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Healing the health care system: Summaries from the Department of Health Policy Summer Seminar

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Healing the Health Care System

INTRODUCTION

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THE DISEASE MANAGEMENT FIELD continues to evolve. The range of chronic diseases treated has expanded to include such conditions as obesity and pain management, and the care continuum now encompasses wellness, prevention, and population health. One population that is an ideal candidate for our collective efforts is that of older adults. Global and national population projections reveal the impending staggering increase in the age 65+ cohort, which will cause a sharp increase in the demand for health care and other services due to such age-related issues as multiple chronic conditions, falls, and depression.

To begin to address these issues, the Department of Health Policy at Jefferson Medical College devoted its annual Summer Seminar to providing a forum for collaborative discussion focusing on the needs of the aging population. Two of the presentations focused on Pennsylvania, although the demographics presented by Nora Dowd Eisenhower reflect national and global trends, and the recently passed legislation outlined by Rosemarie Greco can be used as a yardstick against which other states can judge their own progress. Dr Susan Reinhard's presentation keys in on the need for expansion of scope of practice and consumer-oriented care. Our keynote speaker, Dr Robert Butler, details the challenging issues we must face and resolve in order to cope with the impending crisis. And finally, a panel, comprising representatives from payor, practitioner, and consumer groups, offer their candid, unscripted reactions to the presentations in a segment titled "Bridging the Gap Between the Vision and Implementation." Summaries of these presentations follow.

I hope that you will invest your time in reviewing these materials, and begin to think about the significant role that disease management can play in reforming the health care system to meet the needs of the older adult population. I am, as always, interested in your feedback. You can reach me via email at david.nash@jefferson.edu.

DEMOGRAPHIC TRENDS: MAKING THE CASE FOR HEALTH SYSTEM REFORM IN PENNSYLVANIA

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Introduction

In January 2007, at the beginning of his second term, Pennsylvania Governor Edward G. Rendell introduced his health care reform plan. He dubbed it the Rx for PA – or Prescription for Pennsylvania. The timing of the announcment was fueled by the previous 4 years of intense focus on the challenge of expanding access to high-quality and affordable health care to more Pennsylvanians. The urgency behind the health care reform efforts can be better understood by looking at PA's demographic landscape, which sets the stage for its future health care environment.

The Demographics

Demographic projections for PA mirror trends across the United States and developed

nations worldwide. According to a report issued by the Central Intelligence Agency in 2001, by the year 2050 the global 65+ age cohort will triple in size to 1.5 billion people, or 16% of the total population. However, the majority of the growth will occur in developed countries. In contrast, developing nations will experience simultaneous growth in their younger populations, with the largest proportional youth populations in Pakistan, Afghanistan, Saudi Arabia, Yemen, and Iraq. The report also indicates that by the year 2015 a majority of the world's population will live in cities.[1]

Based on these global demographic projections, it is clear that developed countries will face unprecedented challenges as they work to meet the changing needs of their aging populations. These same challenges are reflected in our national demographic projections. In the United States, the number of people older than 65 was 36.8 million in 2005, which represents an increase of 3.2 million, or 9.4%, since 1995.[2] In addition, the population over age 65 is projected to grow from roughly 40 million people this year to nearly 90 million people in 2050, an increase of 125%.[3] The 85+ population, those older adults often considered to be the most frail, is expected to increase from 4.2 million in 2000 to 8.9 million in 2030.[2]

PA ranks third in the nation for percentage of the population over age 65 and fourth in the nation for the number of people over age 85. By the year 2020, 1 in 4 Pennsylvanians will be age 60 or older; the 85+ population is expected grow by 52%. Equally significant, younger age groups in PA are expected to decline. By the year 2020, for the first time, the population over the age of 65 will equal the population under the age of 15.[4]

History = Cohort

While the figures are startling, why are the demographics important? What can the projections for PA tell us about the changing needs of older Pennsylvanians? The answer lies, in part, in the character and profile of the people who are just beginning to age into the programs and services for older adults. In 2006, we experienced a landmark event when the first baby boomers turned 60. Essentially, the boomers will change everything about aging as we know it, but we can use social marketing concepts to gain insight into the ways in which current systems must change in response to shifting demands. Boomers have always demanded change and possess a very different mindset and value structure from "seniors" as we know them today.

