November 22, 2011

To: Trustees

From: Christopher A. Langston

Subject: Background Materials for Strategic Planning Discussion

Attached is a review of the analysis behind our aging and health program. We hope that you will find this useful as a springboard to our strategic planning process unfolding over the next three Board meetings. As we discussed at our September meeting, after our initial discussion in December, we expect to return to these issues at different levels of specificity in March and again in June.

December 2011 – The nature of the problem and broad environmental trends – an initial effort to develop a shared understanding of the problems in aging and health and the social forces that we expect to impact our work over time.

March 2012 – Strategies for addressing the problem(s) through grantmaking and other activities.

June 2012 – Specific objectives, targets, and allocations to support success.

As an outcome of this quarter's meeting, we hope that Board members and staff collectively can identify prototypical problems that our work is intended to address and that we can add to the list of environmental trends with which we will need to contend as we work to improve the health of older Americans.

Strategic Planning Background

As discussed at the September 2011 grants committee meeting, our strategic planning process will proceed over three quarters, discussing successively more concrete aspects of our planned work.

- Stage I, drawing upon this document: We will discuss the nature of the problem(s) we wish to address around the health of older adults and the large, societal-level forces that we foresee impinging on this issue.
- Stage II (March 2012): We plan to discuss the various opportunities/solutions to address the problem in the environment as we see and foresee it.
- Stage III (June 2012): We expect to discuss the specific means and allocation of resources we will use to make progress and the measurable objectives whereby we will track our progress.

While we anticipate some small and/or non-controversial grants may be presented during this time (see tabs E and F), the major direction of grantmaking will follow from these discussions. Staff will be developing specific grants over the next five years shaped by this process.

To begin, we offer the following review of the state of aging and health in the United States. To move forward in our planning, we must first establish a common understanding of the situation in the lives of older persons as well as a broader understanding of the changing forces that we expect to impact our work in the future. At the Foundation, we have not explicitly examined the framing of the issue nor developed a consensus understanding between Board and staff. Clearly, how we define the nature of the problem will strongly shape the range of options that we might undertake.

To assist our understanding of the problem, we also polled the community at large through a health AGEnda blog post entitled, “Help Us Spend $100,000,000 (Really Well).” Although a few of the comments, found in Appendix A, suggested new funding directions, the majority called for continued investment in our historical funding areas, primarily workforce training in geriatrics. In the following pages, we will offer our analysis of the nature of the problem of aging and health to serve as a starting place for further conversation.

As the first outcome of this discussion we should be able to identify typical examples and key characteristics of the problems we hope to solve in the lives of older adults. We would like Trustees to offer their views as to what kinds of health-related problems in the lives of older Americans they feel are most appropriate for us to address. (In appendix B to this document we offer a series of case studies drawn from the lives of family members of staff as examples as the kinds of issues we feel the Foundation should address.) From concrete examples such as these in the lives of Trustees and staff as well as more objective analysis of health care utilization and demographics, we hope to establish a shared understanding of our mission.

Second, given a clearer understanding of the nature of the problem, we would also like to get Trustee insights into the broad forces that they foresee impacting our work. Changes in technology, the economy, and public policy are inevitable and create a context that may help or hinder our efforts. We offer a preliminary list on page 9, but as we look into a dynamic and confusing future we will benefit from the broad expertise of the Board.

<u>The Nature of the Problem</u>

The story of aging and health in the US is in many ways a positive one: life span has increased, and rates of disability in late life are lower than they were 40 years ago. Social security and Medicare combined have reduced the poverty that had been characteristic of late life up until the 1960s. But poverty and health care costs are strongly related, especially among older adults. Recent analyses of poverty rates that consider more fully both income from transfer payments (e.g., the earned income tax credit) and living expenses (e.g., out-of-pocket health care costs), reveal that the rates of poverty are nearly equivalent among children and older adults in the US – 18 and 16 percent, respectively[i].

