Aging

Aging

Americans are living longer and healthier lives than ever before. The U.S. Census Bureau has projected that the older population will double from 36 million in 2003 to 72 million in 2030, and will increase from 12 percent to 20 percent of the population in the same time frame. By 2050, the older population is projected to number 86.7 million. But, as the title of Robert Friedland and Laura Summer's groundbreaking 1999 report reminded us, demography is not destiny. How we experience this demographic change will depend on a variety of factors, including social and economic decisions that are ours to make. So while the growth of the population aged 65 and over presents a challenge for families, health care providers, policymakers, and others, forethought in policy planning and a willingness to invest resources where they are needed most can make the difference between this aging boom being a crisis or an opportunity (Mockenhaupt et al. 2006; U.S. Census Bureau 2005; Friedland and Summer 2006).

While the growth of the population aged 65 and over presents a challenge, forethought in policy planning and a willingness to invest resources where they are needed most can make the difference between this aging boom being a crisis or an opportunity.

In the past century, average life expectancy at birth has risen from 47.3 years to 76.9 years. Two out of every five 65-74 year olds (41 percent) report their health as being excellent or very good (U.S. Census Bureau 2005). There is less disability among older people today than there was 30 years ago, and many chronic ailments such as heart disease, lung disease, and arthritis are occurring an average of 10 to 25 years later than they did in the past (Kolata 2006). This progress is a result of medical, public health, and technological advances, as well as major investments by the federal government in the health of older people. Medicare, the federal health insurance program created in 1965 for all people age 65 and older regardless of their income or medical history, now covers nearly 43 million Americans (The Henry J. Kaiser Family Foundation 2006). Also created in 1965, the Administration on Aging (AoA) provides home- and community-based care for older persons and their caregivers. Area agencies on aging, established in 1973 to respond to the needs of Americans aged 60 and over in every community, plan, coordinate, and offer information on community-based services, in-home services, and housing and elder rights programs. The National Institute on Aging, formed in 1974, provides leadership in aging research, training, and the dissemination of health information. And in 1987 the Nursing Home Reform Act established basic rights and services for residents of nursing homes, setting standards that form the basis for present efforts to improve the quality of care and the quality of life for nursing home residents (Klauber and Wright 2001).

Of course, a fit 65-year-old and a frail 85-year-old often have completely different health care and social support needs. The oldest old, those aged 85 years or older, are growing as a share of the older

population. In 1900, only 122,000 people were 85 years or older. By 2000, this group was 34 times as large at 4.2 million people (U.S. Census Bureau 2005).

The aging of the population is of concern to the health care and health policy communities primarily because older adults experience high rates of chronic diseases. Eighty percent of older Americans are currently living with at least one chronic condition, and 50 percent with at least two. In addition to causing pain, disability, and loss of function and independence, chronic diseases are a major contributor to health care costs (Merck Institute of Aging & Health and CDC 2004). Older people with chronic and disabling conditions are high users of medical resources, accounting for a disproportionate share of health care expenditures. They visit the doctor, use prescription drugs, and are hospitalized more often than younger people (Rice and Estes 1984). This has major implications for the elderly, especially at a time when the rising costs of health care are being shifted to the individual, and for health systems, particularly at a time when the long-term solvency of the Medicare program is being called into question (Novelli and Workman 2006).

Because older Americans are high users of the health care system, they are especially vulnerable to its failings.

Of course, many chronic diseases are preventable. The odds of chronic disease and disability clearly grow with age, but bad health is not an unavoidable effect of aging (Merck Institute of Aging & Health and CDC 2004). A growing body of research—conducted by and inspired by the MacArthur Foundation's Network on Successful Aging—suggests that behavioral change can ease health care costs for seniors and make a remarkable difference in their quality of life. In many cases, it seems that civic engagement, physical activity, and community design that supports independent living can delay or prevent disease and disability (Mockenhaupt et al. 2006; Farquhar 2006).

