REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

ACCESS TO AND AVAILABILITY OF GERIATRICIANS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SEAL

REPORT DOCUMENT NO. 75

COMMONWEALTH OF VIRGINIA
RICHMOND
2007

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Preface

House Joint Resolution 135 of the 2004 General Assembly Session would have required a study of the access to and the availability of geriatricians. Although HJR 135 was tabled in the House Rules Committee, Delegate Harvey Morgan requested that Joint Commission on Health Care (JCHC) staff study this issue and report on findings and recommendations to the Commission.

Geriatricians are physicians who have expertise in age-related issues or gerontology, the study of the aging process. There is a national shortage of geriatricians in the United States, which is projected to worsen as baby boomers age. Financial disincentives pose the greatest barrier to entry into the field of geriatrics. Low Medicare reimbursement rates are considered to be a major reason that relatively few physicians choose to specialize in geriatrics. Consequently, many believe federal reforms are needed, including modifying Medicare's payment system and the payment policy for federal training programs.

Virginia began funding the Virginia Geriatric Education Center after Congress discontinued funding such centers in 2005. The Center and the Geriatric Academic Career Awards Program were provided a total of $375,000 GFs and $375,000 NGFs for each year of the 2006-2008 biennium. The funding is designed to "continue geriatric training and education programs across Virginia for a wide range of health-related professionals and service providers."

In response to the 2006 JCHC study, the following legislative options were adopted by the Commission:

- Request by letter from the Chairman that the Virginia Geriatric Education Center report to the Commission prior to the 2008 Session on its recommendations for improving access to and availability of geriatricians.
- Request by letter from the Chairman that the Health Workforce Advisory Committee in its deliberations consider the issues of the access to and availability of geriatricians in the context of future health workforce shortages associated with the aging of Virginia's population.

On behalf of the Joint Commission and staff, I would like to thank all the individuals and organizations who assisted in this study effort.

Kim Snead
Executive Director

March 2007

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Access and Availability of Geriatricians

Access to and Availability of Geriatricians

Executive Summary

Authority for Study

House Joint Resolution 135 of the 2004 General Assembly Session would have required a study of the access to and the availability of geriatricians. Although HJR 135 was tabled in the House Rules Committee, Delegate Harvey Morgan requested that Joint Commission on Health Care (JCHC) staff study this issue and report on findings and recommendations to the Commission.

Background

Geriatricians are physicians who have expertise in age-related issues or gerontology, the study of the aging process. Gerontology emphasizes diagnosis and treatment of problems that are more common in older adults, particularly:

- confusion and dementia,
- depression,
- instability and falls,
- incontinence,
- chronic pain management,
- sensory impairment, and,
- end-of-life care needs.

Geriatricians are trained to care for some of the most complex patients – many of whom are near the end of life. (*Report to the Congress: Impact of the Resident Caps on the Supply of Geriatricians*, MEDPAC, November 2003) The need for and benefits of specialized care for older persons are described in a report of the Alliance for Aging Research as follows:

> "Older people have medical needs different from younger adults. The average 75-year-old person has three chronic medical conditions and regularly uses about five prescription drugs, as well as multiple over-the-counter remedies. In many instances older people are using 12 prescription drugs or even more at any given time. Changes with aging can alter how the body metabolizes, absorbs and clears these drugs from the body. Also, symptoms of illness can present differently in older people than in the young or middle-aged. For many older people, chronic age-related conditions such as memory loss, depression, or incontinence, pose a direct threat to their ability to live independently. Careful management of these conditions by a multi-disciplinary team becomes paramount to maintaining long-term health, vigor and the capacity for personal growth and independence. Often the key to effective management of the complex and over-lapping health

challenges of older patients is a health care professional who has at least some training and orientation in geriatric health care….

