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Making Geriatrics a Primary

LYNNE JETER
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National expert discusses decade of change in high demand specialty


Dr. Ken Brummel-Smith

TALLAHASSEE— Ken Brummel-Smith, MD, almost bypassed specializing in geriatrics because of the lack of educational opportunities at medical schools during the early 1970s, when he attended, and the lack of geriatric residency slots nationwide. Instead, it was a chance encounter that sculpted his career path and enabled him to establish the nation's first Department of Geriatrics for an allopathic school.

"My first job after fellowship was teaching a family medicine residency, and my director told me about the Society of Teachers of Family Medicine having a conference on teaching geriatrics in the family medicine residency program, and said it was going to be a big deal someday. When asked if I'd go and see what I could find out about it, my first thought was, wow! A free trip to Boston! I really didn't have much knowledge about geriatrics then," said Brummel-Smith, past president of the American Geriatrics Society, and founding chair of the Department of Geriatrics at the Florida State University College of Medicine (FSU-COM). "After getting enthused at the conference and involved in developing educational programs, I switched from family medicine to geriatric medicine."

Since then, the field of geriatrics has exploded. As baby boomers have aged, the need for geriatricians grows. Currently, 38,000 geriatricians are projected to meet the country's needs.

"We're at 7,000 now," said Brummel-Smith. "The main problem is we don't have enough applicants. When I started in 1980, hardly anyone believed it was worth talking about. Now, there's interest from the general public, but not enough interest from medical students. Lack of money and prestige are two reasons why."

To address the shortage, Brummel-Smith routinely encourages high school groups pursuing medical paths to strongly consider geriatrics.

"I always give them data that says: if you look at the top income to the lowest income, geriatricians are at the bottom of the scale," he said. "We actually make less money with a specialty in geriatrics than we would in our primary specialty of family medicine or internal medicine. But interestingly, you can line up the reverse in job satisfaction. Geriatrics has the highest; neurosurgeons, among the highest paid, have the lowest. We tell them to think about paying your bills and your loans, but don't think you need to sacrifice your life to do it. Choose a specialty you love rather than one that pays well. And you'll be happy the rest of your life."

Brummel-Smith also ensures that all FSU-COM medical students have rotations in geriatric medicine in the school's community-based curriculum model.

"Otherwise, if you took 1,000 people in a community, 700 would have a reason for thinking about their health during that month," he explained, referencing the well-known study, "The Ecology of Care," which first

appeared in the New England Journal of Medicine in 1961, and was recently revisited with similar results. "About 300 would have contact with the healthcare system in some way. About 100 would be admitted to a hospital, and one would go to an academic teaching medical center. So the population of patients who are taken care of, and the doctors taking care of them in an academic medical setting, is almost completely unreal realty. Then medical graduates after residency go into practice where the real situation is. For family medicine physicians, 30 percent will be geriatric patients. For internists, it's 40 to 50 percent. And they're just not prepared for it. So during medical school and residency, students get a negative view of geriatrics because you're not seeing that many older patients in academic medical centers, and they hardly ever see geriatricians as role models. Combined with the negative financial incentives, and the negative emotional incentives that a lot of academic doctors put on geriatrics, it doesn't surprise me that few people choose geriatrics."

The tide is slowly turning in favor of geriatric medicine. CMS has elevated geriatrics to primary care status, paying $38,500 per resident annually, a 10 percent payment bonus from $35,000. The shift from production- to value-based medicine will also make a difference. South Carolina has adopted a student loan repayment program as an incentive for geriatricians, a move Brummel-Smith hopes other states will emulate.

"In general, there'll never be enough geriatricians to take care of all people over the age of 65," he said.

Even though baby steps are helpful, it remains problematic for geriatricians, who don't fit the standard productivity model of many medical groups.

"Geriatric patients don't fit into the 15-minute visit model," he explained. "Older patients have more medical needs and take longer for each appointment. Also, the way our healthcare system is working right now and the way of reimbursement, you're not being paid to make a patient well. You're paid to provide certain services. And many things that need to be done aren't strictly medical. There's coordination with long term services and supports and social issues and all sorts of things."

For example, on a recent clinic day, Brummel-Smith spent an hour with the wife and daughter of a geriatric patient who was too demented to understand his condition.

"We wanted time to have an in-depth discussion about care planning," he said. "I couldn't bill for that because under Medicare rules, you can only bill for the patient's care if the patient is there. But we were doing deep patient care planning that was very emotionally difficult, and it's going to lead not only to a very good outcome as he nears the end of his life, but also it'll help save CMS a lot of money for unnecessary care he wouldn't want in the first place. There's no way I could bill for that."

The PACE Elderplace Program in Oregon, which Brummel-Smith led before relocating to Florida, used a global-capitated model he calls "the ultimate model for reimbursement."

"If the capitation is fair – and that doesn't mean exorbitant or skimpy – then you can appropriately care for the patients, and let the geriatric team and the patient decide the right treatment rather than having insurance companies make the decisions," he said. "We were free from all billing constraints, and we knew we had a certain amount of money to care for all our participants. We had quality measures to meet – some were patient-generated – so we were doing things they wanted, not just what we thought was good for them. It really was the perfect way to practice medicine."

Overall, there's an upside to the gap of supply and demand of geriatricians. Even though geriatrics is labeled for patients over the age of 65, most seniors up to age 74 are relatively healthy and don't need a geriatrician, Brummel-Smith said.

“The perfect patients for a geriatrician are those above age 75, and especially those with multiple chronic conditions and long-term care needs, such as dementia, and the kinds of problems that are very difficult for internists and family physicians to take care of in a standard 15-minute visit,” he said, pointing out the American Geriatric Society considers the specialty both a primary care and consultation model.

“We manage primary care for that population of complex and frail elders, and consultations to other physicians for the ‘younger’ old people,” he explained, “and for older people who are generally receiving good care from their primary care provider.”