Because older Americans are high users of the health care system, they are especially vulnerable to its failings. Many U.S. residents struggle to get comprehensive, continuous care from our nation's disjointed health care system. This process is particularly arduous for the elderly, due in great part to the fact that the acute and long-term care systems function separately. Acute care, designed to diagnose, treat, and prevent illness, is provided in doctors' offices, clinics, and hospitals. Long-term care, designed to manage chronic conditions and assist the functions of daily life, is provided by a wide range of caregivers in many settings. The two types of care are also financed differently, with Medicare picking up most of the cost of acute care for those 65 and older, and Medicaid covering the cost of long-term care for low-income seniors (Alper and Gibson 2001). For those who do not qualify for Medicaid, long-term care presents a considerable financial burden, and few people have insurance policies that will pay for that care (Friedland and Summer 2006).

Promising efforts have been made to integrate acute and long-term care,

especially for the frail elderly. Some, which have used a small-scale team approach to create a seamless system of care, have been successful, while others, which have attempted large-scale system coordination, have had more mixed results (Alper and Gibson 2001; GIH 2001). Two of the most promising models have been the Program of All-Inclusive Care for the Elderly (PACE), which uses multidisciplinary teams to provide acute and long-term care in both inpatient and outpatient settings, and Social Health Maintenance Organizations (SHMOs), which combine managed care and expanded home- and community-based services. Both blend Medicare and Medicaid financing in order to integrate health and social services for frail older adults (Mockenhaupt et al. 2006).

Both our acute and long-term care systems are turning their attention to training and supporting the workforce of paid and unpaid caregivers (Mockenhaupt et al. 2006). Many health care providers do not have the training they need to appropriately treat older patients (Merck Institute of Aging & Health and CDC 2004). Geriatricians, valued for their skill at supervising treatment of multiple chronic conditions, weighing the pros and cons of numerous prescriptions, seeking answers outside medicine for persistent problems, coordinating with family members and other providers, and objecting to needless tests, are few. In 2005 there was one geriatrician for every 5,000 Americans 65 and older (Gross 2006). Some argue that more geriatricians need to be trained; others argue that more providers need to learn how best to respond to the needs of aging patients. And the shortage of geriatricians is not the only concern; the health care system is also experiencing shortages of nurses, geriatric social workers, and front-line workers in hospitals, nursing homes, and home health programs.

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Most of the nation's long-term care services are provided by unpaid caregivers: the family, friends, neighbors, and other community members who help the elderly through their days. Although it saves the nation billions of dollars a year, this arrangement comes with a price. Many of these caregivers find themselves overwhelmed, isolated, emotionally drained, and in dire need of information, training and support (Mockenhaupt et al. 2006). And those who are members of the so-called sandwich generation find themselves simultaneously caring for their children and parents, making great sacrifices of time and money to do so.

Determining how the care provided to the elderly will be financed in the future is a major concern. Medicare's Part A Trust Fund, which pays for inpatient hospital, skilled nursing facility, home health, and hospice care, is funded mainly by a dedicated tax on earnings paid by employers and workers, and is projected to exhaust its reserves by 2018. And contrary to popular belief, Medicare pays only about half of older American's health care expenses, with the balance covered by private insurance, Medicaid, and older people themselves. Out-of-pocket health care expenses and long-term care costs pose a significant financial burden for many elderly, and the financial security Medicare was designed to offer older people has eroded as these costs have continued to rise (The Henry J. Kaiser Family Foundation 2006; Friedland and Summer 2006).

All of these issues are made more complex by the growing diversity within the aging population. The gaps in access, quality, and health status that have long been documented between poor and nonpoor, well educated and less educated, and whites and people of color, will become even more pronounced as the population ages. Already, unmarried women and people of color are especially vulnerable to chronic health problems, poverty, and unmet health and social needs as they grow older. Research has also shown specific risks for other populations, such as older lesbian, gay, bisexual and transgender people, who are often more likely to live alone and less likely to have family support than the larger aging population. The diversity by age among those over 65 also means that while some older people will face age-related declines, others will continue to perform as well as the nonelderly and will crave opportunities to make meaningful contributions to their communities and to society (Mockenhaupt et al. 2006).

