hospitalists and geriatricians.⁵ Chang et al.’s article presents a framework for how to align and integrate common education competencies and assessments for general medicine and geriatrics that reflect care for people with complex care needs.⁶ Two articles address diverse clinical programs relevant to improved care of older adults; as noted in Table 1, they describe initiatives that could be promoted through state or federal health policies.^{7,8} One also notes the need to build partnerships outside of medical schools to include interdis-

Table 1. Policy Agenda to Advance Care of Older Adults

Research	<div>Include older age as a criterion for study enrollment</div> <div>Make adjustments to include cognitively impaired people in research</div> <div>Measure outcomes pertinent to older adults such as functional status</div> <div>Include individuals in skilled nursing facilities or other long-term care settings</div> <div>Develop a hospital medicine-geriatric medicine research initiative</div> <div>Promote implementation science research to clarify best practices relevant to the health needs of older adults</div>
Education	<div>Develop a collaborative medical education agenda between internal medicine and geriatric medicine educators</div> <div>Develop milestones and competencies that reflect care for people with multiple conditions or geriatric care needs</div> <div>Build partnerships outside of medical schools to include interdisciplinary focus, teams and cross-institutional training</div>
Clinical practice	<div>Engage care “receivers” and tailor home care to needs of patients when discharged from the hospital</div> <div>Build “recovery plans” into transitional care</div> <div>Focus on patient and family goals of care so that care better meets the complex care needs common in older adults</div> <div>Adapt primary care delivery models to support the care of older adults</div>

ciplinary teams with community-based resources relevant to the older adult care.

POLICY OPTIONS FOR ADVANCING GERIATRICS RESEARCH

The principal source of US government support for health sciences research is the National Institutes of Health (NIH), which has had a commitment to geriatrics research for over 60 years. The first NIH institute was the National Cancer Institute (NCI), which by 1940 had a “Unit on Aging.”⁹ Over the next 3 decades, the NIH initiated numerous geriatrics-related initiatives, and in 1974 the National Institute on Aging was established. Since 2004, the appropriations for the NIA have been relatively flat at around \$1 billion per year.¹⁰ In 2013, approximately 66 % of this was expected to be spent on research grants, 8 % on research centers and 2 % on research training.¹¹ In comparison, several other institutes of the NIH have much larger budgets, such as the NCI with approximately \$5.6 billion per year and the National Heart Lung and Blood Institute with \$3.1 billion per year.¹⁰ Various NIH institutes support research relevant to aging populations (for example, many forms of cancer and heart disease are most prevalent after age 65); nonetheless, given the magnitude of the impending social challenges related to such geriatrics condi-

tions as frailty and cognitive impairment, further research investments are clearly warranted. The Agency for Healthcare Research and Quality (AHRQ) and the Veterans Administration (VA) have also been supporters of research relevant to clinical geriatrics. AHRQ has been experiencing particular challenges in maintaining its congressional appropriation in recent years, given political concerns regarding public funding of comparative effectiveness and health economics research.¹² A recent article summarized the 30-year history of the VA’s Geriatric Research and Education Clinical Centers program, currently at 20 centers; the article describes how the GRECCs have “made major contributions to the advancement of aging research, geriatric training, and clinical care within and outside the VA.”^{13,14}

Despite the need for further investments, the outlook for federal appropriations for health care science is bleak in the near term, with federal research funding slated for years of additional cuts.¹⁵ Some recommendations in Table 1 may not necessarily require additional resources, but could be accomplished with a clearer focus on investment of available public resources. One example is including older age as a criterion for study enrollment; similarly, new focus could improve inclusion of cognitively impaired people in research and enhance the measurement of outcomes pertinent to older adults. Advocacy to the research agencies and professional associations who relate to them could promote support for such initiatives and heighten awareness among the research professionals who inform the agencies through the peer review process.

Other recommendations will require new resources since they compete with other research interests, populations and disciplines, each seeking scarce resources to support their own research agenda. Examples of geriatrics recommendations in these companion articles include research in long-term care settings, hospital medicine-geriatric medicine research initiatives and promoting implementation research relevant to complex health care needs. Another research topic not explicitly mentioned in these articles but of great interest to public policy-makers is overdiagnosis and overtreatment in older adults. The bright spot for support for these emerging priorities is the Patient Centered Outcomes Research Institute (PCORI). As a non-government not-for-profit corporation publically funded outside the annual appropriations process, PCORI will invest over \$500 million in taxpayer funds annually over the next several years. Even more importantly, PCORI priorities are well suited to address key research questions identified in these articles, focusing on research that “helps people and their caregivers communicate and make informed health care decisions.”¹⁶ PCORI has identified several broad topics for research priorities, including “Improving Health Care Systems,” “Communication and Dissemination Research” and “Addressing Disparities.”¹⁷ In addition to accepting applications in these broad areas, PCORI is in the process of identifying more specific topics for focused investigations; among the first of these is “Preventing