Lifestage Matrix Marketing (LMM) has analyzed the boomers and their predecessors to determine how boomers differ from previous generations and from each other. LMM's cohort analysis is based on the concept that groups of people who are born during a particular time period and come of age together based on the shared experience of a defining moment will display similar characteristics and values for the duration of their lives. Cohorts are different from generations in that they are delineated by their defining moments, as opposed to arbitrary time frames. There may be significant variation in the chronological span of a cohort; thus a cohort could consist of as few as 5 years (the World War II cohort, individuals born 1922–1927) or as many as 17 years (the Post-War cohort, individuals born 1928–1945).[5]

LMM divides the boomers into 2 cohorts, the leading-edge boomers (born 1946–1954) and the trailing-edge boomers (born 1955–1965), and emphasizes that boomers are not a monolithic group. However, overall similarities between the boomer cohorts exist that differentiate them from previous cohorts. For instance, World War II and Post-War cohorts are more likely to espouse a mindset in which individuals are encouraged to fit in, follow the rules, and refrain from making waves. By contrast, the boomer cohorts are more likely to embrace causes and to challenge institutions and authority.[5]

It is evident from the above examples that systems designed to meet the needs of the World War II and Post-War cohorts will be ill equipped to respond to the demands of the boomer cohorts. The leading-edge boomers are just beginning to reach the age of 60, and by the year 2020 the trailing-edge boomers also will be well into their 60s. At the same time, the Depression (1912–1921), World War II, and

Post-War cohorts are dwindling at the older end of the spectrum. LMM uses the term "cohort metabolism" to refer to the constant shifting of cohorts through the life cycle. As mentioned earlier, cohorts carry their particular values and mindsets with them as they move through the life cycle.[5]

Thinking toward the future

How do the social marketing concepts of cohort analysis and cohort metabolism help to inform our health system reform efforts in PA? We must draw on our knowledge of cohorts and their values to adapt our programs and services to the changing population.

In terms of sheer numbers, the increase in the percentage of older adults in PA will create pressure on services including Public Health, Agriculture, Parks & Recreation, Housing, Health Care, Workforce, Transportation, and Education. In the short term, PA will experience growth until 2010 and an increase in the number of workers at the maximum earnings ages (50–62), which can provide a strong income tax base.[6]

However, the boomer retirement will herald a series of challenges. Once boomers start to retire, income tax receipts will decrease and pressure on pension funds, both public and private, will increase. There will be fewer people in the workforce, which will result in a smaller number of workers supporting a much larger number of older adults. In addition, boomer retirement will have implications for health care and housing, and tax breaks for older adults will become very costly.[7]

The need for health system reform

The cost of health care for someone over the age of 65 is 3 to 5 times greater than the cost for someone under age 65.[8] By 2030, the nation's health care spending is projected to increase by 25%.[9]

During the same time frame, PA will experience an increasing shortage of health care providers. Anticipated shortages include physicians (particularly geriatricians) registered nurses, and pharmacists. This is significant because an increase in the number of health care providers will be necessary to provide adequate health care for the growing population of older adults.[10, 11]

On average, 80% of those 65 and older have 1 chronic condition, and 50% have 2 chronic conditions.[9] Currently, approximately 32% of physician care hours are spent caring for people over age 65, and this will likely increase to 39% by the year 2020.[12] Older adults face a host of health issues including macular degeneration, broken bones due to falls, depression, and a rising incidence of HIV.

In light of the demographic changes we know PA will experience over the next few decades, it is clear that the time is right for health care reform. In fact, PA cannot afford *not* to change. Although the future is challenging, we have the opportunity to act and Governor Rendell's Rx for PA is an essential step toward improving the quality of life for all Pennsylvanians.

Acknowledgment

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Rx FOR PA: RIGHT STATE, RIGHT PLAN, RIGHT NOW

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During the summer of 2007, 2 newly-released studies gave us a granulated view of health care in our country and in our state. The Commonwealth Fund's National Scorecard brings into sharply painful focus the fact that of 19 industrialized countries reporting on deaths that occurred before age 75 that could have been avoided through medical treatment, the United States ranked 15. Of 23 industrialized countries reporting on infant mortality, we ranked last. Of the 6 countries reporting on all quality measures in the study, we ranked fifth. And in overall measures of access, equity, and healthy lives we were, again, dead last.[1]

There is 1 category in which we lead the world: we spend more of our gross domestic product on health care than any other country. Consider the recent coverage of the US health care system by the media:

- News outlets all across the nation, such as CNN and the *New York Times*, have been highlighting gross inadequacies and serious flaws in our health care system and recently have begun to draw unfavorable comparisons of quality and cost between the United States and other countries.
- *Newsweek* reported that emergency rooms are overburdened, understaffed, and underfunded. It calls the situation dismal and says there is no single sweeping solution to the problem.[2]

Unfortunately, as the country goes, so goes Pennsylvania (PA). In the Commonwealth Fund study, PA ranks in the bottom quartile on prevention of hospital surgical infections, and ranks 36th in providing recommended care for patients who have suffered heart attacks. Our death rates for breast cancer were in the bottom quartile, and PA ranked 36th on avoidable hospital use and costs.