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Ever mindful of these challenges, funders are focused on a number of efforts related to aging and health, including training and supporting paid and unpaid caregivers, extending independent living, creating seamless systems of care, and helping seniors navigate Medicare.

Training and Supporting Paid and Unpaid Caregivers

As the aging population grows, it becomes increasingly important to have in place paid and unpaid caregivers prepared to meet their health care needs.

Centers of Excellence in Geriatric Medicine and Training: In 1982, following a wide-ranging strategic planning process in which almost 50 areas of grantmaking were considered, The John A. Hartford Foundation's board of directors recognized that the increasing life expectancy and the decline of the infant mortality rate in the U.S. were shifting demographics in a way that would have profound implications for health care. The trustees set out on two new paths: aging and health and health care financing. In 1988, after an Institute of Medicine (IOM) study emphasized that it was necessary to develop the capacity to train academic leaders in geriatrics, the foundation established the Academic Geriatrics Recruitment Initiative, which established 10 centers of geriatrics. In 1993, after a second IOM report emphasized that there were still inadequate numbers of faculty to meet the nation's training and research needs in geriatrics, the foundation transformed the initiative into the Hartford Centers of Excellence program (The John A. Hartford Foundation 2005). Then in 1995, in part because of the lack of national consensus for reform of the heath care system, the foundation shifted its focus away from health care financing to focus solely on aging and health.

The foundation's Centers of Excellence in Geriatric Medicine and Training is now a $36 million dollar initiative to help medical schools prepare faculty to ensure that future doctors are able to meet the needs of older patients. Currently, there are 24 active centers of excellence, 22 in geriatric medicine, and 2 in geriatric psychiatry. The strategy of the centers of excellence initiative is to identify medical schools with the necessary components for training academic geriatricians, such as research infrastructure, advanced training opportunities, and academic mentoring, then add resources to these institutions to train larger numbers of future faculty more rapidly than would otherwise be possible. Centers of excellence funds are used as salary support to allow for protected time to conduct research, train to become clinician educators, and pioneer new models of care (The John A. Hartford Foundation 2006).

In addition to carving out a niche and remaining committed to it over time, foundation staff emphasize the importance of evaluation, communications, and dissemination. The foundation's trustees believe that timely feedback and accurate information on the progress of grantees is so important that they created a freestanding board-appointed evaluation committee. The evaluation and monitoring process involves annual half-day site visits to up to 100 project sites a year, which is a time-intensive and costly process. But they help board and staff members quickly identify trends, gaps, and opportunities. Staff and trustees also noticed that the results of their initiatives were not always disseminated outside the grantees' immediate professional networks, to wider medical audiences, policymakers, or the public. To broaden the reach of its grants, the foundation created the Communication and Dissemination Initiative to help grantees and staff communicate the importance of, and innovations in, geriatric health care (The John A. Hartford Foundation 2005).

Cash and Counseling: Frail elderly people often face serious barriers when seeking personal assistance services. Home care agencies, the traditional providers of these services, frequently experience worker shortages and high staff turnover that make it difficult for them to

meet consumers' needs and cannot always tailor their services to meet an elderly person's specific needs. In 1995, Robert Wood Johnson Foundation (RWJF), the Office of the Assistant Secretary for Planning and Evaluation within the U.S. Department of Health and Human Services (ASPE), and AoA, launched the experimental Cash & Counseling program in Arkansas, New Jersey, and Florida to give Medicaid beneficiaries choice and control over their personal care needs. The program provides a self-directed, individualized budget to recipients of Medicaid personal care services. Participants use the money to hire their own caregivers, often friends or family members who had been providing unpaid care, or purchase items, such as chair lifts or touch lamps, which help them to live independently. Each person's budget is comparable to the value of services that he or she would have received from an agency. Consulting and bookkeeping services are available to help participants weigh their options and keep up with required paperwork (RWJF 2006).

