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## Prescription for America's elder boom: Every doctor learns geriatrics

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Faced with an aging population and a physician shortage, hospitals create geriatric collaborations to manage patients and raise the elder care skills of all doctors.

The elderly woman was arriving at Mount Sinai Hospital's emergency room almost once a week, and not for medical emergencies. She came because she needed prescriptions to be refilled, having taken extra doses in hopes of better results; because she had joint pain; because she had missed a doctor's appointment; because she didn't know how to navigate the medical care maze.

"This shouldn't be happening," the woman's primary care physician said when he contacted a team that was created to improve care for older patients who come through the Manhattan hospital.

The staff of ALIGN (Aging, Life Innovations, Goals & Needs) worked with the woman and her son to create a care management plan involving medical staff and social workers. They arranged for a home health attendant to visit her regularly. They visited her pharmacist to develop prescription instructions that she understood. They called to remind her of pending doctor's appointments.

Notably, the intervention involved just one geriatrician — ALIGN Director Stephanie Chow, MD, MPH, in Mount Sinai Health System's Department of Geriatrics and Palliative Medicine. The ALIGN team, which includes a geriatric nurse practitioner and a geriatric social worker (among others), co-managed the woman's care with her primary physician, who eventually resumed all of her routine care. Hospitals are increasingly using such collaborations between geriatricians and clinicians to cope with a demographic challenge to the nation's health care systems: an aging population that will need more care, and a shortage of clinicians trained to provide it.

"Their care is going to depend on a lot of physicians, physician assistants, advanced practice nurses, and other clinicians," says Mary Tinetti, MD, chief of geriatrics at Yale School of Medicine in Connecticut. "Any [provider] who touches older adults needs to understand the appropriate care of older adults."

People over 65 consume more health care than any other age group. They account for more than 40% of hospital admissions and tend to stay longer, which is why older people account for almost half of all hospital bed days, according to a [2019 study](#) (<https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.15901#jgs15901-bib-0010>) in the *Journal of the American Geriatric Society*. Over half of all visits to office-based physicians, aside from those for infant care, are by people age 65 and older, the study found.

What's more, by 2034 the population of people age 65 and over is expected to grow by 42.4% from where it stood in 2019, according to the AAMC's [most recent projections](#) (<https://www.aamc.org/data-reports/workforce/data/complexities-physician-supply-and-demand-projections-2019-2034>) of physician supply and demand. Also by that year, the report projects a shortage of between 37,800 and 124,000 physicians. As for geriatricians specifically, the U.S. Department of Health and Human Services [projects a shortage](#) (<https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/geriatrics-report-51817.pdf>) of nearly 27,000 by 2025.

"We will never have enough geriatricians" to meet the rising need, says Lisa Granville, MD, associate chair of the Department of Geriatrics at Florida State University (FSU) College of Medicine in Tallahassee.

That's why geriatric leaders are collaborating and educating to expand the capacity of all physicians and other health care workers to care for elderly patients.

### Putting patients' priorities first


The movement to create [age-friendly health systems](#) (<https://www.aha.org/center/age-friendly-health-systems>) focuses on what matters most to the patient — that is, their priorities for how they want to live now — rather than only alleviating particular conditions. The framework for this approach is the Four Ms: what matters to the patient, medication, mentation, and mobility.

"You have to help people identify the outcomes they most want," Tinetti says. "What matters most? To be free of pain so he can do carpentry? Feel less fatigue so she can babysit her grandchildren?"

For many older patients, geriatricians say, mobility and independence top the list.

Adhering to those wishes can force hard decisions. Because people develop more medical conditions and more severe conditions as they age, their care grows more complicated. They take more and more medications. At some point, treating certain conditions might make it harder for the patient to do what they most want to do — like play golf.

A few years ago, doctors at a large primary care practice in Connecticut were challenged with how to treat the myriad ailments of a 92-year-old woman who insisted on golfing — 18 holes, walking the course. Advanced heart failure had left her too short of breath for that, yet she refused more tests and medications to manage her conditions.

Fortunately for her fairway ambitions, the practice was participating in the [Patient Priorities Care](https://patientprioritiescare.org/)  pilot, through which primary care physicians, cardiologists, and others learn to apply age-friendly principles to the care of older adults. For this patient — as described by Tinetti, one of the project leaders — the doctors focused on whatever would get her back on the golf course. She'd have to take certain tests and medications to improve conditions that interfere with that objective, play only nine holes, and use a golf cart. The woman agreed.

For patient priority approaches to work, doctors must also consider factors that might affect how a patient responds to treatment, such as their physical frailty, mental acuity, and supports from family and friends to manage their care at home.