A second study released gives further evidence of our system's dysfunction. The Pennsylvania Health Care Cost Containment Council (PHC4) study on cardiac care spotlights the high financial and human cost of health care acquired infections (HAI) in our state, and the perverse reimbursement structure that pays for them.[3] The PHC4 study shows that patients who undergo cardiac surgery and acquire an HAI spend 14.6 more days in the hospital and are 11.1% more likely to die than those who did not acquire an HAI. The average insurance provider pays double for a patient with an HAI.

The study also reveals that high cost does not necessarily ensure high quality – often just the opposite is true. What is wrong here? How long can this continue without maiming our economic competitiveness and impairing the fiscal soundness of our families and businesses?

A new Kaiser Health Tracking Poll[4] found that when Americans were asked which 2 issues they would most like to hear Presidential candidates speak about, 43% mentioned Iraq, but health care was second at 21%. When asked what 2 health care issues respondents would most like to hear discussed, 36% mentioned coverage for the uninsured and 27% mentioned

reducing cost. Coverage was the most important issue regardless of party affiliation, and respondents overwhelmingly cited higher premiums and other out-of-pocket expenses as their biggest cost concerns. However, only a small minority (13%) rank health care as their most important voting issue. The majority (68%) include it among other important issues to be considered.

Maybe that is why the federal government hasn't shown the political will or collective appetite for designing a national health care solution; the votes are not yet high enough to count. Many believe that Congress would have more confidence in acting if states were to succeed in implementing sustainable, cost-effective health care insurance models.

So far, 34 Governors have introduced proposals to reduce the number of uninsured residents in FY 2008. Two states, Illinois and Pennsylvania, have already implemented programs to provide affordable health care coverage for uninsured children, and Governor Rendell's Cover All Pennsylvanians plan was embedded in his proposed budget for 2007–2008. But this Governor does not believe that covering the uninsured in Pennsylvania is the health care reform silver bullet.

Think about it – if all Pennsylvania's uninsured were insured, it would not make the rest of us healthier. Covering the uninsured would not give all Pennsylvanians easier access to quality care, make our hospitals safer, enable the Insurance Commissioner to regulate premium increases, make health care costs and quality transparent, or enable health care professionals to practice as a team. Nor would covering the uninsured enable those with chronic illnesses to get essential care and avoid unnecessary trips to emergency rooms.

Health care reform solutions by their very nature are complex and controversial. They require commitment to a common purpose and changes that make some uncomfortable. *Rx for PA* goes well beyond coverage for PA's uninsured. It has been described nationally as among the most comprehensive of the 34 state health care plans. Yet, within the Keystone State, the several months after the Governor proposed his Rx for PA were marked by questions about its viability and dire predictions. Despite that, in mid-July a contentious General Assembly passed a set of Rx for PA bills into law.

Six of the new acts authorize health care professionals (ie, physician assistants, certified registered nurse practitioners [CRNP], certified nurse-midwives [CNM], clinical nurse specialists, and dental hygienists) to practice to the fullest scope of their education, training, and clinical experience. That means CNMs, who deliver more than 10% of the live births in PA – and nearly 50% in some rural areas – will now be allowed to write prescriptions for their patients. PA previously was the only state with this prohibition. In addition, CRNPs will now be able to make referrals for their diabetes patients and to order home health care and hospice care for the frail and elderly. Dental hygienists will be able to go into nursing homes and visit the homebound to provide care.

Another part of the recently signed Rx package deals with HAI's. A few years ago, PA became one of only a dozen states to implement reporting of HAIs.

The new bill sets PA at the forefront of the nation on this issue, taking aim at 2 different but related concerns: transparency and surveillance. Transparency allows for greater accountability, creating a mutual responsibility between providers and patients to establish a safe environment. PA is the first state to require fully transparent reporting – every hospital must report on every infection for all patients in the full facility at all times - not just some infections or for limited times as other states require.

