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The Triple Aim: A Golden Opportunity for Geriatrics

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The “triple aim”, goals articulated by Donald Berwick, former administrator of the Centers for Medicare & Medicaid Services (CMS), has presented the field of Geriatrics with a golden opportunity. What other health professionals are better prepared to help our nation improve care, improve health (and in the case of vulnerable older adults, maintain function and quality of life), and at the same time make care more affordable? The field of Geriatrics has been gearing up for this opportunity for decades.

Geriatrics has been the “Rodney Dangerfield” of health professions. We have gotten little respect. At the same time, we have not made as much progress as we might have hoped (1, 2). A majority of the public still does not seem to even know what a geriatrician is (3). Practicing physicians often say: “Why do we need Geriatrics? I’m a geriatrician. I’ve been taking care of geriatric patients for 30 years.” Experience, however, does not necessarily make one sensitive to the complex interplay between medical, psychosocial, and functional problems that confront older people and their families. Nor does it make one a respectful member of an interdisciplinary team, or an expert at helping patients and their families navigate care transitions to ensure patient safety, comfort, function, and quality of life. We know from the Assessing Care of the Vulnerable Elderly (ACOVE) studies that geriatric conditions are often not identified and optimally managed by many physicians (4). In fact, many of the same physicians who claim to be geriatricians obtain multiple specialist consultations that can lead to expensive and unnecessary diagnostic and therapeutic procedures, and the prescription of combinations of numerous medications that are fraught with potential drug-drug and drug-disease interactions (5).

Geriatrics has also been a tough sell in many academic medical centers. “Have you seen the Dean’s mother in your clinic yet?” has been a common lament among Geriatrics program leaders when discussing a lack of respect and corresponding lack of resources. Indeed, many Geriatrics programs have done well because an experienced geriatrician helped resolve the Dean’s (or other leader’s) parent’s problems after they had gone from doctor to doctor trying to find advice about complex medical, functional, and psychosocial issues. The Dean while I was at Emory University School of Medicine, a dermatologist, got a chuckle when I told him that I was quoted in Time magazine saying: “A dermatologist can shave a few moles off

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in less than 10 minutes, read the pathology slides, and get reimbursed ten times more than a geriatrician who takes two hours sorting out a new 90 year-old patient who comes to the office with a foot high stack of medical records, a big bag of pill bottles, and two distressed daughters”. As a dermatologist, my Dean thought this was funny, and said he was going to quote me to the Emory faculty dermatologists who were at the time asking for higher salaries. In that context it was funny. But it is also sad and true.

Things are changing. Even the bitterest rivals in Congress, as well as leading physicians from all backgrounds, agree that the Medicare fee-for-service system is not sustainable (6). The perverse financial incentives embedded within it will lead to its demise. These incentives commonly drive health care providers to do more for vulnerable elderly people, when they often need less. The newly established CMS Innovations Center and Medicare-Medicaid Coordination Office (“Office of the Duals”) are tackling these financial incentives and the counterproductive cost-shifting between the Medicare and Medicaid programs that finance the care of vulnerable elderly and other high risk populations by supporting the implementation and evaluation of a variety of innovative models of care (7).

Think about the models of care that colleagues in the field of Geriatrics have developed over the last few decades: the Program for All-Inclusive Care of the Elderly (PACE) and similar models (8,9); comprehensive community-based geriatric assessment and management interventions that can be incorporated into medical homes and accountable care organizations, such as Geriatric Resources for Assessment and Care of Elders (GRACE) (10,11); Acute Care for the Elderly (ACE) hospital units (12); care transition interventions such as the Transitional Care Model (13,14) and the Care Transitions Intervention (15,16); and Interventions to Reduce Acute Care Transfers (INTERACT) (17,18). Colleagues in other fields, in collaboration with Geriatrics health professionals, have also developed innovative interventions, such as the Society for Hospital Medicine's enhanced discharge intervention BOOST (Better Outcomes by Optimizing Safe Transitions) (19). The field of Palliative Care has led the way in advocating for better advance care planning and increasing the utilization of interventions such as POLST or MOLST (Physician (or Medical) Orders for Life Sustaining Treatment) (20). While the evidence is modest that any of these interventions result in improvements in care quality and the health of the geriatric population while reducing costs is modest, they do provide models of care that can be further developed and targeted for more cost-effective implementation.

The field of Geriatrics should embrace the golden opportunity afforded by the triple aim as health care reform continues to evolve. Geriatrics health professionals should play an integral role, along with colleagues from other disciplines, in rigorously evaluating innovations that build upon existing models of care and reimbursement for vulnerable older people in order to make them more efficient and applicable across settings, and advocate for them when they are shown to be effective. Such innovations can play a critical role in the success of medical homes, Accountable Care Organizations, and other health system, and they should be widely disseminated. The Journal has two sections devoted to models of care and dissemination, and many other journals and websites would be appropriate for these topics.

The field of Geriatrics should also collaborate with other disciplines to train a new cadre of health professionals who understand the complexities of geriatric care, and at the same time have the knowledge and skills to serve as leaders in health systems. Such training is essential, as geriatrics health professionals must be at the table when decisions are being made about how to best provide health care for the most rapidly growing segment of our society.

If we do not take advantage of these golden opportunities before us, our vulnerable older patients, their families, and their caregivers will not get the best that our field has to offer.

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