Unfortunately, the value received for this public and private health care spending is relatively low and health care often fails to meet the needs of older Americans. Quality of health and health care in the United States is poor compared to other developed countries on many measures. Life expectancy at 65 (20 years for women and 17 for men), while increasing, is not increasing as fast as it is in other countries – such that it has fallen to 17th out of 30 among the OECD countries.[ii] While the origins of the chronic diseases that are the final causes of disability and death for older adults (e.g., heart disease, diabetes, hypertension, COPD) have strong roots in life style and behavior

(e.g., diet, smoking, exercise), the current cohort of older adults (those born before 1945) has had more physically active and healthier lives than subsequent cohorts (with the exception of higher rates of smoking). International comparisons also suggest that American health behaviors are not notably worse than those in other countries – the US is among the lowest in both smoking and alcohol use, but is among the worst in rates of obesity. Regardless of where one might seek to place "blame", one of the gaping failures of our "health system" is its inability to provide primary care and support behavior change that would promote healthy aging and prevent and delay chronic illness.

The evidence is overwhelming that older Americans in particular are not getting the quality of health care they need to maximize their independence and well-being.[iii] ***Our central thesis is that if older Americans got better quality health care (i.e., more attuned to special needs, more integrated, more comprehensive), they would live longer and healthier lives and society would have lower costs of care.***

While a general issue in the US system, quality of care for older adults is particularly significant for four major reasons:

- Quality matters more immediately to older people than younger people. Because of reductions in physiological reserve and resilience, failure to address problems or inappropriate care has more impact on older adults than younger adults. Conversely, older adults stand to get more out of high quality care than younger people who are less likely to experience different outcomes, even in the face of wide variations in care.
- There are many health issues specific to older adults. Many chronic illnesses are virtually synonymous with age: rates of vision loss, hearing loss, arthritis, high blood pressure, heart disease, and cognitive impairment rise from being negligible in younger people to very common among older adults. Even though these health challenges are predictable, weak training of health professionals in these specific issues combined with our fragmented delivery system means many of these challenges simply go unanticipated, unaddressed, and unremediated. Just as pediatrics addresses the specific threats of early development, geriatrics (writ large – not just the field of medicine) is needed to address the specific and unique developmental threats of late life.
- Part of what is special (and emotionally difficult) about aging is that unlike childhood, the developmental period in late life inevitably ends in death. While

quality of care makes a difference and can both add years to life and life to years, everyone still dies. Due in part of our extreme discomfort with death in 21st-century America, care of older people is stigmatized and denigrated in many ways. At some hard to define point, it becomes even more essential to make care congruent with personal goals and not to let the default of very aggressive care overwhelm personal choices.

- Costs of care among older adults are extremely high. While this may seem like a given, the example of other countries shows that better health outcomes can be produced at lower costs. The value produced by Medicare spending seems low and in many cases is actually counterproductive. Projected increases in costs of care for older Americans are a major threat to our national economy. In the current political debate, this often leads older Americans to be caricatured as "greedy geezers" relentlessly demanding more services. This narrative ignores the fact that payments for health care services are actually payments to health care providers and organizations.

Demographics and Technology

The US (along with most countries in the world) is aging—the share of persons over 65 is projected to grow from a current 13 percent to over 20 percent in the next 20 years (from 35 to 75 million people). Smaller family size and successful control of many early-life causes of death is creating a society where the demographic structure looks less like a pyramid with large numbers of young people at the bottom and a few older adults at the top, and more like a rectangle, with more equal numbers of people in each age cohort.

Moreover, extension of life expectancy means that even among older people, the proportion in the oldest old category—85+—are expected to grow dramatically from 12 percent to over 24 percent, such that older adults will more and more be the oldest old. Because of the size of the baby-boom cohort (who just started turning 65 in 2011) these changes are now arriving very dramatically in the US, but they will last beyond the baby boom and have many implications across all sectors of society including education, work, family, and, of course, health care.

Pressing Health Problems and Failure to Address Them

Unfortunately, while modern public health and medical care have contributed to increased life expectancies, they have not been as successful in adding "life to years"

as they have been in adding years to life. Older Americans have high burdens of chronic illness, with the over 80 percent of those over 65 reporting one or more chronic illnesses and over 50 percent two or more.[iv] Over 42 percent of older adults report a limitation in their daily activities due to health or disability, 11 percent report severe, multiple limitations.[v] Despite greatly improved knowledge of how health care can help older adults age successfully (much developed with Foundation support), this knowledge is still not put into general practice. For a variety of reasons, the quality of care of chronic illness in older Americans is poor, fragmented, and not comprehensive, which leads to impaired independence and reduced quality of life—what Mark Lachs calls "excess disability."

