SPECIAL ARTICLE

Mainstream or Extinction: Can Defining Who We Are Save Geriatrics?

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The guiding principles and skills of small "g" geriatrics increasingly inform healthcare delivery, person-oriented research, medical education, and health policy. At the same time, the field of big "G" Geriatrics struggles to recruit new fellows and to provide a single, consistent, unified understanding of who we are and what we do. Our extinction has been predicted from the beginning and repeatedly over the years,[1,2] but previously, our options appeared to be extinction as a species from lack of replication versus survival as a marginalized field. Our current situation includes an alternative scenario: our principles will define mainstream health care while the field disappears. Before launching into what is wrong with our current strategies and tactics and what we should do differently to increase our chance of survival, let's remember that we have had many successes.

PROGRESS IN GERIATRICS SINCE THE 1980S

Geriatrics has developed a strong research and clinical base over the past 30 years. Dementia and multifactorial geriatric syndromes such as falls are two examples. The perception was still prevalent in the 1980s that "senility" was a normal part of aging. Dementia is now gaining parity with cardiac disease and cancer in the public's attention and in the scientific community's commitment to unraveling their pathological mechanisms. In the early 1980s, falls were considered—if at all—as inevitable consequences of aging. Thirty years later, there have been more than 100 randomized clinical trials (RCTs) of fall prevention strategies. Prevention of falls and other multifactorial geriatric syndromes such as delirium, incontinence, and immobility are critical targets of research and clinical practice.[3]

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Presented in part at the Reynolds Foundation Meeting, Las Vegas, Nevada, October 2014.

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DOI: 10.1111/jgs.14181

The 1990s and early 2000s witnessed the development of geriatric models of care such as Acute Care of the Elderly,[4] Geriatric Resources for Assessment and Care of Elders,[5] Program of All-inclusive Care for the Elderly,[6] Hospital Elder Life Program,[7] Nurses Improving Care for Healthsystem Elders,[8] and several others, all of which are now implemented throughout healthcare settings. Comanagement models with orthopedics, surgery, and other subspecialties have also spread broadly. Lest we think innovation is a recent phenomenon, an article from the 1980s described geriatric-orthopedic comanagement, and another article asked, "Can readmissions to a geriatric medical unit be prevented?"[9,10]

There have also been many promising developments in health policy. Geriatric concepts, such readmissions of persons with multiple chronic conditions, have become quality measures, as have assessment and management of several geriatric syndromes.[11–14] The Centers for Medicare and Medicaid Services (CMS) now provides modest payments for home visits, transitional care, and care coordination; payment for engaging in advanced care planning discussion has been reintroduced.[15,16]

The movement to value-based healthcare payment has stimulated the uptake of innovations, such as team-based care, patient safety, patient preferences, care of complex patients, palliative care, and transitions of care, that have roots in Geriatrics or are based on geriatric principles. We have come a long way in 30 years.

SO WHAT'S THE PROBLEM?

Despite these successes, it remains unclear what value-based and alternative payment models, essential to continued geriatric success, will look like. Health systems, particularly academic medical centers, still favor high-volume remunerative specialties and procedures. Quality metrics that determine what gets done and rewarded remain focused predominantly on diseases and events, despite lip service given to person-centeredness.[12] Medical education similarly persists in its organ- and disease-based paradigms.

The major threat to Geriatrics is best identified by looking in the mirror. We are timid about pushing our evidence, taking credit for our accomplishments, marketing our products, and defining our field. Who but other Geriatricians knows that the roots of patient safety are in early

JAGS 64:1400–1404, 2016
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0002-8614/16/$15.00

geriatric work on adverse effects of hospitalization or that innovations in transitions of care and postacute care are based on work by geriatricians?[17]

A personal anecdote reflects our timidity in pushing our evidence. Around the same time that authors of a meta-analysis reported that, "Current evidence suggests that multifactorial fall risk assessment and intervention may reduce the number of fallers by only a modest amount,"[18] I headed a Food and Drug Administration committee charged with advising whether there was sufficient evidence to warrant the transition of statin drugs from prescription to over-the-counter status. Several cardiologists who spoke called for "putting statins in the drinking water," given the strong evidence of safety and effectiveness. The prevailing evidence suggested that statins reduce risks of stroke or myocardial infarction by about 25% to 30%—the same benefit accrued by multifactorial fall prevention.