The human benefits of improving the health and independence of older people are obvious. The financial benefits are enormous. If proper geriatric care resulted in a conservative reduction of hospital, nursing home and home care costs of just 10 percent a year, the nation would have saved $50.4 billion in health care costs in the year 2000. The potential savings by the year 2020 of such a modest reduction would be $133.7 billion in that year alone. Beyond direct savings in heath costs, a healthier more independent older population would contribute immeasurably to the nation by easing the cost growth of Medicare, Medicaid, and Social Security and by decreasing the need for nursing home and long-term care." (*Medical Never-Never Land: Ten Reasons Why America Isn't Ready for the Coming Age Boom*, Alliance for Aging Research, 2002)

Supply of Geriatricians. There is general agreement regarding the need for additional geriatricians in the U.S. As noted by the Alliance for Aging Research:

"Despite a general consensus that a core group of trained geriatricians is necessary to maintain the health and functioning of older people, a critical shortage of geriatric trained professionals persists in the United States. There are currently only 9,000 physicians with geriatric certification in the U.S. However, the U.S needs 20,000 to provide adequate treatment to its older population. The Alliance for Aging Research estimates the U.S. will need approximately 36,000 geriatricians to treat 70 million older people by the year 2030. Unless a significant commitment is made to geriatric medical education, the U.S. will fall short of this projection by as many as 25,000 doctors. In addition, many of the nation's 650,000 physicians in current practice will require continuing education with significant infusions of geriatric training." (*Medical Never-Never Land: Ten Reasons Why America Isn't Ready for the Coming Age Boom*, Alliance for Aging Research, 2002)

Between 1988 and 2003, the number of physicians certified in geriatrics grew. Those receiving added qualifications in geriatrics include:

- 9,900 allopathic family practitioners and internists,
- 2,500 psychiatrists, and,
- 500 osteopathic family practice and internists.

Based on the number of physicians in training programs, it is predicted that 350 new geriatricians should enter practice each year for the next decade. However, in recent years, the rate for recertification in geriatrics has been less than 50 percent. This reduction in recertification will result in a decline in the number of practicing geriatricians over the next decade even with growth in fellowship

training programs. (*Report to the Congress: Impact of the Resident Caps on the Supply of Geriatricians*, MEDPAC, November 2003)

In Virginia, the Board of Medicine lists 962 doctors self-reporting a specialty in geriatrics. Of the 962 licensees, 566 list a practice address in Virginia. (*Virginia Board of Medicine Practitioner Information*)

Medical School Curriculum. The Association of American Medical Colleges (AAMC) has completed ongoing reviews of the geriatric content of college curricula as well as surveys of students after their graduation. The 1998 AAMC survey found that "the percentage of medical schools with at least some form of required geriatric exposure increased from 82% in 1985-1986 to 98% in 1996-1997…." However in 2003, 34% of medical school graduates responding to AAMC's survey "reported that geriatrics was inadequately covered in all 4 years of medical school." (*Geriatric Content in Medical School Curricula: Results of a National Survey*, JAGS 53:136-140, 2005)

Research suggests factors that may account for "the relatively small number of applicants to geriatric fellowship programs and the recruitment of only a small number of U.S. medical school graduates." These include:

- Medical problems of older people have often been viewed as unexciting and irreversible.
- Physician interest in geriatrics builds on interest in primary care (which is now weakening).
- Compensation for both academic and nonacademic primary care physicians and geriatricians remains relatively low compared to that of procedure-oriented specialists.
- Providers' dependence on Medicare for revenue once they are in practice.
- Lack of faculty role models.

(*Report to the Congress: Impact of the Resident Caps on the Supply of Geriatricians*, MEDPAC, November 2003)

Barriers to Entry into Geriatrics

Financial disincentives pose the greatest barrier to entry into the field of geriatrics. Low Medicare reimbursement rates are considered to be a major reason that relatively few physicians choose to specialize in geriatrics. Consequently, many believe federal reforms are needed, including modifying Medicare's payment system and the payment policy for federal training programs. The American Geriatrics Society (AGS) and the Association of Directors of Geriatric Academic Programs (ADGAP) have indicated federal reforms should include addressing the payment system for Medicare's

reimbursement system, making changes in Medicare's disease management program, and revising the payment policy for federal training programs. (*Geriatric Medicine: A Clinical Imperative for an Aging Population*, AGS/ADGAP Policy Statement, Annals of Long-Term Care/Volume 13, No. 4/April 2005)