An independent evaluation of the program by Mathematica Policy Research Inc. found that, in all three participating states, when Medicaid beneficiaries of various ages and disabilities were given the opportunity to direct their own supportive services and hire their own caregivers, their quality of life improved, satisfaction with services increased, unmet needs for care were reduced, and access to home care increased without compromising beneficiaries' health or safety (relative to randomly assigned control groups that received services from agencies). Moreover, by the second year of enrollment, the consumer-directed option cost no more than agency care, due to lower spending for nursing home and other Medicaid services. Twelve additional states have now received funding from RWJF, ASPE and AoA to replicate or expand the Cash & Counseling model (Robert Wood Johnson Foundation 2006).

Extending Independent Living

For most older people, institutionalization is a measure of last resort (Rice and Estes 1984). Preventing institutionalization requires redesigning communities to help people stay healthy, live independently, and lead fruitful and fulfilling lives (Mockenhaupt et al. 2006).

Fall Prevention: Falls are a common and often devastating problem among older adults. In California alone, over 1 million people age 65 and older fall each year. More than 100,000 of these falls result in a serious injury or fatality. In fact, almost 40 percent of those hospitalized for hip fractures never return home or live independently again, and 25 percent die within a year. Most falls are associated with one or more risk factors including weakness, unsteady gait, confusion, medications, and environmental hazards. Research has shown that attention to these risk factors can significantly reduce fall rates, and the most effective (and cost-effective) fall reduction programs are multifactorial. Optimal approaches involve a combination of medical management, physical activity, and

> Frail elderly people often face serious barriers when seeking personal assistance services.

home modification. The high level of coordination needed to carry out these programs requires the support of strong community partnerships (Archstone Foundation 2006).

Since 1996, fall prevention has been an area of interest for the Archstone Foundation with more than 25 grants being awarded totaling over $10 million. During the first 10 years of grantmaking, the Archstone Foundation focused on broad public health and health care delivery issues. In 1995, the foundation began a two-year evaluation process

Preventing institutionalization requires redesigning communities to help people stay healthy, live independently, and lead fruitful and fulfilling lives.

examining the first 10 years of operation. Through this process, the board of directors decided to target its work exclusively on issues of aging. Since 1995, the foundation has taken a leadership role in the field of aging, funding a variety of aging projects that address keeping frail elders in their homes for as long as possible, the quality of nursing home care, and end-of-life issues. As the foundation's knowledge of the field grew, it began focusing grantmaking on preparing society for an aging population. Then with the economic challenges of 2002 and 2003, the foundation refocused its strategy on three priority areas for initiative-based grantmaking, committing a total of $24 million over five years for fall prevention, elder abuse and neglect, and end-of-life issues. In addition, the foundation values the ability to be responsive to needs that fall outside of the three priority areas and will continue to conduct responsive grantmaking as a means to address emerging needs in the community (Archstone Foundation 2006).

In 2003, the foundation brought together key stakeholder groups throughout California to begin a strategic planning process to help prevent falls among older adults. This resulted in the foundation's establishment of the Fall Prevention Center of Excellence. The center is a public-private partnership responsible for coordinating a statewide effort to address falls among seniors and deliver integrated fall prevention services. Funding will be allocated to test programs, expand integrated programs and support broad-based community coalitions. In April 2006, the foundation announced the approval of 11 grants under the California Senior Fall Prevention Projects, totaling $364,822 over eighteen months (Archstone Foundation 2006).

Aging in Place: The mission of The Horizon Foundation is to promote and enhance the health and wellness of the Howard County, Maryland community. Following extensive planning, in 1999, foundation's trustees determined that the health and wellness of older adults would be a major, continuing priority. Over a period of five years, The Horizon Foundation teamed with the county office on aging and other community practitioners and leaders to create a service model designed to start permitting the quality of life and quality of care that older residents both want and deserve—ideally, in their own homes, and at a cost that the community can afford.