Injuries from Falls in the Elderly.” Certainly the criteria for prioritizing research outlined in the PCORI legislation suggest that many additional clinical geriatrics issues will be highly salient.¹⁷

POLICY OPTIONS FOR ADVANCING GERIATRICS EDUCATION

Federal investments supporting health professional training date back to the Medicare program founding when Congress acknowledged a public interest in reimbursing teaching hospitals for training costs incurred in Medicare beneficiaries care. Medicare Graduate Medical Education (GME) funding mechanisms have evolved over the decades, and the federal commitment has grown to over \$10 billion in payments to teaching hospitals for Medicare’s portion of the both the direct (i.e., salary and benefits) and indirect costs of resident and fellow training. In recent years, the number of positions funded has been capped, and various deficit reduction proposals target indirect medical education reimbursements. In its June 2010 report, the Medicare Payment Advisory Commission (MedPAC) recommended “The Congress should authorize the Secretary to change Medicare’s funding of GME to support the workforce skills needed in a delivery system that reduces cost growth while maintaining or improving quality;” the report specifically noted geriatrics as among the relevant skills to consider.¹⁸ While this type of Medicare GME reform has not yet been enacted, Congress has commissioned an Institute of Medicine study on reform of GME governance and financing.¹⁹

The Health Resources and Services Administration (HRSA) is another source for federal funding of geriatrics training. The geriatrics programs currently supported by HRSA include the Geriatric Education Center cooperative agreements (42 awarded in 2013), grants for “Geriatric Training for Physician, Dentists, and Behavioral and Mental Health Professionals” (12 awarded in 2013), the Geriatric Academic Career Awards (58 awarded in 2013) and the Nursing Workforce Development program in Comprehensive Geriatric Education, with about \$35 million appropriated for these programs in recent years.²⁰ Various HRSA health professions training programs have struggled for consistent congressional support even prior to the economic downturn and face cuts through the “sequester” and other challenges in this era of federal budget austerity.

One new HRSA initiative established under the ACA that enhances primary care training, including geriatrics, is the Teaching Health Center Graduate Medical Education (THCGME) program. Under the THCGME program, HRSA has \$230 million over 5 years to support ambulatory care organizations (teaching health centers or “THCs”) that sponsor new or expanded primary care residency programs

(including geriatrics).²¹ Since 2011 HRSA has awarded 45 centers located all over the US in both urban and rural areas. Three of the inaugural 11 THCs have a focus on geriatrics training.²² Thus, the THCGME program could be an ideal platform for building training partnerships outside of medical schools to include interdisciplinary focus, teams and cross-institutional training. Unfortunately, unlike Medicare GME, which is funded as part of the Medicare entitlement program, the THCGME program will require additional congressional appropriations to continue past 2017 and thus faces the same long-term federal funding challenges as other HRSA programs.²³

States are interested in geriatric-related education and research also. For example, 15 State Medicaid Agencies received contracts in 2010 for “*State Demonstrations to Integrate Care for Dual Eligible Individuals*” from the CMMI (Centers for Medicare and Medicaid Innovation).²⁴ These states are evaluating innovative ways to improve and coordinate care for the “dually eligible” (Medicare and Medicaid) population, who are mostly older adults with chronic conditions.²⁴ Some states fund education for workforce development. An example of this is the Geriatric Education and Training Initiative funded by the Commonwealth of Virginia.²⁵ States spend approximately two-thirds of their budgets on long-term services and supports and thus have an urgent need to improve care for their older beneficiaries with complex conditions.

POLICY OPTIONS FOR SUPPORTING NEW GERIATRICS CLINICAL INITIATIVES

As noted previously, both states and the federal government are increasingly committed to developing policies that promote effective clinical initiatives and improve the care of older adults. With the ACA’s Medicaid expansion for many near retirement age adults without health insurance, states’ interest in and capacity to maintain health and delay disability for older adults will continue to grow.