Medicare Payment Policies. A 2005 joint policy statement by the American Geriatrics Society and the Association of Directors of Geriatric Academic Programs indicated:

> "Because of the complexity of care needed and the time required to delivery quality care, Medicare payment policies currently provide a disincentive for physicians to enter the field of geriatrics and to carry a full caseload of Medicare beneficiaries who are frail and chronically ill. *First*, the physician payment system does not cover the cornerstone of geriatric care – assessments and the coordination and management of care – except in limited circumstances….*Second*, the Medicare physician reimbursement system bases payment levels on the time and effort required to see an 'average' patient and assumes that a physician's caseload will average out with patients who require longer to be seen and patients who require shorter times to be seen over a given time period….*Third*, certain practice settings where geriatricians typically work [the example of nursing home settings was given] may appear unattractive to trainees."

Despite these noted drawbacks, the policy statement referenced a study reported in the Archives of Internal Medicine in 2002 that practicing geriatricians reported "unusually high job satisfaction." (*Geriatric Medicine: A Clinical Imperative for an Aging Population*, AGS/ADGAP Policy Statement, Annals of Long-Term Care/Volume 13, No. 4/April 2005)

Medicare Disease Management Provisions. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included several new chronic care provisions, including a large-scale disease management pilot program. However, the new disease management program is not expected to address adequately the needs of older persons with multiple chronic conditions, or address the financial disincentives within Medicare that have limited the supply of geriatricians.

Examples of Virginia Initiatives

The Virginia Geriatric Education Center (VGEC) is a consortium of Virginia Commonwealth University, Eastern Virginia Medical School, and the University of Virginia. (It should be noted that each of these institutions has a geriatric fellowship program.) VGEC received federal funding until 2005, when Congress de-funded Geriatric Education Centers. An amendment to the Virginia budget was approved to provide $375,000 GFs and $375,000 NGFs for each year of the 2006-2008 biennium for the operation of VGEC and the Geriatric Academic Career Awards Program. VGEC and the awards program are administered by

the Virginia Center on Aging. The budget language indicated that the "funding will continue geriatric training and education programs across Virginia for a wide range of health-related professionals and service providers."

The Eastern Virginia Medical School (EVMS) Glennan Center for Geriatrics and Gerontology "focuses on the preventive, interventional, and research aspects of age-related diseases. By applying the findings from aging research to intervene in chronic disabilities of aging, the Glennan Center will help older patients maintain the highest possible degree of function and independence and avoid unnecessary and costly institutionalization."

In addition, EVMS created the GerIMed residency program "which is one of only two of its kind in the country. Residents receive intensive training in subjects such as palliative care, in-patient geriatrics and nursing home care. Graduating residents are eligible to sit for board certification in internal medicine as well as geriatrics….EVMS was also one of the first medical schools in the country to include a mandatory clerkship in geriatrics." (*EVMS Chronicle*, Summer 2006)

Legislative Options

Option 1

Take no action.

Option 2 - *Adopted*

Request by letter from the Chairman that the Virginia Geriatric Education Center report to the Commission prior to the 2008 Session on its recommendations for improving access to and availability of geriatricians.

Option 3 - *Adopted*

Request by letter from the Chairman that the Health Workforce Advisory Committee in its deliberations consider the issues of the access to and availability of geriatricians in the context of future health workforce shortages associated with the aging of Virginia's population.