The first step in this process was the multifaceted Aging-In-Place Initiative from 1999 to 2002. From the beginning, the foundation's approach was based on three overarching principles: forging a strong partnership between the public and private sectors, integrating service components into a seamless service delivery model that is supported by appropriate planning and evaluation, and developing benchmark information against which progress toward aging in place could be measured, and measuring that progress. Guided by these principles, the Aging-In-Place pilot program consisted of four service components: home repair, remodeling, and assessment; fall prevention; mental health; and affordable in-home care.

The first five years of the initiative provided foundation staff with valuable implementation experience, data, and community partnerships, which have informed the initiative's current work and future goals. Inspired by Denmark's highly regarded system of integrated care for older adults, the foundation and its partners decided to focus their joint efforts on increasing the period of functional health of older adults with chronic conditions, with the potential dual benefits of improving health care utilization systems and the quality of life of the county's seniors. Together, the program elements of this phase offer potential for linking adults with chronic conditions with the services they need to enable them to remain in their homes as long as they want to do so, as well as to reduce the costs of their care (The Horizon Foundation 2005).

Naturally Occurring Retirement Communities: The New York-based United Hospital Fund established its Aging in Place Initiative in 1999 to foster the development of new models of care supporting the health and well-being of older people living in the community. These models bring together health care and community resources to address the needs of residents of naturally occurring retirement communities (NORCs), which are housing developments, neighborhoods, or geographic areas built or established for multiage populations but becoming home, over time, to large concentrations of seniors. The initiative is led by Fredda Vladeck, who, with the residents of Manhattan's Penn South Houses, worked to create the first NORC supportive service program. Since then, the number of such programs across the country has grown to more than 80. These programs have proven to be invaluable in helping seniors stay in the homes where they have long resided, which, not surprisingly, many prefer (United Hospital Fund 2006).

The initiative's NORC Health Care Linkage Project, a collaborative effort made possible by grants from the United Hospital Fund and The New York Community Trust, is currently entering its third and final phase. Launched in June 2003, the project aims to strengthen effective linkages between supportive service programs in naturally occurring retirement communities and key health care providers serving the community. In 2006, funding was awarded to four programs that illustrate the various ways to address these issues:

- The Lincoln Square Neighborhood Center is creating an integrated medication information sharing system between Lincoln-Amsterdam Senior Care and Roosevelt Hospital's emergency department to promote medication safety and adherence practices for seniors with multiple chronic health conditions.

- Montefiore Medical Center is linking its discharge planning process to the array of supportive nonmedical services available to seniors living in the Co-Op City Senior Services Program—thus creating a virtual care network.

- Samuel Field YM & YWHA is linking the Deepdale Cares NORC Program to community physicians through a falls prevention project that works with community physicians to reduce clients' risk factors for falls.

- Spring Creek Community Corporation is establishing a coordinated and systematic approach between Spring Creek Senior Partners and community physicians on the identification, assessment, and treatment of seniors suffering from depression (United Hospital Fund 2006).

To synthesize lessons from the Health Care Linkage Project with the best thinking from around the nation on developing supportive health and social service programs to help seniors living in naturally occurring retirement communities, United Hospital Fund has launched the NORC Action Blueprint Project with the Daniels Fund, The Fan Fox & Leslie R. Samuels Foundation, and the Harry and Jeanette Weinberg Foundation. The goal of the Blueprint Project is to provide community leaders with information on programs to help seniors live as

OBESITY ON THE RISE AMONG THE ELDERLY

The increase in prevalence of obesity among older adults has been dramatic. Between 1960-1962 and 2003-2004, the percentage of people age 65-74 who were obese rose from 18 percent to 35 percent. This is of concern both because obesity is associated with increased risk of disease and disability, and because it has been estimated that Medicare spends about 34 percent more on an obese person than on someone of normal weight.