Now, PA also is the first state in the country to address surveillance; not just reporting, but "in the moment" monitoring and analysis so that facilities can review how well their infection control programs work and rapidly respond to any developing problems.

The cost of inaction is too great. This is why we will not rest, but instead will pursue the Cover All Pennsylvanians portion of *Rx for PA* in the fall of 2007 to provide insurance coverage for the uninsured.

It is not only for their benefit, but for all Pennsylvanians. It is clear that even if the politicians lag behind, the majority of people understand this. If we ensure that all Pennsylvanians have access to affordable health care, and if we ensure that quality is of the highest stan-

dard for prevention, treatment, and patient safety, we will lower the cost of health care for everyone and help to raise our quality of life.

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HEALING THE HEALTH AND LONG-TERM CARE SYSTEM

Transcribed and adapted for publication by
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Two keys to healing the health and long-term care system are scope of practice and person-centered care. From the perspective of Susan Reinhard, RN, PhD, director of the AARP Public Policy Institute, changing the law is only the beginning of what really needs to be done. "We cannot meet the challenges of an aging society if we insist on doing what we have been doing."

The current system of both acute and long-term care (LTC) has been organized in what has been known for the past 50 years as the "medical model," which is provider centered. We are all challenged now to become more person centered, more consultative, and community-based. We should work toward more consumer choice and control, and funding should follow the person (ie, funds should be available for a person's care wherever they decide to receive care).

To make this happen we need policy changes and, equally as important, we will need changes in professional norms. All stakeholders have to see it as possible and desirable. "We need to confront ageism and turfism. It is about more than keeping older adults safe: it's a matter of what is reasonable in their lives, what affects their quality of life, how we negotiate any risk that is occurring in their lives, and move forward."

The policy goal is to remove barriers that prevent professionals and paraprofessionals from reaching their full capacity to meet the needs of older adults—barriers that prevent full deployment of competent and cost-effective providers. The policy of AARP is: "Amend current licensing laws to allow nurses, nurse practitioners, and allied health professionals to perform duties for which they have been trained . . . " Many barriers are created by state regulations; there is enormous variation in state nurse practice acts and regulations for dieticians and other allied health professionals. Regulations across the country are contradictory, outdated, and counter to best practices, all of which affects quality of care.

"Extensive research validates that care provided by APNs (eg, nurse practitioners) is safe, cost-effective, and needed. No studies have shown them to have an adverse effect on consumers." These practitioners should be allowed to practice to the fullest extent possible.

Examples of professional practice models that have proven effective are: Evercare, a Medicare Managed Care demonstration in which nurse practitioners led the care of institutionalized elders; PACE (Program for All-inclusive Care of the Elderly), community-based managed care provided by an interdisciplinary team (eg, physicians, nurses, dieticians) for frail, chronically ill older adults; and community nursing centers or nurse-managed health centers. Scope of practice regulations in individual states affect the efficiency of all of these models.

Older consumers prefer to have care in their homes. "They want Marcus Welby back." Things are changing in that direction; there are newer models in which home care is reimbursed by Medicare. Medicare is now reimbursing for physicians and APNs to visit patients in assisted living facilities. But, in order for older adults and people with disabilities to

stay in their homes and communities, they need help with routine health maintenance activities (eg, routine medications, bowel and bladder regimens, tube feeding). Nurse delegation and consumer direction are 2 effective avenues for accomplishing this.

Nurse delegation

After assessing the consumer and the aide, the nurse instructs the aide and demonstrates how to perform the required task. The aide then performs the task to document competency. The nurse provides written instructions for the aide and continues to monitor the consumer. In this way, people can get their medications without requiring nurse involvement.

Consumer direction

The consumer or a designee instructs and directs the aide in the tasks with which the consumer needs assistance. A nurse or physician may be enlisted to teach the task, and some programs may require initial nurse or physician approval, but there is no ongoing nurse involvement with the aide. Caregivers are empowered to provide direction for those older adults affected by dementia. This is considered an exemption from the nurse or physician practice act, as opposed to delegation.

This is the future—no nurse or physician delegation is involved (except for supervision by the state); the consumer is responsible for instructing, directing, and supervising the aide. Boards of nursing and states must become comfortable with removing the routine health maintenance functions from the nurse practice act, even for persons with dementia.