JCHC Staff for this Report

April R. Kees
Principal Health Policy Analyst

Access to and Availability of Geriatricians

(Revised)

Presentation to:

Joint Commission on Health Care

April Kees
Principal Health Policy Analyst

September 14, 2006
Richmond, Virginia

Presentation Outline

- ***Background and Research***
- **Examples of Virginia Initiatives**
- **Policy Options**

Authority and Background for Study

- **HJR 135 of the 2004 General Assembly Session would have required a study of the access to and the availability of geriatricians.**
- **HJR 135 was tabled in the House Rules Committee.**
- **The Joint Commission began the completion of the study at the request of the Chairman.**
- **HJR 135 would have required an assessment of the degree to which geriatrics is covered in a variety of health professional programs at the graduate and undergraduate level.**

Background Information

- *Geriatricians are physicians who have expertise in aging-related issues or gerontology, the study of the aging process.*
  - *Their profession emphasizes the diagnosis and treatment of problems that are more common in older adults, particularly confusion and dementia, depression, instability and falls, incontinence, chronic pain management, sensory impairment, and end-of-life care.*
  - *Geriatricians are trained to care for some of the most complex patients-many of whom are near the end of life.*
  - *These providers are oriented toward primary-care board certified in family practice, internal medicine, or psychiatry and have completed at least one additional year of training in geriatrics.*
  - *To be certified in geriatrics, a physician must complete a one-year fellowship following his or her residency training in family practice, internal medicine, or psychiatry.*

Source: *Report to the Congress: Impact of the Resident Caps on the Supply of Geriatricians,* MEDPAC, November 2003.

Background Information

- Currently, 20,000 geriatricians are needed nationally to meet the needs of the elderly population.
  - — Only 9,000 geriatricians are in practice.
  - — Estimates suggest that 36,000 geriatricians will be needed by 2030.
  - — There is also a concern regarding a shortage of academic geriatricians.
- In Virginia, the Board of Medicine data lists 962 doctors self-reporting a specialty in geriatrics.
  - — Of the 962 licensees, 566 list a practice address in Virginia.

Source: *Medical Never-Never Land: Ten Reasons Why America Isn't Ready for the Coming Age Boom,* Alliance for Aging Research 2002 and *Virginia Board of Medicine Practitioner Information,* BOM, September 2006.

Supply of Geriatricians

- Between 1988 and 2003, the number of physicians certified in geriatrics grew. Those receiving added qualifications in geriatrics include:
  - — 9,900 allopathic family practitioners and internists,
  - — 2,500 psychiatrists, and
  - — 500 osteopathic family practice and internists.
- Based on the number of physicians in training programs, it is predicted that 350 new geriatricians should enter practice each year.
  - — However, the rate for recertification is running at less than 50 percent.
  - — This will cause a decline in the number of geriatricians over the next decade even with growth in fellowship training programs.
  - — Previous predictions were expecting a drop of 34 percent in the number of certified geriatricians.
- Over the past decade, the number of geriatric fellowship programs and the number of geriatric fellows have slowly increased.
  - — *About 3 percent of residents completing internal medicine and family practice residencies pursue fellowships in geriatrics, and about 8 percent of psychiatry residents pursue psychiatric geriatric fellowships.*
  - — The fill rate for these fellowships fell from 89 percent in 1998 to 69 percent in 2002.

Source: *Report to the Congress: Impact of the Resident Caps on the Supply of Geriatricians,* MEDPAC, November 2003.

Supply of Geriatricians

- According to information provided by the American Geriatrics Society (AGS), approximately 900 full-time academic geriatricians reside in US medical schools.
- AGS also estimates that 2,400 geriatric academicians are needed to perform various functions.
  - *Integrating geriatrics into other specialties and across other health care settings;*
  - *Training new geriatric fellows; and,*
  - *Performing new research into means of caring for older persons.*
- The White House Conference on Aging Policy Committee estimates that there are 600 physician faculty teaching geriatrics.
  - They also suggests that more than 1,450 are needed to prepare physicians to care for older individuals.
- Regardless of the exact number, additional academic geriatricians are needed to train additional geriatricians to enter the field.

Source: *Susa Emmer & Laura Alledorf, Memorandum*, with the American Geriatrics Society, to the White House Conference of Aging Policy Committee, September 9 2004 and *Final Report and Recommendations*, 2005 White House Conference on Aging Mini-conference on Geriatric Health Care Workforce Issues, July 16, 2005.