Another example of our reluctance to push our advances is reflected in our inadequate efforts to compel the incorporation of self-reported measures of function into electronic health records and quality measurement. Function, along with symptom relief, is the health outcome that older adults care most about.[19] Furthermore, evidence shows that chronic conditions exert their effects by compromising function and causing symptoms.[20] Are not function and symptom burden, along with individuals' specific outcome goal ascertainment and achievement, therefore the outcomes that should inform clinical decision-making and the quality of clinical care? How can any clinician care for older adults without systematically assessing, managing, recording, and tracking function and symptoms? The Institute of Medicine, CMS, and the National Quality Forum, among other health policy bodies, are looking for leadership to push function forward as a quality measure.[21,22] So what is holding it up? One roadblock is that we cannot agree on the "right" measures despite the fact that the myriad of existing instruments measure the same concepts.[23] A slew of disease-specific functional measures is rapidly filling this void. The window of opportunity will close soon.

We continue to accentuate our negatives to the public—including potential recruits. "Shortage of Geriatricians" is the most common topic geriatricians' comment on in the lay press.[24] We lament that careers focused on caring for older adults can be burdensome and financially unattractive. Every year we publicize the number of unfilled geriatric fellowship slots. Then we wonder why trainees don't want to join our club.

Perhaps most disconcerting is that we have failed to provide a single, consistent, unified understanding of who we are and what we do. Everyone knows what a pediatrician, surgeon, or cardiologist does, but it is not surprising that the public is unaware or confused about what a geriatrician is, given the conflicting perceptions among geriatricians themselves.[25] Are we meant to be the primary care providers for all older adults[26,27] or only the oldest old?[27] Are we the experts in healthy aging[28] or a specialty with skills in chronic care, frailty, geriatric syndromes, long term care, or conditions of aging?[2,29,30] Although the multifaceted nature of what we do is one of the attractions for many of us, it also impedes a clear understanding of the field by other healthcare professionals and the public.

How might we address these problems?

DEVELOPING A UNIFIED VISION OF WHO WE ARE AND WHAT WE DO

In addition to claiming credit for what we create, marketing our products, and stopping our whining, geriatrics' best chance for survival comes from uniting and focusing its training, clinical, and health policy efforts to align with current needs, opportunities, and realities (Table 1).

Geriatric Training Strategy

Trying to increase the number of geriatricians by lamenting the shortage hasn't worked in three decades. It has probably discouraged promising candidates. Let's abandon that tactic. In its place, we can embrace who we are—or could be: a small elite workforce that discovers and tests geriatric principles through our research, that teaches these geriatric principles to all health professionals and to the public, and that disseminates and implements these geriatric principles through our health system and health policy leadership. Our mission should not be to train enough geriatricians to provide direct care but rather to ensure that every clinician caring for older adults is competent in geriatric principles and practices. In the 1990s, we debated whether geriatrics was a primary care or specialty discipline.[30] It is neither. Geriatrics is a "metadiscipline"—perhaps the only one—that transcends and informs all other disciplines. Its knowledge base and principles should guide all care. The right metric for success should not be the number of fellowship slots filled, but rather the number of health professional trainees with geriatric skills and behaviors and, most importantly, the number of older adults that clinicians care for using geriatric principles.

This is not to say we haven't already done a lot of training of nongeriatric health professionals—quite the contrary. Work we have done with subspecialties and surgery shows how effective we can be;[31] these are among our most successful training efforts. Building on this success, particularly targeting primary care clinicians, who provide the vast majority of care to older adults, we should move further in this direction as a small elite training force imparting its knowledge and skills to all fields of health care.