Details about the best nurse practice states (selected from the literature) follow. The regulatory environment in these states supports consumer access and choice, and encourages APNs to function within the scope of practice. There are no onerous requirements that are not evidence based (eg, frequent filing of collaborative agreements). Lab testing, physical therapy policies, and prescriptive authority are unencumbered.

- Arizona: rated the strongest state for consumer access to nurse practitioners (according to recent research). The board of nursing has sole authority over nurse practitioners (as is the case in over 30 states); practice is not encumbered by members of other professions. There is innovative LTC via managed care. APNs, delegation, and full scope of practice have led to many options so that there is little reliance on nursing homes.
- Washington: considered a pioneer in LTC. APNs had prescriptive authority more than 2 decades ago. Home and community-based care (HCBC) is encouraged; friends and family members are freely allowed to perform care activities and be paid for supportive care. Nurse delegation is crucial; it is allowed and encouraged. There is a global budget so that funding for all LTC (eg, nursing homes, assisted living) is in one pot, so that as consumers make choices, the dollars follow them. HCBC absorbs the growth in service demand; nursing facility caseloads are trending down as HCBC is trending up. It is successful because it enables people to do what they have been trained to do – to support people in their homes and communities.
- Oregon: a pioneer in LTC. For approximately 25 years, nurses have delegated to lay caregivers. "The nurse teaches the caregiver one-on-one. If the nurse thinks the caregiver can do the task, the nurse has the authority to let them do it—it's that simple." There is no formal research to support this scenario, as there is in Washington, but there have been no consumer complaints for 25 years.

  APNs can practice fully in scope with unencumbered prescriptive authority. Case managers (generally social workers) monitor consumers' care. Seven of 10 seniors in Medicaid are served in the community instead of nursing homes, which is the highest percentage in the country. The Oregon experience proves what we can accomplish if we change the way we do and think about things.
- New Hampshire: requires that nurse practitioners be nationally certified by their profession (ie, the American Nurses Credentialing Center, not the board of nursing). There

is no other restriction on entry into practice. Consumer direction is emphasized.

- New Mexico: by some measures, this is "the most balanced state in terms of how LTC dollars are spent." Unencumbered practice is a policy goal. There is a significant amount of personal care and consumer direction. Despite the use of lay caregivers, safety problems have not been an issue.

The populations of the United States and the world are aging. We need to become more creative in how we organize and regulate the health and LTC system. "Although change is unsettling, we *must* change the way we do things. It is up to us."

REDESIGN OF HEALTH CARE FOR AN OLDER AMERICA

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The demographic trends in Secretary Eisenhower's presentation clearly show the impending significant increase in the number of older adults and the attendant impact on health care and other services and costs. Keynote speaker Robert N. Butler, MD, President and CEO of the International Longevity Center, outlined the issues that must be addressed and resolved *before* we are in crisis.

Caregiving crisis

Two key areas are workforce retention and workforce development. We currently face shortages of primary care physicians, registered nurses, paid in-home caregivers, and nursing home personnel. We must develop incentives for retention and find creative ways to promote recruitment. Team-based care must become the norm and teams must be designed to include the full spectrum of professionals, including nurse practitioners, physician assistants, social workers, and allied health personnel. All must be trained in how to best care for older adults.

Equally as important is providing career development opportunities for home health aides, who are critical to effective and successful long-term care. Currently this group has no national certification, no national curricula or training, and no professional association. They are poorly paid, without pension or health benefits, and are not treated with dignity. They can earn more working at a fast food restaurant than they can doing this very necessary work. Dr Butler is currently working on a $4 million project with a number of organizations (eg, MetLife, Pfizer) to address these inequities. The project goal is to engage community colleges to offer career ladder options to these workers – to give them dignity, avenues for professional growth, and real opportunities (eg, as radiology technicians, certified nursing assistants, licensed practical nurses).

Health care costs

We must explore alternative sources of paying for health care. "Discussion continues about increasing the tax on tobacco, but "alcohol has not been taxed since the 1950s – despite the fact that 8% of Americans are adversely affected by alcoholism." A value-added tax also should be considered, as well as a multiple payer system.

We are paying a high price in the global economy for not having a universal risk pool. The familiar example of the bottom line impact is that GM charges $1500 more per auto to cover their limited risk pool compared to foreign auto makers.

We also must rethink the enormous sums spent on procedures vs. primary care (ie, cognitive services). "A physician can make an accurate diagnosis 80%–90% of the time if allowed the time to take a thorough history and perform a physical exam."