Geriatric Fellows in Training

Number of Geriatric Fellows in Training, by Specialty and Year of Training

	1995	1996	1997	1998	1999	2000	2001	2002
First year fellows	152	221	286	328	364	326	340	365
Family practice	11	8	23	30	39	25	34	36
Internal medicine	106	136	182	209	230	222	225	256
Psychiatry	35	77	81	89	95	79	81	73
All years	261	324	389	426	466	407	432	454
Family practice	22	22	29	37	42	28	36	41
Internal medicine	201	220	276	298	326	293	302	327
Psychiatry	38	82	84	91	98	86	94	86

Source: 1995-2001 data from JAMA medical education issues (1996-2002); 2002 data based on preliminary information from AMA and *Report to the Congress: Impact of the Resident Caps on the Supply of Geriatricians,* MEDPAC, November 2003.

Medical School Curriculum

- The Association of American Medical Colleges (AAMC) completed a survey on geriatric content in the curriculum and a survey of students on topics after graduation.
  - The 1998 study found that "the percentage of medical schools with at least some form of required geriatric exposure increased from 82% in 1985-1986 to 98% in 1996-1997…."
  - By 2003, 34% of medical school graduates responding to AAMC's questionnaire, "reported that geriatrics was inadequately covered in all 4 years of medical school."

Source: *Geriatric content in Medical School Curricula: Results of a National Survey,* JAGS 53:136-140, 2005.

Supply of Geriatricians

- Research suggests factors that may account for "the relatively small number of applicants to geriatric fellowship programs and the recruitment of only a small number of U.S. medical school graduates." These include the following:
  - *the medical problems of older people have often been viewed as unexciting and irreversible,*
  - *physician interest in geriatrics builds on interest in primary care (which is now weakening),*
  - *compensation for both academic and nonacademic primary care physicians and geriatricians remains relatively low compared to that of procedure-oriented specialists,*
  - *providers' dependence on Medicare for revenue once they are in practice, and*
  - *lack of faculty role models.*

Source: *Report to the Congress: Impact of the Resident Caps on the Supply of Geriatricians,* MEDPAC, November 2003.

Supply of Geriatricians

- *Financial disincentives pose the largest barrier to entry into the field. Geriatricians are almost entirely dependent on Medicare revenues. Given their patient caseload, low Medicare reimbursement levels are a major reason for inadequate recruitment into geriatrics.*
- *The Medicare bill included several new chronic care provisions, including a large-scale disease management pilot program. However, the new disease management program will not adequately address the needs of persons with multiple chronic conditions, nor will it address the financial disincentives within Medicare that have limited the supply of geriatricians.*
- *Different reforms are needed to increase interest in geriatrics, such as changes in the Medicare fee-for-service payment system, changes in the new disease management program, and changes in payment policy for federal training program.*
- *Twenty percent of the Medicare population has at least five chronic conditions, accounting for two thirds of program spending.*
- *Individuals with five or more chronic conditions represent a large portion of a geriatrician's base.*

Source: *Geriatric Medicine: A Clinical Imperative for an Aging Population,* AGS/ADGAP, March 2005.

Geriatricians in Virginia

- As mentioned previously, the Board of Medicine data lists 962 doctors self-reporting a specialty in geriatrics.
  - — The 962 licensees include Doctors of Medicine, Osteopathic Medicine, and/or Podiatry that are either currently or previously licensed in the Commonwealth of Virginia.
  - — Of the 962 licensees, 566 list a practice address in Virginia.
- This is up from 919 doctors self-reporting a specialty in geriatrics in 2004.
- All three medical schools in Virginia have geriatric fellowship programs.

Source: *Virginia Board of Medicine Practitioner Information,* BOM, July 2004 and September 2006.

Virginia Demographics

- Virginia's older population grew by approximately 35 percent from 1970 to 1980 and by approximately 25 percent from 1980 to 1990.
- During that time, the overall population grew by about 15 percent.
- The growth rate of the older population grew by about 17 percent in the 1990s.

