TuSalud

Who Will Care for Older Adults? We've Plenty of Know-How but Too Few Specialists

Despite the surging older population, there are fewer geriatricians now -- just over 7,400 -- than there were in 2000.

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Thirty-five years ago, Jerry Gurwitz was among the first physicians in the United States to be credentialed as a geriatrician — a doctor who specializes in the care of older adults.

"I understood the demographic imperative and the issues facing older patients," Gurwitz, 67 and chief of geriatric medicine at the University of Massachusetts Chan Medical School, told me. "I felt this field presented tremendous opportunities."

But today, Gurwitz fears geriatric medicine is on the decline. Despite the surging older population, there are fewer geriatricians now (just over 7,400) than in 2000 (10,270), he noted in a recent piece in JAMA. (In those two decades, the population 65 and older expanded by more than 60%.) Research suggests each geriatrician should care for no more than 700 patients; the current ratio of providers to older patients is 1 to 10,000.

What's more, medical schools aren't required to teach students about geriatrics, and fewer than half mandate any geriatrics-specific skills training or clinical experience. And the pipeline of doctors who complete a one-year fellowship required for specialization in geriatrics is narrow. Of 411 geriatric fellowship positions available in 2022-23, 30% went unfilled.

The implications are stark: Geriatricians will be unable to meet soaring demand for their services as the aged U.S. population swells for decades to come. There are just too few of them. "Sadly, our health system and its workforce are wholly unprepared to deal with an imminent surge of multimorbidity, functional impairment, dementia and frailty," Gurwitz warned in his JAMA piece.

This is far from a new concern. Fifteen years ago, a report from the National Academies of Sciences, Engineering, and Medicine concluded: "Unless action is taken immediately, the health care workforce will lack the capacity (in both size and ability) to meet the needs of older patients in the future." According to the American Geriatrics Society, 30,000 geriatricians will be needed by 2030 to care for frail, medically complex seniors.

There’s no possibility this goal will be met.

What’s hobbled progress? Gurwitz and fellow physicians cite a number of factors: low Medicare reimbursement for services, low earnings compared with other medical specialties, a lack of prestige, and the belief that older patients are unappealing, too difficult, or not worth the effort.

“There’s still tremendous ageism in the health care system and society,” said geriatrician Gregg Warshaw, a professor at the University of North Carolina School of Medicine.

But this negative perspective isn’t the full story. In some respects, geriatrics has been remarkably successful in disseminating principles and practices meant to improve the care of older adults.

“What we’re really trying to do is broaden the tent and train a health care workforce where everybody has some degree of geriatrics expertise,” said Michael Harper, board chair of the American Geriatrics Society and a professor of medicine at the University of California-San Francisco.

Among the principles geriatricians have championed: Older adults’ priorities should guide plans for their care. Doctors should consider how treatments will affect seniors’ functioning and independence. Regardless of age, frailty affects how older patients respond to illness and therapies. Interdisciplinary teams are best at meeting older adults’ often complex medical, social, and emotional needs.

Medications need to be reevaluated regularly, and de-prescribing is often warranted. Getting up and around after illness is important to preserve mobility. Nonmedical interventions such as paid help in the home or training for family caregivers are often as important as, or more important than, medical interventions. A holistic understanding of older adults’ physical and social circumstances is essential.

The list of innovations geriatricians have spearheaded is long. A few notable examples:

Hospital-at-home. Seniors often suffer setbacks during hospital stays as they remain in bed, lose sleep, and eat poorly. Under this model, older adults with acute but non-life-threatening illnesses get care at home, managed closely by nurses and doctors. At the end of August, 296 hospitals and 125 health systems — a fraction of the total — in 37 states were authorized to offer hospital-at-home programs.

Age-friendly health systems. Focus on four key priorities (known as the “4Ms”) is key to this wide-ranging effort: safeguarding brain health (mentation), carefully managing medications, preserving or advancing mobility, and attending to what matters most to older adults. More than 3,400 hospitals, nursing homes, and urgent care clinics are part of the age-friendly health system movement.

Geriatrics-focused surgery standards. In July 2019, the American College of Surgeons created a program with 32 standards designed to improve the care of older adults. Hobbled by the COVID-19

pandemic, it got a slow start, and only five hospitals have received accreditation. But as many as 20 are expected to apply next year, said Thomas Robinson, co-chair of the American Geriatrics Society's Geriatrics for Specialists Initiative.

Geriatric emergency departments. The bright lights, noise, and harried atmosphere in hospital emergency rooms can disorient older adults. Geriatric emergency departments address this with staffers trained in caring for seniors and a calmer environment. More than 400 geriatric emergency departments have received accreditation from the American College of Emergency Physicians.

New dementia care models. This summer, the Centers for Medicare & Medicaid Services announced plans to test a new model of care for people with dementia. It builds on programs developed over the past several decades by geriatricians at UCLA, Indiana University, Johns Hopkins University, and UCSF.

A new frontier is artificial intelligence, with geriatricians being consulted by entrepreneurs and engineers developing a range of products to help older adults live independently at home. "For me, that is a great opportunity," said Lisa Walke, chief of geriatric medicine at Penn Medicine, affiliated with the University of Pennsylvania.

The bottom line: After decades of geriatrics-focused research and innovation, "we now have a very good idea of what works to improve care for older adults," said Harper, of the American Geriatrics Society. The challenge is to build on that and invest significant resources in expanding programs' reach. Given competing priorities in medical education and practice, there's no guarantee this will happen.

But it's where geriatrics and the rest of the health care system need to go.

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