It is time to face the fact that private insurers contribute significantly to the added expense. For example, France devotes 10% of its gross domestic product to health care. The World Health Organization and others consider France to have

the best health care system, yet it has no private insurance. In contrast, the United States devotes 16% of its gross domestic product to health care. A portion of that cost is devoted to selling, marketing, and claims; that money does not advance direct delivery of health care to people.

Stabilize Social Security

US Comptroller General David Walker has explained that we can fix Social Security by raising the wage base from $97.5M to $150M, thereby solving 60% of the Social Security shortfall over the next 75 years. There are other modest changes that can be made, such as the concept that if people are living longer, they should work longer. In addition to economic contributions, "studies by the National Institutes of Health (c. 1960s) have shown that people who work longer and have something meaningful to do, live longer and have a better quality of life – which is not such a horrible penalty. Even a few additional months in the workforce could have an extraordinarily positive effect on Social Security funding, as Congressional and Senate hearings found."

Health care reform

When Medicare was established 40 years ago, its creators did not foresee the environment in which we now find ourselves. Medicare requires thoughtful, structural reform, and the effective incorporation of health promotion, disease prevention, and community-based approaches such as the *Life* program sponsored by the National Institute on Aging.

Dr Butler has been chosen to champion the *Life* program, which is focused on lifestyle interventions and independence for elders. The program will be conducted in a variety of centers throughout the United States to demonstrate the vast importance of physical fitness in maintaining vigor and health of the older population. "The 12th cause of death in the age 65+ population is falls, which are very much a function of issues of balance and muscle strength, particularly the quadriceps."

So much can be done in terms of prevention and the maintenance of vigor and health of the older population by simple efforts. Dr Butler recommends establishing a national walking program, and focusing more attention on brain health. "It is more than just an adage that a sound mind equals a sound body. MRI data show increased blood flow in those individuals who are physically more active."

Other areas of health care that require more focus and funding are:

- chronic disease management and expensive conditions such as diabetes, asthma, heart disease
- medical errors and nosocomial infections
- end-of-life care and palliative care
- development of more thoughtful, science-based treatment guidelines

Research development

Since the 1930s, there has been a dramatic increase in understanding exactly what the basic biology of aging is. We have had great success in targeting specific diseases, but not the interrelationships among a variety of diseases. For example, we still don't know why 80% of all cancer occurs after age 50, or why the incidence of Alzheimer's disease, coronary heart disease, and hypertension increase with age.

We must invest in aging and biomedical research. "If 1% of Medicare dollars were devoted to health services delivery research, nursing research, biomedical research, and the basic biology of aging, it would triple the current National Institute of Aging budget to $3 billion." This is how to face the reality of and best prepare for the aging population.

Disorders of longevity must be addressed. Increasingly, we realize that geriatric diseases are really diseases of longevity that had their beginnings much earlier in life. We must begin to adopt a lifespan perspective when thinking about prevention.

We also need to rethink pediatric diseases and address them earlier. For example, osteoporosis is largely a consequence of the fact that bone was not banked early in life, due to such factors as inadequate intake of calcium, lack of antigravity exercises, and vitamin D. Atherosclerosis also has its origins in childhood; atherosclerotic streaks have been found

during autopsies of children as young as toddlers.

Alzheimer's disease is becoming a crisis. It is "the polio of geriatrics" and the nursing home is the iron lung of geriatrics. Funds and focus must be devoted to the prevention and treatment of Alzheimer's.

We must realize that genes account for only 20% of the length of life we have; 75% of what happens to us within our prescribed genetic period of life is under our control in terms of our own behavior and the impact of our environment on us. The statistics on actual causes of death reveal that tobacco, poor diet and inadequate physical activity, and alcohol consumption claim too many lives, although it is within our power to prevent these deaths.

Conclusion

A dramatic culture change is needed. "We need a new mindset, new ways of thinking about aging, new recognition that longevity is here, and that it will probably get even more profound with genomics, regenerative medicine, nanotechnology, new immune adjuvants, and other technological and genetic advances in this century." It is time to transform the culture and personal experience of aging.

REACTOR PANEL: BRIDGING THE GAP BETWEEN THE VISION AND IMPLEMENTATION

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Representatives from 3 major stakeholder groups – consumers, payers, and practitioners – reacted to aspects of the morning's presentations and commented on what role they and the groups they represent could play. Following are excerpts from the discussions.

Q: What do you think of the expanded practice role? What does this mean for you, your organization, and the groups with which you are involved?