Population Projections by Age Group for Virginia

Age Group	1990	2000	2010	2020	2030
0-19	1,704,603	1,937,189	2,020,471	2,169,302	2,349,714
20-59	3,572,849	4,075,669	4,423,820	4,537,766	4,666,961
60-84	850,197	978,373	1,303,155	1,722,226	2,035,728
85+	59,709	87,268	145,454	172,607	222,697
Total	6,187,358	7,078,499	7,892,900	8,601,901	9,275,100

Source: JLARC staff analysis of VEC data.

Source: JLARC staff analysis of VEC data.

Virginia Demographics

- VEC projections suggest dramatic increases in the older population in Virginia during the first several decades of the 21st century.
- By 2010, older Virginians will account for over 18 percent of the population.
- By 2020, the percentage will increase to 22 percent.
- By 2030, the older population will represent almost 1 in 4 Virginians, about 25 percent of the population.
- This growth is anticipated in part due to the aging of the "Baby-Boom Generation."

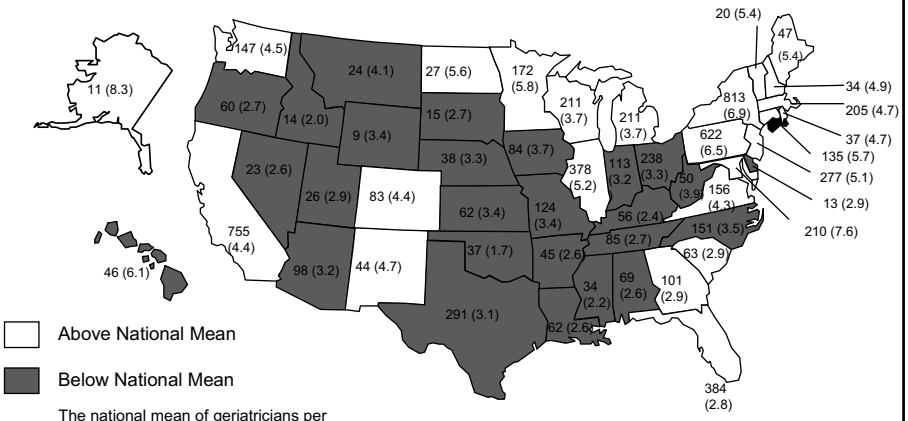
Projected Percentage of Total VA Population by Age Group

Age Group	1990	2000	2010	2020	2030
0-19	27.5	27.4	25.6	25.2	25.3
20-59	57.7	57.6	56.0	52.8	50.3
60-84	13.7	13.8	16.5	20.0	21.9
85+	1.0	1.2	1.8	2.0	2.4

Source: JLARC staff analysis if VEC data.

Source: JLARC staff analysis of VEC data.

Distribution of Certified Geriatricians in the United States - 2003

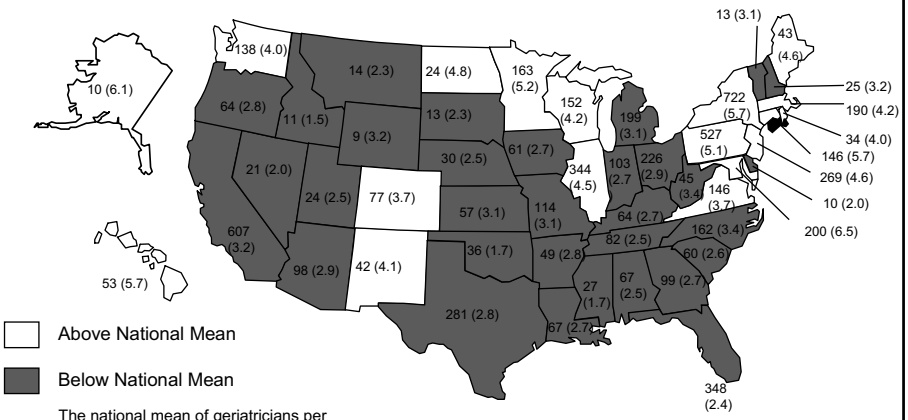


The national mean of geriatricians per 10,000 population age >.75 is 4.2 (state ratios in parentheses)

Source: American Board of Medical Specialists, 2003 Annual Report and Reference Handbook and Census 2000 as complied by the Administration on Aging.

