

# The Changing Face of General Internal Medicine and Lessons Learned from Geriatric Medicine

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This issue of JGIM contains a collection of articles focused on geriatrics that is being published at a significant juncture in United States healthcare, perhaps not seen since the introduction of Medicare in the 1960s. As the need to address the complex intersection of an aging, sicker population is compounded by potential limitations of staffing, healthcare delivery, reimbursement, and policies, these articles help frame the discussion of the future role of general internal medicine.

Older adults (people 65 and older) currently comprise 13 % of the US population and account for 43% of annual inpatient care spending. That portion of the population is expected to continue using more health care services, and to increase from 13 % to 19 % of the population by 2030.<sup>1</sup> Older adults are at greater post-hospitalization risk; one in 20 die during hospitalization and another 20–30 % die within one year following hospital discharge.<sup>2</sup> Since this population has the highest prevalence of chronic illness and highest per capita health care spending, effective and efficient care of older adults is critical to controlling future federal spending.

Areas addressed by the authors of these articles include: further evaluating the training of primary care providers; re-evaluating methods for health care delivery; and continuing down the path of new funding and research mechanisms in geriatrics. Additional commentary regarding these topics is provided below.

## REVISING MEDICAL TRAINING

As the United States population experiences an increasing burden of chronic illness and functional decline, primary care clinicians must cultivate increased skills necessary for facilitating transitions and readmissions, managing multimorbid patients, developing prognosis, setting goals, and delivering team-based care.<sup>3</sup> Lessons learned from

geriatric medicine place continued focus on patient-centered care that optimizes patients' function and independence, while addressing patient and family care goals. However, there are challenges to providing this type of holistic care. For example, current payments do not support the extra time required for evaluation of cognitive impairment or physical disabilities. Similarly, most guidelines address one condition rather than the interaction between multiple comorbidities, making it difficult to practice evidence-based medicine.

Chang et al. discuss the challenges faced by internal medicine residents in caring for an increasingly complex, older patient population.<sup>4</sup> They propose a model of collaboration between internal medicine and geriatric medicine, combining the resources and educators in both disciplines, with the goal of increasing innovation and improving graduate medical education outcomes. Benefits of collaboration include increasing efficiency of effort (e.g., shared resources and decreasing duplication of existing efforts), and increasing patient outcomes and satisfaction.

## HEALTH CARE DELIVERY

Reflecting these changes in the United States population, health care delivery is likely to see significant growth in the evaluation and incorporation of innovative care delivery systems working to improve access, and to optimize health, quality, and utilization outcomes of acutely ill geriatric patients. Emerging health communication technology tools, including interactive voice response (IVR), text-messaging, electronic medical records, as well as telephonic calls by case managers and/or patients' clinical team, are increasingly used to empower patients, their providers, and the healthcare system to actively engage in managing their disease and lifestyle. These tools may provide electronic reminders and track patients' physical activity, blood pressure, and medication adherence, among other factors. However, more work is needed to better understand the role of technology in improving health outcomes, particularly among older adults. For example, there is a need to determine successful models of reimbursement for these

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innovations, how best to match the right technology to patients' needs, and how best to integrate technological advances into healthcare systems.

Health Information technology will likely provide a way to improve efficiencies in the way we provide care to adults. A recent article by Weiner et al. (2013) estimates that if health information technology (HIT) were fully implemented in 30 % of community-based physicians' offices, the demand for physicians would be reduced by about 4–9 %.<sup>5</sup> Delegation of care to nurse practitioners and physician assistants supported by HIT could reduce the future demand for physicians by 4–7 %.<sup>5</sup> The use of HIT could also address physician regional shortages by enabling 12% of care to be delivered remotely or asynchronously. These estimated impacts could more than double if comprehensive HIT systems were adopted by 70 % of U.S. ambulatory care delivery systems.<sup>5</sup>

## RESEARCH

Wald and colleagues present a strategy to define a research agenda addressing the increasing intersection of hospital medicine and geriatrics.<sup>6</sup> The Patient Centered Outcomes Research Institute (PCORI) framework for inclusion of stakeholder input informs the agenda. In the short-term, the authors recommend that funding agencies not only provide details on the proposed number of enrolled older adults, but also offer explicit details for meeting enrollment goals. Secondly, they recommend providing supplements to identify and propose research protocol solutions for overcoming enrollment barriers for older adults. If we are to expand and include measurable outcomes pertinent to older adults, we also must define and operationalize the definition of a clinically meaningful difference using measures that are sensitive to detect changes. Self-reported health is typically assessed on a 5-point rating scale and has been recommended as a potential measure<sup>7</sup> with predictive validity; however, demonstrating changes on a 5-point scale is difficult.

Particularly deserving of attention is the need to adjust our methods of treatment, evaluation, and research. The healthcare system is experiencing continuous pressure to improve quality and safety while simultaneously decreasing resources. Innovative models for health care delivery that are adequately evaluated and acceptable to stakeholders (e.g., patients, provider, healthcare system) are sorely needed. Methods for rigorously evaluating these models are available, but are not adequately used. The field of implementation and dissemination science can provide insight into how to rapidly evaluate various programs and disseminate findings. However, additional pieces of the puzzle are needed beyond the science. Efficacious programs and studies accounting for stakeholders' perspectives are

needed before implementation. Successful programs identified in the various articles include the Program of all inclusive care for the elderly (PACE)<sup>8</sup> and the Geriatric Resources for Assessment and Care for Elders (GRACE), but they have not been broadly disseminated.<sup>9</sup> Second, we need to better engage stakeholders who make funding decisions. As Day et al. discuss, one of the largest barriers to effective care delivery is that current administrative and payment systems do not easily support the implementation of existing evidence and best practice for multimorbid adults in the primary care arena.<sup>3</sup> Finally, we must all strive for excellence in training and funding implementation research.

Understanding program implementation is essential. Treatment fidelity contributes to successful dissemination of research in clinical practice and applied settings. In fact, inattention to and limited reporting of treatment fidelity may be a key reason for delays and challenges of implementing programs in the healthcare system. There is a substantial gap between research and clinical practice; research findings are being "lost in translation."<sup>10</sup> One source suggests that it requires an average of 17 years for just 14 % of new approaches to penetrate daily clinical practice.<sup>11</sup>

## CONCLUSION

In the research arena, the elephant in the room is cost. The cost of conducting research with older adults tends to be higher than in other populations, yet funding levels are stagnate or decreasing. So, while Lindquist et al.'s statement that 'just because it is difficult, does not mean it should not be done' is a reasonable comment,<sup>12</sup> to fully meet this goal will require further acknowledgment of the need to include funds to adequately support incorporating older adults in research.

To meet this challenge of caring for an increasingly complex patient population, changes in training are needed. States and the Federal government have a need for the health profession workforce to develop collaborative care skills and geriatrics clinical competencies. On the clinical program side, an evaluation of programs targeted toward improving the care of older adults is needed in addition to promoting delivery system changes. These changes are likely to require additional resources. To garner scarce resources and meet the growing health care needs of the United States, data regarding programs' return on investment and success on improving stakeholder outcomes will be essential. Positioned in the context of the current public policy climate and offering a pathway for how important initiatives can be advanced during a time of government austerity, these articles identify an ambitious set of research opportunities, health professional training needs, and clinical initiatives.

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