Develop a Single Geriatric Curriculum

Trainees, clinicians, and health systems want to use the "best tool and curriculum." They are confused when there are multiple tools and curricula covering the same topics. The presence of multiple tools can be misinterpreted as lack of evidence or consensus on the topic. Clinician educators would do well to abandon the one-off curricular projects, joining forces to develop and disseminate a single, unified national geriatric curriculum. WebGEMs is a good start, but efforts need to be sped up and formalized.[32] Engaging geriatric educators from around the country in a "Manhattan Project for geriatric curriculum" could accomplish great things in a short time. Costs could be recouped by selling this well-branded product. At least as much academic pres-

Table 1. Strategies and Tactics for 21st-Century Geriatrics

Current "G"eriatrics Strategies and Tactics	Suggested "g"eriatrics Strategies and Tactics
Focus on shortage of geriatricians and the on unpopularity of the field (e.g., ". . . 36,000 geriatricians needed to care for increasing number of older adults)	Train a small cadre of geriatricians who ensure geriatric competency in all clinicians.Care directly only for the subset of the most complex patients.Provide e-consults or telemedicine support to clinicians caring for all other older adults.
Develop and implement multiple standalone site- and condition-specific models of care	Agree on, and disseminate, the core geriatric principles and elements imbedded in all these models.Ensure these principles and elements define care across all settings.
Focus program building and administrative efforts on providing discrete geriatric services	Ensure that geriatric principles are health system guiding principles (and acknowledged as such)
Practice and teach traditional disease-based care with attention to geriatric conditions and syndromes added on.	Make geriatric care mainstream care.Develop and disseminate patient health outcome goals-directed history, examination, assessment, plan, and decision-making.
Develop a confusing and redundant array of curricula, educational materials, and tools.	Develop and disseminate a single, unified national geriatric curriculum.
Focus on specific entities which are likely to change (e.g., list of inappropriate medications)	Focus on foundational principles and concepts (principles of appropriate medication management)
Contribute to plethora of condition- or event-specific quality measures	Lead efforts to develop a few patient-centered measures to drive value-based payments such as: Were patients' goals ascertained, addressed, achieved? Was treatment burden minimized? These efforts will need to include incorporation of patient reported outcomes such as function, symptom burden into the electronic record
Espouse a confusing and conflicting array of primary clinical focus from healthy aging to primary care to chronic disease to frailty to long-term care to oldest old	Endorse multimorbidity and complexity as our defining condition
Whine about lack of recognition	Celebrate and broadcast our successes and advances
Underplay our evidence; extenuate the negative to the public	Embark on a full, unified public relations campaign to let the public (and ourselves) know who we are and what we do and why our expertise is unique and necessary.

tige and credit toward promotion would accrue to participants in a nationwide project as from creating one-off tools that achieve little uptake. Once created, this curriculum should be disseminated broadly through multiple mechanisms. Curriculum is increasingly moving from the classroom to the web, and we can do the same. A few geriatric educators can reach large numbers of health professional trainees and practitioners through the Internet and telemedicine.

One area on which we could have a profound effect is development of a 21st-century history, physical examination, and Subjective, Objective, Assessment, Plan that reflects the needs and realities of 21st-century patients. Such a history would recognize that the focus of health care for today's complex patients of all ages is no longer on the "disease" but on the individual's health concerns within their life context and their own values, health goals, and care preferences. Clinical assessment and management skills should reflect this shift from disease-based to person-centered care, including the translation of clinical data and evidence into person-centered decision-making based on people's health outcome goals and preferences. If Geriatrics is willing to lead this effort, the effect on health care will be felt for generations to come.

Geriatric Clinical Care Strategy

Our best opportunity (and major threat) lies in how we respond as health systems struggle (willingly or not) to move from fee-for-service, volume-based to value-based health care. Let's explicitly, uniformly, and unequivocally market and brand ourselves as THE experts in complexity and all that comes with it, including uncertainty, tradeoffs, interdisciplinary teams, multiple coexisting conditions, patient goal–driven care. Geriatrics may rarely be mentioned in discussions about high-cost complex patients, but our principles are. We can change this. We can help health systems and implement the geriatric principle-based approach to care and enhance our visibility, credibility, and marketability by doing so.