"For the older person having surgery, the pre-op evaluation is not just looking at traditional things like the heart and lungs, but also at things like memory and functioning," says Kenneth Covinsky, MD, MPH, a clinician and researcher in the Division of Geriatrics at the University of California, San Francisco, School of Medicine (UCSF).

"Maybe surgery is not a good idea if they can't walk as well after the surgery. Or [the doctor] might do a great job of medicine reconciliation, but fail to recognize that the patient has early-stage dementia and can't [follow the plan] at home."

The co-management initiatives at UCSF and Mount Sinai make such considerations routine.

### **Teams co-managing patients**

Mount Sinai's Department of Geriatrics and Palliative Medicine established ALIGN in 2016 because the Mount Sinai Health System was being stressed by older, high-risk patients. "There were not enough geriatricians to continuously care for all those patients, and the patients were requiring acute outpatient care that wasn't available in the current models of care," Chow says.

As a result, older patients were especially likely to have long hospital stays and to be readmitted after surgery.

ALIGN works with several surgical units — including urologic, renal transplant, orthopedic, and vascular — to co-manage the care of all patients age 65 and up who are slated for surgery. (The group also assesses certain elderly patients in the emergency department.)

"We do a lot of evaluation of cognitive status and explore what matters most to them in life," Chow says. They also assess frailty, medication mix and management, and what supports the patient needs outside the hospital, such as transportation to doctor's appointments.

At UCSF Medical Center, Stephanie Rogers, MD, MPH, oversees a similar co-management initiative with the orthopedics department. Each morning, a team gathers to go over every orthopedic case the geriatricians are following. In the room (or joining via video) are the primary physician, a geriatrician, a nurse, a physical therapist, a pharmacist, and sometimes a social worker, among others, says Rogers, the associate chief for geriatrics clinical programs.

Medication is a common topic of conversation and negotiation among the providers in these collaborations, Rogers and Chow say. They note that most older people need lower doses of medications than other adults do because of differences in metabolism, but the prescriptions given in hospitals typically do not reflect that distinction.

Sometimes the geriatricians suggest forgoing a medication or finding an alternative, although the medication would make sense in isolation. Recently, Rogers recalls, a surgeon wanted to give an elderly patient medication to reduce her blood sugar levels because high blood sugar might impede her healing after surgery. Rogers worried that reducing the patient's blood sugar might trigger hypoglycemia, which could send her into a state of delirium or cause her to pass out and get injured in a fall. They decided against the medication.

Rogers notes that this kind of thinking requires “a total flip” in how physicians typically treat specific conditions. “A lot of physicians are very disease-centric,” she observes. “You use a drug to treat hypertension. My approach is harm reduction,” which sometimes requires holding back on certain treatments to avoid exacerbating other conditions or undercutting functions (such as mobility) that are priorities for the patient.

Says Rogers, “Sometimes I feel that I think backwards from everybody else in the hospital.”

### **Educating more physicians**

As effective as any collaborative care initiative might be, none of them can cover every older patient in a health system. That’s why geriatricians use collaborations to educate all providers.

“There’s a real need to expand the content knowledge and expertise related to geriatric and palliative care for all clinicians,” notes Amy S. Kelley, MD, MSHS, a professor in the Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mount Sinai. “If you’re a surgeon or an oncologist, you should have core palliative care and geriatric skills because this population is going to show up in your practice and in your hospital.”

Elevating those skills is especially important in Florida, where 21% [\[https://www.census.gov/quickfacts/FL\]](https://www.census.gov/quickfacts/FL) of residents are 65 or older. State law requires FSU College of Medicine to teach geriatrics across all four years for medical degrees, and the school carries out an [array of education projects](https://reach.med.fsu.edu/projects/) [\[https://reach.med.fsu.edu/projects/\]](https://reach.med.fsu.edu/projects/) for physicians and other health care workers.

One such project conducts educational sessions for community clinics run by the nonprofit North Florida Medical Centers and tracks data about the quality of geriatric care, says Nicolette Castagna, MA, MPH, who leads community engagement in FSU’s Department of Geriatrics. Another provides physician assistants who have been trained in geriatrics at FSU to join physician practice teams in order to elevate elder care and educate the team members, Castagna says.

At UCSF, Rogers sees those principles being absorbed by physicians who work with her co-management project. She routinely reviews the charts of elderly patients in orthopedics, looking for adjustments that might be required to prescriptions and procedures. Most medical residents who write those charts eventually get to a point where she tells them, “I have nothing to add. You did this beautifully.”

“These residents are about to disperse across the country, and they have this geriatric lens to doing medicine,” Rogers says. “It warms my heart.”



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