For example, the personal story told on the health AGEnda blog "For Christmas I Gave My Father a Trip to the Hospital" (see Appendix B) touches on many of these issues. In this case, a concern with one possible health problem, swollen ankles, with Chris's 73-year-old father led to incompetent care (overmedication), which set off dangerous side effects (falls and critically low blood pressure) that were not properly addressed by the system, had high potential for serious injury, and led to a completely unnecessary high-cost, risky hospital admission. The simplest geriatric dictums—"start low and go slow" with medications, and when new symptoms appear "ALWAYS suspect medications"—would have led to a different outcome.

Falls themselves are a prototypical geriatric syndrome and need to be understood by professionals as important sentinel events. Along with depression, delirium, incontinence, weight loss, sleep disorders, and memory issues, falls are not a particular disease but rather reflect a wide variety of underlying changes and issues in older adults. Disease-oriented health care frequently fails to properly assess the causes of these creeping problems and therefore to provide appropriate interventions. Repeated large scale testing has shown that only approximately 30 percent of appropriate care (e.g., assessing gait and balance and changes in blood pressure) is offered for geriatric syndromes like falls. Moreover, the same research has shown that when more appropriate care is provided older adults have better outcomes, including longer lives[vi].

Sophisticated professionals across all disciplines and professions are essential to control conditions like these through a wide variety of powerful medications, surgical procedures, and other interventions. However, as in these examples, failure to appreciate the special needs, the trade-offs, and the delicacy of geriatric care can lead

to poor outcomes and needless expense. These problems are repeated over and over again across the country. (See also in Appendix B: *What I Am Thankful for [and What I am Decidedly Not]* by Rachael Watman and *A Disastrous Discharge* by Nora OBrien-Suric.)

Costs and Consequences

The consequences of the health care system's lack of preparation for older adults are dire for individual people and their families, but also pose a profound challenge to our society in escalating costs. Older adults are already the core business of health care, currently accounting for almost 50 percent of hospital occupancy, 30 percent of primary care visits, 70 percent of home health cases, 90 percent of nursing home residents, and 95 percent of hospice cases. Medicare already costs over $500 billion annually and almost half of the state and federal Medicaid spending is for people in long-term care (largely older adults). The uncontrolled escalation of health care costs and specifically Medicare costs has major budgetary implications for the federal government. Despite this impact, it is only recently that the Medicare program has worked vigorously to improve quality and reduce per-capita costs. And despite the key role that a well-trained workforce will have in delivering this high-value care, especially to older adults, national spending on workforce related to their care lags spending on pediatrics by large margins.

Chronic conditions and functional limitations are major predictors of health care spending for both public programs and families. As Foundation grantees have demonstrated, without special intervention, Medicare beneficiaries have a 20 percent chance of a readmission to hospital within 30 days (versus a rate of 10 percent for working younger adults). Each readmission represents pain and suffering and risk of death for patients; some 15,000 Medicare beneficiaries die each month as a consequence of adverse events in hospitals.[vii] Readmissions cost approximately $19 billion annually. The Agency for Health Research and Quality estimates that 10 percent of all hospital admissions in a year are unnecessary—4 million in 2009—reflecting conditions that should have been successfully managed in the outpatient sector. However, 60 percent of these unnecessary admissions (2.4 million) are among Medicare beneficiaries (as opposed to their 13 percent share of the population), with tremendous cost implications.

As commentators from all parts of the political spectrum have observed, to retain its economic viability the US must reduce health care spending, improve quality of care, and in so doing increase the value of health care – regardless of the source of payment. The good news is that as opposed to most industry sectors, in which cost and quality are inversely related such that increases in one mean reductions in the other, in health care there is a substantial opportunity for a win-win. The United States can and must substantially increase quality while reducing the cost of care. Health care for older people is central to this issue.