The biggest take-home message is that health insurance does not equal access to care. Addressing this issue will require health care professionals, policy makers, lawyers, payers, and consumers to work together to ensure that all Americans have access to high-quality health care.

The American Association of Family Practitioners has assessed the future of family medicine, and one of their findings is the need to develop open access models. That will require initiative on the practice's part, particularly in rural areas. But that initiative must be aligned with economic incentives; practitioners must be compensated appropriately.

Q: Who will take care of this aging population?

One of the most important roles that academic geriatrics can play is to train physicians and all health care providers to provide science-based, community-based, team-based care that is not ageist. Until the health care system changes to support that type of care, nothing will change.

Early intervention is key; there is no question that the illnesses we treat in the elderly population could be prevented or mitigated with proper care and proper health practices in younger adults and children.

I think the answer is that we must train this population to take care of themselves. We must create an environment in which they can do that.

VoxMedica held a series of high-level forums on the transformation of health care. Three distinct issues arose in the discussions, only 1 of which was addressed here today:

1) Establish a transparent system in which people can make informed decisions about their care and about providing care.

2) Improve the dialog between health care providers and their patients. Patients will never be empowered to take better care of themselves unless someone talks to them in a meaningful way about their situation.

3) Free up and mobilize the health care resources we have. This includes making better use of non-

physician health care providers and allowing them more freedom in providing care.

I'd like to hear panel input on points 1 and 2.

Communication:
The effectiveness of physician-patient dialog is central to the educational programs discussed earlier. Medical students must be trained to be excellent communicators and educators.

At the same time, it is impossible to have a patient-centered health care system in which people have control over their health care choices without improving health care literacy among patients. We must educate our patients within the limits of their abilities *before* asking them to make their own decisions.

The issue of increasing dialog speaks to the need for a personal medical home provided by primary care physicians (PCP). Studies have proven that quality improves and costs decrease in states with a high number of PCPs to population (vs. states with a high number of subspecialty physicians). The difference between the best and worst states amounts to a savings of $2000 per Medicare beneficiary per year. Multiply that by the number of beneficiaries projected by the year 2020 and it might be possible to save $71 billion by having a personal medical home and not really changing anything about how that personal medical home works.

However, that will not improve the dialog. Current reimbursement does not allow physicians to investigate alternate ways to communicate with patients.

Transparency:
The top issues for consumers are: 1) efficiency (ie, to be seen quickly by a qualified provider) and 2) transparency (ie, to know what care will cost).

Consumers "move the needle" in health care. For example, when convenient care clinics first came on the market 6 years ago, they were a cash business. Now, 50% of the services are reimbursable by insurance, and that is due to consumer pressure. The consumer moves the needle, but we must follow.

There has been resistance to providing quality information to the public, and one cannot make informed choices without such information. Both monetary and *care provision transparency are needed.*

Q: What is being done here at Jefferson to meet the challenges of caring for an aging population?

We have worked for 10 years in the geriatric arena to train medical and other health professions students in the community-based setting (ie, a network of home care, nursing homes, retirement communities, and assisted living), and a few national incentives have grown from this. We were briefly funded to train health professionals across eastern Pennsylvania and all of Delaware, and are optimistic that we will receive renewed funding to be able to resume that work.

Our deans have made a tremendous commitment to changing the culture of health care education, and recently funded and provided support for a center for interprofessional education. Exciting programs will begin to roll out this year for all students across campus.

Q: How is Jefferson working to increase the number of geriatricians?

We now train 4 fellows a year, which is exciting in the face of the flat national trends of the last several years. Only about 300 geriatricians graduate nationally each year, which is not enough to provide care for all older adults. At the same time, the number of certified geriatricians has been plummeting because there is no value to that certification; certified geriatricians are not recertifying.

We have had increasing success in recruiting from internal medicine and family medicine residency graduates. They notice that the patients they care for in their residency clinics are old and they want to learn how to better care for this population.

Also, because these are people who are interested in academic medicine, they want to be able to teach others how to care for this population. We are optimistic that we will have a cadre of teachers and researchers who will expand the knowledge base for educating doctors, social workers, and others who will provide care to older adults.

Q: Will we all be affected by depression when we're old?
The problem is not depression, but denial. Most people in our society are unaware that there are better ways to care for the elderly. In an ageist sense, people just accept that when you get old you fall and break your hip, or you get demented or have a stroke. It is critical that we improve medical students' training to increase awareness of options for treating age-related issues.