Joint Commission on Health Care

Distribution of Certified Geriatricians in the United States - 2005



The national mean of geriatricians per 10,000 population age >.75 is 3.6 (state ratios in parentheses)

Source: American Board of Medical Specialists, 2005 Annual Report and Reference Handbook and Census 2004 as complied by the Administration on Aging.

Joint Commission on Health Care

Location of Virginia Geriatricians

- As previously mentioned, Virginia Board of Medicine data lists 962 doctors self-reporting a specialty in geriatrics with 566 listing a practice address in Virginia.
- Information on over 33,000 Doctors of Medicine, Osteopathic Medicine, and Podiatry either currently or previously licensed in the Commonwealth of Virginia is contained in the data.
- The table to the right summarizes the data by selected districts.
- Physicians can practice at multiple addresses resulting in duplication in the totals.

Geriatricians and Physicians by Region – 2006

District	# Geriatricians	# Physicians
Central	142	5,033
Culpeper	53	1,952
District of Columbia	42	1,789
Fredericksburg / Northern Neck	25	776
Hampton Roads	153	5,153
Northern VA	161	5,712
Southwest	87	2,340
Staunton	37	1,195
Total	700	23,950

Source: *Virginia Board of Medicine Practitioner Information*, BOM, September 2006.

Presentation Outline

- ❑ **Background and Research**
- ■ ***Examples of Virginia Initiatives***
- ❑ **Policy Options**

The Virginia Geriatric Education Center

- The Virginia Geriatric Education Center is currently a consortium of Virginia Commonwealth University, Eastern Virginia Medical School, and the University of Virginia.
  - — Developing curriculum and training programs for health professionals.
  - — Geriatric and gerontology training programs will be developed for health professionals.
  - — Key goal is to promote the independence of older persons.
  - — They are concentrating on five main areas:
    - cognition/dementia,
    - end-of-life care,
    - prevention of falls,
    - mental health, and
    - nutrition/obesity.

The Virginia Geriatric Education Center

- An issue of concern over the last year was that the United States Congress de-funded Geriatric Education Centers.
- An amendment to the Virginia budget provided*: general fund and nongeneral fund money for the operation of the Virginia Geriatric Education Center, a consortium of Virginia Commonwealth University, the University of Virginia, Eastern Virginia Medical School and the Geriatric Academic Career Awards Program. Both of these programs will be supervised and administered by the Virginia Center on Aging. The funding will continue geriatric training and education across Virginia for a wide range of health-related professionals and service providers.*
  - — $375,000 GFs and $375,000 NGFs were provided for each year of the 2006-2008 biennium.
- Funding for Geriatric Education Centers may be reinstated in the 2007-2008 federal budget.

EVMS Glennan Center for Geriatrics and Gerontology

- The Center was established to *provide for Eastern Virginia Medical School, the Tidewater community and the Commonwealth of Virginia a Center of Excellence focused upon:*
  - *Research in aging and age associated diseases;*
  - *education of health care providers and community members regarding these same issues of aging and age-related diseases; and*
  - *thoughtful and compassionate care for older people.*
- *The Glennan Center focuses on the preventive, interventional, and research aspects of age-related diseases.*
  - *By applying the findings from aging research to intervene in chronic disabilities of aging, The Glennan Center will help older patients maintain the highest possible degree of function and independence and avoid unnecessary and costly institutionalization.*

EVMS GerIMed Residency Program

- The Eastern Virginia Medical School (EVMS) created the GerIMed residency program "which is one of only two of its kind in the country."
- *Residents receive intense training in subjects such as palliative care, in-patient geriatrics and nursing home care. Graduating residents are eligible to sit for board certification in internal medicine as well as geriatrics.*
- EVMS was "also one of the first medical schools in the country to include a mandatory clerkship in geriatrics."

Source: *EVMS Chronicle*, Summer 2006.

Presentation Outline

- ❑ **Background and Research**
- ❑ **Examples of Virginia Initiatives**
- ■ ***Policy Options***

Policy Options

Option I: Take no action.