The analysis of Foundation staff and expert advisors over the years has been that a major cause of the gap between the health and vitality that are possible for older Americans and that which they currently have is due to failures in the education and training of the health care workforce and poor design of the health care delivery system in which they work. ***If anything, this "theory of change" underlying our grants strategy seems more credible today than when the program started in 1982, and more and more evidence is available to support it. While we have made substantial progress towards improved educational preparation and developed compelling delivery improvements, there is still enormous need for further improvement.***

Defining the Problem

The problem of aging and health is a serious one for people, families, and society, making it a very appropriate focus for the Foundation. While it comprises a relatively small swath of the population, the breadth of the problem makes it hard to sum up in a few words and makes it possible for different observers to concentrate on different areas. Over the years, the Foundation has addressed many of these challenges, depending upon where there seemed to be opportunity for change and a lack of other funders working in the space. As a sampler, current projects and various Board speakers have touched on many of these issues:

- There are behavioral and lifestyle issues among people (younger and older) that influence their health as they age (e.g., Terrie Wetle's presentation to the Board in March 2008 on public health and aging).
- Older adults do not get the kind of primary care they need to meet their chronic care needs (e.g., Chad Boult's work on Guided Care, presented June 2010).

- Older adults have special needs for care on such issues as mental health, sensory impairments, falls, pain, etc. (e.g., Jurgen Unutzer's work, presented by him June 2008).
- Hospital care of older adults is needlessly risky and likely to have unintended negative consequences (e.g., infections, loss of function, as described in June, 2011 by Elizabeth Capezuti and in September 2011 by Cliff Ko).
- Long-term care services for those older people who are already seriously impaired are in constant crisis due to staff turnover, financing difficulties, and poor quality of care (e.g., the work of PHI, presented by Stephen Dawson in 2007).
- An important subset of long-term care is family caregiving; loved ones are an essential support for older adults, providing enormously valuable care. Family caregivers need at least as much support from society as parents of young children (e.g., our current AARP project in partnership with the Administration on Aging).
- In late life, end-of-life/palliative care issues become common and essential (as discussed by Diane Meier in her June 2011 presentation to the Board).
- Alzheimer's disease stands out among other common, disabling, terrifying disease of age (e.g., Richard Mayeux's presentation to the Board in 2010).
- Payment and regulatory barriers continue to be obstacles to improving care (e.g., Meghan Gerrity, MD, former member of the Relative Value Resource Update Committee RUC, presenting 2008).
- Public attitudes and knowledge about aging and health must change (e.g., Mark Lachs's presentation to the Board in March 2010).

For the most part the Foundation has used its human capital investment strategy as an approach to all of these parts of the issue, funding scholars and leaders agnostically without regard to which specific issues they focus upon. In our Integrating and Improving Services work, we have tended to be opportunistic and cover a wide range of issues as seems to fit the moment, but have returned to primary care again and again as the lynchpin of improved health outcomes for older adults.

Macro Forces and Game Changers of the Future

While our program has never been static through its nearly 30-year history, it has been based on the same general understandings of the problems of health care for older adults. While ignorance, ageism, and complacency may be unchanging challenges of

our work, we need to anticipate other forces that will be the broader context for our work.

Economic and budget constraints – The growth of health care's share of GDP shows little sign of slowing (currently 16 percent). Economists might observe that as a rich society, health care expenditures above 20 percent of GDP could be seen as a reflection of market tastes. However, the share of public expenditures absorbed by health care is clearly unsustainable. At the same time, it is politically inconceivable that society would entirely walk away from the intergenerational transfer payments needed to provide care to older Americans. Society finds itself between a rock and a hard place.

Payment reform – Therefore, there is a powerful drive towards changing how we pay for care such that we can "bend the cost curve," i.e., not actually reduce spending but reduce its rate of growth to something more akin to the overall rate of growth of the economy. While the specifics are very controversial, there seems a very broad consensus that "volume based" fee-for-service is misguided and must be changed. This reality seems sufficiently overwhelming that over time, policymakers will be forced to confront the entrenched interests of the health care industrial complex. This has enormous potential to change the incentives that have governed health care, particularly for older people, and finally answer the cynical provider's question about quality: "What's in it for me?" Knowledge and skills that can keep people well and reduce utilization of expensive services will finally be valued among those who count (the dollars). Like any powerful force, this change will be disruptive, altering the landscape and producing high levels of uncertainty and instability. Professions and delivery organizations will be shaken to their cores.