Q: What did you think of statement that Alzheimer's is the polio of geriatrics?
It is an apt comparison. Some day we will be able to prevent Alzhiemer's with vaccines, but what we must do now is address the risk factors (eg, high blood pressure, diabetes, physical and mental inactivity). These are modifiable factors that we can change today to help prevent Alzheimer's.

Polio pales in comparison to Alzheimer's because polio affected a small number of people. If you live to be 85 or older, you have a 50% chance of getting Alzheimer's.

We must raise the visibility of this disease. One way is to ensure that residents and medical students spend time in nursing homes and are exposed to patients with Alzheimer's; that will raise awareness and the education will spread.

Another venue is for the pharmaceutical industry to raise awareness via ad campaigns. Consider how many more women are now aware of and asking about osteoporosis, spurred by advertising for different osteoporosis drugs. The same is beginning to happen with Alzheimer's; the awareness is increasing.

We must think about what we're doing as we fix things so that people live long enough to get Alzheimer's. Alzheimer's must become a focus.

Q: Some of Pennsylvania's plans have been detailed this morning. What is CMS doing along these lines?
CMS has the same issues as Pennsylvania, but on a national level. Last fall, the chairman of the Federal Reserve told Congress that the aging population will have the greatest effect on the economy, although this group represents only 20% of the entire US population. If unchecked, Medicare/Medicaid and Social Security will spend 60% of the entire federal budget annually by 2030. This is potentially a huge problem. Secretary of Health and Human Services Michael Leavitt has stated that we have an economic imperative to transform health care - and that it is everyone's responsibility, not just federal payers.

So what are we doing? Congress is listening to all groups, including Medpac. They passed the Medicare Modernization Act (MMA) of 2003, the Deficit Reduction Act of 2005 (DRA), and the Tax Relief and Healthcare Act of 2006, which contains a physician quality reporting initiative. Many demonstration projects are now at the level of the individual practitioner.

A number of other demonstration projects are focused on care coordination and the continuum of care. Medicare recently allocated $547 million (over 5 years) to 13 states and Washington, DC to improve their Medicare programs and to develop programs designed to keep the elderly *out* of nursing homes.

In addition, demonstration projects have been developed under the MMA and DRA that allow physician-hospital gain-sharing, which previously was unheard of and not legal. The legality is now being investigated in Congress.

Q: What role do payors play in some of the reform activities mentioned this morning?
The issues are complex. We have an obligation to do better, and that involves investigating alternative approaches. But we must recognize that unless all stakeholders are involved, we will fail. There is a moral imperative for us to do something sustainable.

Independence Blue Cross is working on a number of fronts: partnership with government on different types of endeavors (eg, CHIP and adult basic programs); partnership with different organizations (eg, a charitable medical grant program that supports 28 free clinics in our region); and workforce development (eg, primary care physician and nurse shortages).

Q: Reactions?
Workforce development. We need to think strategically about how to improve the situation for health care workers and, by extension, the consumer. We must assess all levels of health care

providers and determine how best to use their talents. For example, the shortage of family physicians is a crisis, but there are currently 141,000 nurse practitioners who can help alleviate that crisis.

We must provide opportunities for advancement. How do we develop a career ladder for registered nurses to become advanced practice nurses, and for nursing home caregivers to become registered nurses?

Incentives. We do not provide proper incentives to people for interacting with the health care system. The incentive system itself sometimes discourages both good care and access. Some studies have shown that tiered co-pays for prescriptions actually decrease compliance and worsen outcomes. Insurers need to look at innovative ways to adjust provider and consumer incentives to ensure better outcomes.

Q: What do you think consumers really want from the health care system, and did you hear any of it today?

Consumers want de-institutionalization, more community-based care (eg, in the home, neighborhood). That will increase consumer satisfaction, and it will be facilitated by technology.

The boomers are relying on technology to solve their problems. They must be educated to look at other, more realistic solutions (eg, self-care, education).

Technology is driving the cost of health care but, in the majority of instances, it has not improved quality of care or outcomes. Practitioners who use or order the technology and consumers who believe that current or future technology will "fix" them – both are guilty.

We must examine how we train medical students and ensure that medical schools focus on community needs, not institutional needs. We must determine how to align economic incentives so that this type of focus is viable for the academic medical centers. We also must determine how to help rural students afford to attend medical school, as they are the most likely to decide to practice in rural settings.

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