The current fee-for-service-oriented health system is fragmented and does not reward models needed to promote an aging population’s health and wellness. For many states, the social service programs to support aging are also fragmented; the multiple agencies potentially involved in an individual’s care include: Area Agencies on Aging, county-based services, Meals on Wheels or other food programs, and transportation programs. Payment reform efforts in states offer an opportunity to support and integrate aging initiatives and new care models for older adults. Current state initiatives include incentives and resources to enhance communication and coordination among primary care, specialists and caregivers as well as strategies to blend

funding and activities to coordinate the multiple state agencies involved in supporting aging adults.^{26,27} For example, Colorado and Oregon have each created Accountable Care Organizations (ACOs) that focus on integrating previously siloed care, supports and services.^{28,29} While these models hold promise, they currently lack geriatric-specific quality metrics to adequately measure their progress. Many states in the Medicaid Medical Directors Learning Network have put policies in place to reduce readmissions, including non-payment policies and care coordination models. Finally, states are considering palliative care coverage and other Medicaid benefit expansions to advance the care of older adults with complex conditions.

The federal government has an interest in promoting delivery system change to achieve more effective and efficient care of older adults. To help address federal budget pressures from Medicare (and Medicaid) cost growth, the ACA established the CMMI, committing \$10 billion over 10 years to test “innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care” for Medicare, Medicaid and Children’s Health Insurance Program beneficiaries.³⁰ The ACA gives the Health and Human Services Secretary authority to expand successful models to the national level as long as the CMS actuary certifies the model “reduces overall costs and is quality neutral or better.”³¹

A variety of delivery system initiatives relative to geriatrics are already underway, such as the Independence at Home Demonstration (IH) and the Comprehensive Primary Care Initiative (CPCI). In IH, the CMMI is working with medical practices to evaluate delivering comprehensive primary care services in the home for Medicare beneficiaries with multiple chronic conditions.³² The CPCI is promoting medical home-type transformations of nearly 500 primary care practices serving over 300,000 Medicare beneficiaries, providing additional resources to support care for those with high health care needs.³³ The CMMI is also sponsoring the State Innovation Models Initiative supporting promising activities in 25 states; the largest state innovations investments are in states ready to “transform its health care delivery system through multi-payer payment reform and other state-led initiatives.”³⁴

Health Care Innovation Awards has funded over 200 grants to implement new strategies to improve care and lower costs, many with a focus on Medicare beneficiaries with high health care needs.³⁵ The CMMI still has many more initiatives to undertake by the end of its ACA funding in 2019, so this remains a promising federal mechanism for supporting program innovations and implementing scientific research in geriatrics.

Other federal agencies provide information helpful for geriatric clinical work. The Centers for Disease Control has a healthy aging data portfolio with a “State of Aging and Health in America” report that makes recommendations for clinical activities to promote healthy aging.³⁶ The Food and

Drug Administration has guidelines for geriatric labeling and use of drugs in older adults.³⁷

COORDINATING PUBLIC AND PRIVATE INVESTMENTS IN ADVANCING GERIATRICS

While the focus of this commentary is on the public policy environment relevant to the proposed array of research opportunities, health professional training needs and clinical initiatives, we should acknowledge the particular value in coordinating private with public investments. For example, many private foundations and some industries that provide geriatric products or services play an important role in supporting research and training. Examples include the Reynolds Foundation training programs that include mini-geriatrics fellowships for hospitalists.³⁸ The Hartford Foundation supports various geriatrics education resources and initiatives, including the “ConsultGerRN” application to provide a point-of-care resource for nurses.³⁹ The Macy Foundation focuses on training health professionals to improve the health of older Americans.⁴⁰ Coordinating scarce public investments in geriatric training with these private resources and initiatives will prove even more important in the future.

Interestingly, pressure on public spending may stimulate even greater private investment in the types of clinical program innovations recommended in this series. Changes in the structure and reimbursement models for both Medicaid and Medicare will create more large networks of private payers and an increasing number of integrated provider networks, such as ACOs, with a financial and professional interest in successful clinical program innovations for geriatrics populations. Academic geriatricians will do well to become familiar with the initiatives and networks in their state and be alert for opportunities to advance promising clinical programs.

APPLYING SKILLS IN COLLABORATION TO THE POLICY ARENA

Within academic medicine, geriatrics has been an “early adopter” of collaborative care models and interdisciplinary research and teaching. These skills and connections will prove useful in promoting this important agenda during a challenging time for health policy advocacy. Collaboration with local and state policymakers gives internists and geriatricians a local audience and opportunity to leverage and advance their work. Successful programs started locally can be spread nationally since CMMI and PCORI are eager to fund the evaluation of promising initiatives that promote more efficient and patient-centered care for patients with

complex health care needs. Various public policy makers and organized delivery system leaders operating under new payment incentives will need a health professions workforce with the necessary collaborative care skills and geriatrics clinical competencies. In the face of the policy challenges that persist after the “great recession,” it will be important for academic geriatrics and general internal medicine to join forces with these public and private interests to secure the resources needed to implement this agenda to advance geriatrics research, education and practice.

Conflict of Interest: The authors declare that they do not have a conflict of interest.

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