Source: Federal Interagency Forum on Aging-Related Statistics 2006; Lakdawalla et al. 2006.

independently as possible in their own homes and communities. The Blueprint Project will define guiding principles, identify elements of successful NORC supportive service programs, present helpful program development and management tools, and take a broad look at program financing. The end product will be a Web-based tool, the Blueprint, which will facilitate access to this information for existing and new audiences and will allow for the information to be modified as lessons are learned and needs evolve (United Hospital Fund 2006).

Creating Seamless Systems of Care

This nation's fragmented health care systems leave many seniors and their families frustrated by poor communication between providers or lack of coordination between services, which can lead to duplicated tests, treatment errors, or other threats to quality care. Several communities have experimented with system integration and care coordination in an attempt to find more consistent strategies for caring for older patients (Alper and Gibson 2001).

Program of All-Inclusive Care for the Elderly (PACE): In the late 1970s On Lok Senior Health Services in San Francisco's Chinatown developed a fully integrated model of acute and long-term care for very frail seniors. Nurtured by Robert Wood Johnson Foundation, On Lok now operates seven centers serving San Francisco's diverse senior population—including Chinese, Vietnamese, Filipino, Korean, Central and South American, Mexican, African-American, Italian, and Russian elders—with each patient's needs monitored by an interdisciplinary care team and adjusted as his or her health care needs change. The foundation's interest in On Lok grew out of the foundation's efforts to improve care and support for people with chronic health conditions (Alper and Gibson 2001). On Lok was quickly recognized as an innovative coordinated care and financing program. In 1986 it became the model for Medicare's Program of All-Inclusive Care for the Elderly (PACE) demonstration program. In 1997, PACE became a permanent program under Medicare. Several foundations, including Archstone Foundation, The California Endowment, The John A. Hartford Foundation, Inc., Robert Wood Johnson Foundation, and Retirement Research Foundation, have supported both On Lok and the PACE program by supporting policy analyses and program evaluation and helping to expand the program into new communities around the country.

PACE is centered on the belief that the well-being of seniors with chronic care needs and their families can best be met in the community whenever possible. PACE serves patients age 55 and older who are certified by their state to need nursing home care. These frail elders have an average of eight diagnosed medical conditions that affect their health and functioning and 45 percent have dementia diagnoses. To enroll, patients must also be able to live safely in the community and live in a PACE service area. Through PACE, patients receive all the medical and supportive services needed to maintain independence in their homes for as long as possible. The continuum of services includes adult day care; nursing and therapeutic services; medical care; home health and personal care; prescription drugs; social services; medical specialty services such as dentistry, optometry, podiatry, and speech therapy; respite care; and hospital and nursing home care when necessary. PACE is financed through both Medicare and Medicaid. In 2003, more than 10,000 individuals participated in PACE programs associated with 27 facilities in 17 states.

For Robert Wood Johnson Foundation, rationalizing fragmented and unresponsive health care delivery systems has been a worthy but difficult endeavor. What impressed foundation staff about the PACE model was the effectiveness of the team approach, in which dedicated professionals work together to create their own system of care. Advocates of the model argue that the team approach is likely to be a key factor in making integration of acute and long-term care work, because it can lead to better communication among multiple providers caring for the same person and to a more consistent strategy for caring for the patient. In contrast, the foundation has experienced less success with an alternative that simply tries to coordinate the care offered by the long-term and acute systems. Nevertheless, since health care delivery systems are unlikely to undergo a major reconfiguration any time soon, foundation staff believe that coordination may be the most viable strategy to improve care on a large scale within the existing fragmented system (Alper and Gibson 2001).

Care Transitions: When patients are ready to leave the hospital and return home—or move on to another care setting, like a rehabilitation facility—good communication and coordination are essential to a smooth transition. Many patients do not receive clear instructions regarding their new medications or symptoms to watch for, or even the name of a person to contact with questions. For older patients and patients with chronic or complex conditions, improperly handled care transitions frequently result in readmission to the hospital, medical errors, and duplication and inefficiency costs for the health care system (The Commonwealth Fund 2006).