Option II: Request by letter from the Chairman that the Virginia Geriatric Education Center report to the Commission prior to the 2008 Session on its recommendations for improving access to and availability of geriatricians.

Option III: Request by letter from the Chairman that the Health Workforce Advisory Committee in its deliberations consider the issues of the access to and availability of geriatricians in the context of future health workforce shortages associated with the aging of Virginia's population.

Public Comments

- Written public comments on the proposed options may be submitted to JCHC by close of business on October 12, 2006. Comments may be submitted via:
  - — E-mail (mwhite@leg.state.va.us)
  - — Facsimile (804/786-5538) or
  - — Mail to Joint Commission on Health Care
    P.O. Box 1322
    Richmond, Virginia 23218

- Comments will be summarized and presented to JCHC during its October 19th meeting.

APPENDIX A

044010428

HOUSE JOINT RESOLUTION NO. 135

Offered January 14, 2004

Prefiled January 13, 2004

Directing the Joint Commission on Health Care to study access to and the availability of geriatricians and ways to increase geriatrics expertise among Virginia's health professionals. Report.

Patron—Morgan

Referred to Committee on Rules

WHEREAS, with the aging of America has come the need to contain health care costs among senior citizens by developing and implementing wellness programs and preventive care; and

WHEREAS, because older individuals often do not respond to therapies in the same manner as young individuals and often do not display the same or identical symptoms of medical conditions as young individuals, they frequently do not receive the most efficient care; and

WHEREAS, therefore, as the older population increases in the United States, the need to increase the prevalence of geriatrics expertise among all members of the health care community becomes more apparent and important; and

WHEREAS, however, medical education is already bulging with training curriculum and an enormous information explosion; and

WHEREAS, in Virginia, there is a need for a clear understanding of how many geriatricians are available to treat the ever increasing older population and where these experts are located or practicing in Virginia to identify potential needs and to plan for the future; and

WHEREAS, because the need for geriatricians in all fields of study will become more and more crucial as the senior citizen population increases, Virginia must identify its programs, the components of the medical and health care curricula that relate to developing geriatrics expertise, and ways to incorporate additional training on geriatrics into the curriculum of various health care professions in an efficient and effective way; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study access to and the availability of geriatricians and ways to increase geriatrics expertise among Virginia's health professionals.

In conducting its study, the Joint Commission on Health Care shall survey the Commonwealth's three medical schools and other health professional programs in Virginia's private and public institutions of higher education to ascertain how geriatrics is covered in the curricula and what, if any, plans have been or are being made to develop specific programs focused on geriatrics or incorporating appropriate principles into the present programs for surgeons, psychiatrists, neurologists, dentists, other specialty areas, and primary care specialties. The Joint Commission shall also ascertain how the known effects of aging on the immune system, the nervous system and other organ systems are approached or included in the relevant courses of various undergraduate courses for health care professionals or basic science classes for graduate and professional students. In its deliberations, the Joint Commission shall determine the adequacy of the Commonwealth's programs and whether additional projects, programs, or curriculum should be initiated in order to produce an adequate supply of geriatricians to care for Virginia's senior citizens. Upon completion of its data collection and analyses, the Joint Commission shall make recommendations concerning (i) the professionals that should be encouraged to study geriatrics, (ii) additions to any medical school or higher education curriculum, (iii) the number of geriatricians in various health professions and specialties that will be needed in Virginia by 2010, and (iv) initiatives for individuals enrolled in various medical and health care education to become geriatricians.

Technical assistance shall be provided to the Joint Commission on Health Care by the Department of Health, the Department of Health Professions, and the public institutions of higher education, including, but not limited to, the three medical schools. All other agencies of the Commonwealth shall provide assistance to the Joint Commission for this study, upon request.

The Joint Commission on Health Care shall complete its meetings by November 30, 2004, and the executive director shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the 2005 Regular Session of the General Assembly. The executive summary shall state whether the Joint Commission intends to submit to the General Assembly and the Governor a report of its findings and recommendations (for publication as a document). The executive summary and report shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

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