The consensus among leaders of geriatrics academic programs in 2008 was that the people who would most benefit from a geriatrician would be those aged 85 and older and those with frailty, geriatric syndromes, severe functional impairment, and multiple complex healthcare problems.[33] Let's take this consensus as the starting point and move to solidify this as our patient (and research and educational) base. Multiple chronic conditions (multimorbidity) is a concept that has gained traction and should be our "defining condition." We don't have to worry about shrinking our patient base. Adults of all ages with multiple conditions are the majority of healthcare users.[34] Defining ourselves as the experts in complex decision-making for persons with multiple conditions does not preclude interest in healthy aging, nor does it mean focusing only on the frailest individuals. It means defining our unique niche to the public.

While we are at it, let's move away from disseminating the multiple excellent but standalone models—which frankly reinforces fragmentation and suggests we have not figured out what really works—to identifying and disseminating the core elements that anchor all these models. A unified approach to caring for a discrete population of

older adults with multiple complex health conditions—in all healthcare settings—will help brand us in the healthcare world.

Geriatric Health Policy Strategy

Geriatricians hold positions as deans and department chairs and have leadership positions at the American Board of Internal Medicine, National Quality Forum, National Committee for Quality Assurance, and CMS. We should aspire to fill more leadership positions nationally and locally. From whatever positions we hold, let's push in solidarity for the healthcare delivery and payment changes that support integrated, patient outcome–driven care. Let's accelerate the movement away from the plethora of disease-focused measures that foster unnecessary, expensive, ineffective, fragmented, and often harmful care for our patients with complex and multiple conditions. Let's be the ones who define value, particularly for the most complex older patients. Defining value-based care not by one-size-fits- all disease or event metrics such as blood pressure or glycosylated hemoglobin levels or readmissions but as care appropriate to the priorities and needs of each older adults.[35] To accomplish this move to person-centered value, let's lead the effort in developing and implementing person-centered measures such as ascertainment and achievement of patient outcome goals, consideration of patient treatment preferences and care burden, and person-centered and reported outcomes such as symptoms and function.[22,36]

The American Geriatrics Society identified five strategic goals in 2005: to ensure that every older person receives high-quality, patient-centered health care; to expand the geriatrics knowledge base; to increase the number of healthcare professionals who employ the principles of geriatric medicine in caring for older persons; to recruit physicians and other healthcare professionals into careers in geriatric medicine; and to unite professional and lay groups in the effort to influence public policy to continually improve the health and health care of older adults.[29] With the exception of the fourth goal, which hasn't worked for the past 4 decades, the suggestions outlined in this article are tactics aligned with these strategic goals that respond to current opportunities.

GERIATRICS' DEFINING CHALLENGE

The emerging interest in caring for complex patients and multimorbidity is perhaps the crucial defining moment for geriatrics, leading to the "geriatric paradox." There is increasing interest in small "g" geriatrics (the geriatric principles that guide clinical-decision making and clinical care for complex patients) while there remains little interest in big "G" Geriatrics (the training and support of Geriatricians to implement these principles). Health systems (and the public) have not associated the principles they desire—which we know are geriatric principles—with the field of Geriatrics or with the expertise of Geriatricians.

Is our chance of surviving optimized by efforts to recruit and train a large cadre of Geriatricians or a small number who are passionate and capable of inculcating geriatric care and principles throughout health care? Do we focus on direct care of the limited number of older adults we are able to reach or on teaching and disseminating geriatric principles to the broad range of health professionals who care for older adults? Which strategy is most likely to result in our ultimate mission of ensuring that all older adults receive appropriate care?

If we want to unify our efforts around this mission, the 2005 AGS goals are a good place to start, but the strategies and tactics we deploy to achieve these goals must align with current opportunities. I have outlined several action steps in Table 1 that could get us started. It is likely that geriatric principles will be increasingly mainstream, but will geriatricians be in the stream? Agreeing on, and letting the world know, clearly and positively, who we are and what we do is our best marketing tool and best chance for staying in the stream.

ACKNOWLEDGMENTS

The author appreciates Dr. Leo Cooney's efforts reviewing an earlier draft of this manuscript.

Conflict of Interest: The author has no competing interests to report.

Author Contributions: Mary Tinetti is the sole contributor to the concept and design and preparation of the manuscript.

Sponsor's Role: None.

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