With funding from The John A. Hartford Foundation and Robert Wood Johnson Foundation, the University of Colorado Health Sciences Center developed the Care Transitions Measure (CTM), a tool that assesses problems in care coordination from the patient's perspective so that hospital systems can develop targeted solutions. The model consists of the following components:

AS THE NATION GOES, SO GOES MEDICARE

In many ways, developments related to Medicare over the past 25 years have closely tracked changes in our health care system overall. Initially designed to resemble the type of insurance typical in the 1960s, the Medicare program has evolved as the needs of the aging population have changed. When it was established, the program did not pay for preventive services, outpatient prescription drugs, hearing or vision care, catastrophic coverage, or long-term care. In the late 1980s and early 1990s, with researchers exploring the link between disease prevention and successful aging, Congress began to add coverage for preventive services, such as flu shots and cancer screenings, to the program. In 1982, with growing public support for specialized end-of-life care, a hospice benefit was added. In 1998, with health care costs on the rise, the short-lived Medicare Catastrophic Act attempted to cap out-of-pocket costs for beneficiaries. In 1997, as the country experimented with managed care as a way to control costs and improve quality, Congress created Medicare+Choice, to encourage delivery of care through private plans, sweetening the incentive by allowing these plans to offer additional benefits (like outpatient prescription drugs, foot care, eyeglasses, and hearing aids) not otherwise covered by Medicare. Most recently, the Medicare Modernization Act of 2003 added a long-awaited outpatient prescription drug benefit.

Source: Rovner 2000; Alliance for Health Reform 2006.

THE MEDICARE PRESCRIPTION DRUG BENEFIT

In January 2006, Medicare prescription drug coverage became available to the program's 43 million beneficiaries. To receive the coverage, however, beneficiaries must actively opt in to Medicare Part D by selecting a prescription drug plan (PDP). Seven and a half million dual eligibles, Medicare beneficiaries receiving drug coverage through Medicaid, were assigned to Medicare PDPs. The new Medicare drug benefit also includes additional subsidies for beneficiaries with limited incomes, including dual eligibles; Medicare beneficiaries with Supplemental Security Income; and beneficiaries enrolled in the Medicare savings program, which provides assistance paying for Medicare Part B premiums. Other qualified low-income beneficiaries may also be eligible for this extra help, which includes premium and cost-sharing subsidies.

Source: GIH 2006.

- a personal health record that consists of the essential care elements for facilitating productive interdisciplinary communication during the care transition;
- a structured checklist of critical activities designed to empower patients before discharge from the hospital or nursing facility;
- a patient self-activation and management session with a transition coach (a geriatric nurse practitioner) in the hospital, designed to help patients and their caregivers understand and apply the first two elements and assert their role in managing transitions; and
- transition coach follow-up visits in the skilled nursing facility or in the home and accompanying phone calls designed to sustain the first three components and provide continuity across the transition.

The intervention focuses on making sure that each patient is knowledgeable about medications and has a medication management system, understands and utilizes the personal health record to facilitate communication and ensure continuity of care plan across providers and settings, schedules and completes follow-up visit with the primary care physician or specialist physician, and is empowered to be an active participant in these interactions and is knowledgeable about indications that their condition is worsening and how to respond (University of Colorado Health Sciences Center 2006).

A 2004 grant from The Commonwealth Fund supported refinement and testing of the measure, as well as promotion of the CTM's use by health care providers. The Community Health Foundation of Western and Central New York is using the CTM in a new quality improvement collaborative that aims to improve care transitions for the frail elderly population (Community Health Foundation of Western and Central New York 2006; The Commonwealth Fund 2006).

Helping Seniors Navigate Medicare

New Medicare benefits and other changes to the program have placed additional demands on seniors, requiring them to make more complex and consequential decisions about their health coverage.