Information Technology – Despite its high technology glamour, health care has made little use of the kind of information management and information technology that has become common in other familiar sectors. However, the HiTec act, ARRA, and the passage of time have made the spread of information technology inevitable. At the same time, futurists and "gizmo idolaters" will no doubt be disappointed to discover that health care will continue to be relatively labor intensive and continue to require human to human contact, even if via technology. Experience to date also suggests that this transition will be fraught with unintended consequences.

Teams in health care – Because workforce represents a major cost in health care and a serious rate limiting step in delivering needed care, it is essential that health care professionals work collaboratively as members of effective teams. Health care professionals who have long valued independence and self-reliance will need to reorient themselves as members of interdependent teams. The role of nursing vis-à-vis

medicine is clearly a core issue here, as nurses (and other providers struggle for more autonomy and broader scopes of practice). Unfortunately, growing autonomy of non-physician providers is not the same thing as effective team work or even accountability for the quality of care provided.

Consumerism – When facing relatively simple care issues early in life, patient choice may not seem like an important consideration; a patient can be reliably counted on to want a broken leg or pneumonia treated. However, with limited life expectancy and multiple chronic illnesses, patient preferences and goals of care become more idiosyncratic and harder to predict without critical conversations. How the "consumerism" both hoped for and feared from a new cohort of older Americans will interact with aging and the health system is unclear.

Conclusion

Following from our theory of change, we fund physicians, nurses, and social workers in order to incent the development of a cadre of geriatric experts to meet critical training and service needs. We fund the development and dissemination of improved service models because even well trained professionals are only as good as the system in which they work. We regard workforce development and work place redesign as inseparable and irreducible contributors to improvement.

In our grants, as in everything we do, we recognize that Foundation spending is small compared to the billions in health professions education or the trillion spent each year on services for older people. We seek partnerships with other funders to augment our impact. Even more fundamentally, we seek leverage from the educational and service delivery systems to multiply the force for change we can exert, as well as draw on other multipliers like time, influential relationships, and financial incentives. Because of this need, we don't fund the direct provision of service or the training of professionals for clinical service, but only fund where Foundation dollars can realize much greater benefits to larger numbers of people. We don't fund doctors, nurses, or social workers because they need us, but rather because we need them as the critical means to make their entire fields better able to care for older adults.

Unfortunately, there are still relatively few funders or other agents working to improve health care focused on the needs of older adults. The vast majority of stakeholders addressing quality lapses in health care or problems in training focus on other populations and health care issues. We believe that this failure to appreciate the

centrality and urgent need for improved health care for older adults reflects society's ageism, which all too often regards the health care concerns of older adults as depressing, futile, and a waste of resources. Even the existence of geriatric expertise, much less its appropriate deployment in health care training and service delivery, is still not widely appreciated.

While particular projects and strategies within Aging and Health will necessarily change, as a staff, we believe that the Foundation can and should continue to advance this cause through its grantmaking and staff efforts for the foreseeable future — unless or until the quality of care of older adults is no worse than for younger Americans and older adults are able to enjoy their extended years of life with all the health, independence, and dignity possible.

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[iii] IOM (Institute of Medicine). 2008. *Retooling for an aging America: Building the health care workforce*. Washington, DC: The National Academies Pres

[iv] Anderson, G. and Horvath, J. Growing Burden of Chronic Disease. Public Health Reports / May–June 2004 / Volume 119

[v] Federal Interagency Forum on Aging-Related Statistics. Older Americans 2010: Key Indicators of Well-Being. Federal Interagency Forum on Aging-Related Statistics. Washington, DC: U.S. Government Printing Office. July 2010.

[vi] RAND: Assessing Care of Vulnerable Elders: A Rand Health Project. http://www.rand.org/health/projects/acove.html

[vii] Department of Health and Human Services. Office of the Inspector General Adverse Events in Hospitals: National Incidence among Medicare Beneficiaries November 2010 http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf