Geriatric Hopes Rest on Improved CMS Outlays

BY BRUCE K. DIXON
Chicago Bureau

Improved reimbursement remains the focus of efforts to shore up the nation's supply of geriatricians.

Medicare's physician fee schedule for nursing home care urgently needs to be adjusted to reflect the real costs of diagnosis and treatment, according to Dr. Steven A. Levenson, president of the American Medical Directors Association (AMDA).

Without such a change, the number of physicians with geriatric competence will continue to decline, and elderly patients will be subjected to increasingly substandard care, Dr. Levenson predicted.

In early February, AMDA went before the American Medical Association's Resource-Based Relative Value Scale Update Committee (RUC) meeting in San Diego with suggested adjustments to nursing home CPT codes (99304-99310 and 99318) that would increase Medicare reimbursement for new admissions, subsequent visits, and annual visits by physicians.

A 5-year fee-schedule review, which began in 2003, was largely completed last year. But certain code families, including nursing home codes, were not submitted for review until the February RUC meeting.

"At this meeting, we asked that the codes reflect the care of nursing home and postacute patients, and we presented information based on surveys of our members," Dr. Levenson said in an interview.

"The challenge was to get physicians representing certain other specialties who don't work in this environment to understand that the geriatric population has changed, and that these patients pose a real diagnostic and management challenge," said Dr. Levenson, a consulting geriatrician in Towson, Md., who is a medical director of five Maryland facilities owned by Genesis Health Care, which operates more than 200 nursing centers and assisted-living communities in 13 eastern states.

The AMA formed the RUC in 1992 to act as an expert panel in developing relative-value recommendations to the Centers for Medicare and Medicaid Services (CMS). The RUC represents the entire medical profession, with 23 of its 29 members appointed by major national medical specialty societies, from anesthesiology to urology.

Although the RUC makes recommendations only for Medicare fees, it influences nearly all health insurers because most base their fees and reimbursement rates on the Medicare fee schedule, said Dr. Len Lichtenfeld, the American College of Physicians' representative on the committee.

A final decision about the reimbursement proposal won't be made before midsummer, pending review by CMS and a public comment period, he said.

Reimbursement rates lie at the heart of the much-discussed shortage of physicians trained in geriatrics, said Dr. Lichtenfeld, a medical oncologist in Atlanta.

"There's no doubt that primary care interests—family physicians and geriatricians in particular—are sorely lagging other specialties when it comes to [Medicare] reimbursement income. Taking care of nursing home patients is a labor of love," he said.

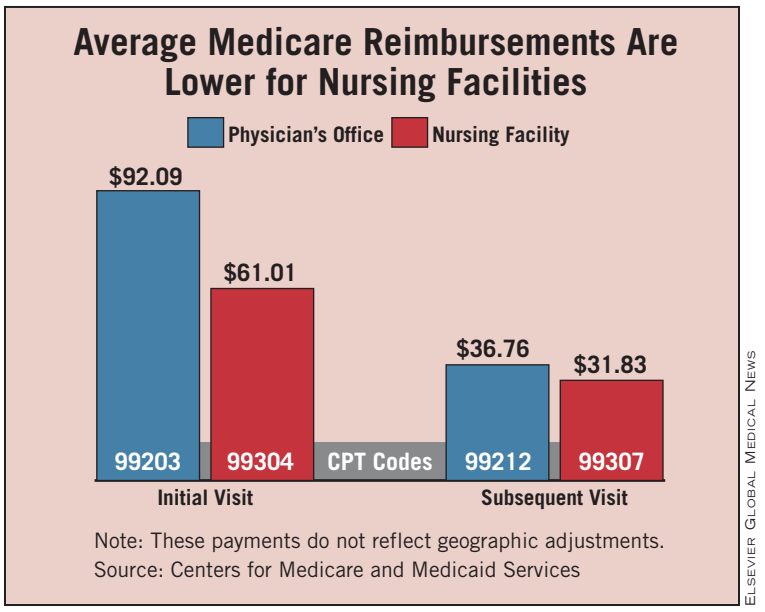
Dr. Sharon Brangman, a member of the board of directors of the American Geriatrics Society, noted that physicians often shy away from geriatric patients because of the complex nature of their illnesses and medications.

"These patients often have complicated social and psychiatric issues and doctors have a limited amount of time they can spend on a given person," said Dr. Brangman, who is professor of geriatric medicine at the State University of New York, Syracuse.

Dr. Arthur Altbuch, a geriatrician in Janesville, Wis., sees nursing home patients, mostly on his own time. "Let's look at the reimbursement rate for a routine visit to a stable nursing home resident, and you are reviewing his weight, vital signs, medications, and basically everything is okay. In Wisconsin, that pays $30.76 under code 99307, and that doesn't include driving back and forth to the nursing facility," he noted.

Increasingly, physicians won't provide care at nursing homes unless they have enough resident patients to make their time there worthwhile, said Dr. Altbuch, director of the family medicine residency program for Mercy Health System, which spans much of Southern Wisconsin and Northern Illinois.

"Mercy Health System employs about 200 doctors, and I am one of only two geriatricians, and therefore I cannot refuse geriatric patients, so I take my lumps," he added.



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The economics of the problem extend beyond Medicare reimbursement. "The average medical student has $100,000 worth of debt by the time he graduates, so to enter a procedural specialty that offers higher pay becomes extremely attractive," said Dr. Robert Butler, president and CEO of the International Longevity Center in New York City.

The relatively small number of geriatricians in the United States—7,000 out of a total physician population of 650,000—is primarily the result of reimbursement issues and the increasing complexity of managing the health of aging patients, but the shortage is aggravated by the junior position of geriatrics in most medical schools, Dr. Butler said an interview.

About 45 of the 144 U.S. medical schools offer significant geriatrics curricula, he noted, but "just because they have a program doesn't mean they require students to go through it."

Dr. Levenson sees that as a growing problem, because thousands of physicians who are providing care to geriatric patients "really don't know what they're doing . . . and create problems that have to be cleaned up by someone else."

On the political front, physicians cannot just wait for events to unfold, Dr. Lichtenfeld said. "They need to step up to the plate and complete these surveys [about reimbursement], or we're dead in the water."

Nor can physicians expect help from the patients themselves, Dr. Altbuch noted. "Nursing home patients don't vote and they have no political clout, and politicians know this." ■

Conciseness, Emotion Help Make Most of Media Exposure

BY JEFF EVANS
Senior Writer

WASHINGTON — Medicine and health are so often in the news that it may be worthwhile to be prepared to do interviews in a variety of media, Ms. Patricia A. Clark said at a meeting of the Society for Pediatric Dermatology.

"The physician today cannot possibly get through his or her entire career professionally without talking to the media, so you better be ready," said Ms. Clark, a communications expert in media training, speech coaching, and message development from Ogden Dunes, Ind. "You do have a good story to tell, right? So the trick is how to tell it."

Before one tries to get a particular message across during an interview, it is necessary to understand the medium through which the message is delivered (television, radio, print) and the messenger.

"If you don't understand the medium you're working with … and if you aren't an appealing messenger—and I don't mean handsome or beautiful, I mean eager, avid, happy to be here," she said, then the interview "won't matter. We will have 'remoted' you out before you get to the message."

Stories on the evening news are packaged into preset lengths: a 90-second story, which normally provides 10-20 seconds for commentary from the physician; or a 110-second story, which could provide 30-40 seconds if the sound bite is good or just 10-20 seconds if it is not. When a person goes on and on and does not deliver a succinct message in those time frames, the media will pull out a piece of what was said when they are putting the story together, leaving the potential for misquotation.

"You're going to say, 'You misquoted me. You took me out of context,' while the media will say, 'No, we tried to save you,' " Ms. Clark said.

The television camera diminishes appearance and does not catch subtlety, so it is necessary to restore what it takes away by increasing your smile, perk, and warmth. And on television, "every time you look away, you give away: You give away believability," she said.

The media likes conflict and controversy, visuals, and emotion, which "for doctors means pulling patients out of your pocket … and putting a face on the complex issues" rather than drawing attention to yourself and your or your specialty's problems, she said.

Stories on the radio are not too much different from television, but the lack of a visual element puts more focus on what is said, so verbs and nouns have to be more illustrative and carry more weight.

Newspaper stories are now smaller than ever, and interview subjects may get only an inch or two of space—the media savvy will be higher in the story while those who are not end up at the bottom, a place fewer people read and that is more likely to be cut for space, according to Ms. Clark.

You are apt to be stuck at the bottom of a story if you are called at 9 a.m. to do an interview and the reporter's deadline is 3 p.m., but you decide to call the reporter back at 2:50 p.m. By doing this, you've hurt yourself and your colleagues. The story is blank at 9 a.m., but it's all ready to go at 2:50 p.m., and other sources have already weighed in with their interpretations of the issue. Your quote will be stuck at the bottom because it is too late to try to integrate it into the story, she said.

"Start thinking about what the press needs rather than what you need, because when you figure out what [they] need, you'll figure out how to get what you need," Ms. Clark said.

Easy practice may be found in the form of a cable access channel that few people watch. Volunteer to be on a show and talk about clinical topics you know well. Talk or call-in radio is another option. Every time you take a call, practice bridging back to your core message, she said. ■