The Central Florida Medicare Rx Coalition: The Winter Park Health Foundation (WPHF) in central Florida names older adults as one of its four priority areas, and focuses on optimizing physical and mental health and well-being and promoting social and civic engagement. Most of the foundation's aging-related grantmaking has been directed at transportation; promoting healthy behaviors; encouraging lifelong learning and enhancing well-being; fostering meaningful connections with family, neighbors, and friends; providing opportunities for meaningful paid and voluntary work; and making aging issues a community-wide priority.

When the Medicare Prescription Drug Improvement and Modernization Act (MMA) was signed into law, WPHF added beneficiary education to its work. Building on the foundation's role as a community convener, foundation staff worked with local partners to build a coalition dedicated to community outreach and education on Medicare Part D. Capitalizing on its reputation, the foundation was able to draw a variety of organizations into its Central Florida Medicare Rx Coalition, including local AARP chapters, the state's health insurance assistance program, county government, and area agencies on aging.

In addition to hosting six Medicare fairs drawing more than 1,200 people, the group also succeeded in mobilizing 2-1-1 hotline staff members to receive and field Medicare drug benefit inquiries. It

also oversaw the distribution of educational materials. Some 158,000 copies of a special edition of the Florida Hospital Premier Health newsletter on the Medicare drug benefit were distributed. The efforts drew a great deal of media attention, most notably in the *Orlando Sentinel* which ran a series of informative stories about the new prescription plan. NBC Nightly News also filmed a segment at the West Orange information session which was aired nationwide. The Medicare Rx Coalition now is developing a work plan for Phase II of its community education and advocacy project focused on enrollment of eligible older adults (Winter Park Health Foundation 2006).

Make Medicare Work Coalition:

The Michael Reese Health Trust is using its proactive grants program to develop a coordinated response to the challenges presented by Medicare Part D in Illinois. Through the Make Medicare Work Coalition, the foundation – along with The Chicago Community Trust and the Retirement Research Foundation – funded key advocacy groups representing seniors and persons with disabilities. These advocacy groups work jointly to enhance advocacy, outreach, education, and enrollment. For example, resources for consumers and advocates were developed, including a Web site and printed materials. A speakers bureau was also created to help local organizations hosting health fairs and other events. In addition, the Make Medicare Work Coalition communicates policy analysis and implementation efforts through e-newsletters, listservs, and teleconferences to policymakers and other stakeholders. It also provides technical assistance to state agencies and the governor's staff on questions related to Medicare Part D and has hosted a legislator briefing on the impact of the new benefit on Illinois' medical programs, the state's budget, and its low-cost drug program.

A key goal of the coalition is to marry policy and education and outreach efforts, using individual experiences to inform wise policy decisions. In its first year, consumers' feedback led to the coalition's policy advocacy on several issues, including the state's implementation of emergency procedures when dual eligibles had trouble receiving their medication. In the coming year, the coalition plan to continue its core activities; adjust to elimination of the state pharmacy assistance program; focus on implementation issues including exceptions and appeals; enhance targeted outreach to vulnerable populations including those eligible for extra help deaf limited English and Medicare Savings Programs enrollees; and conduct policy advocacy for the retention of retiree health benefits (Lavin 2006).

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Fast Facts

Population

The population age 65 and older is projected to double from 36 million in 2003 to 72 million in 2030, increasing from 12 percent to 20 percent of the population (U.S. Census Bureau 2005).

The oldest-old population (those aged 85 and older) is also projected to double, growing from 4.7 million in 2003 to 9.6 million in 2030 (U.S. Census Bureau 2005).

In 2003, non-Latino whites accounted for nearly 83 percent of the U.S. older population, followed by African Americans (8 percent), Latinos of any race (6 percent) and Asians (3 percent). By 2030, the projected composition of the older population will be 72 percent non-Latino white, 11 percent Latino, 10 percent African American, and 5 percent Asian (U.S. Census Bureau 2005).

Since the 1960s, the proportion of the older population living in poverty has declined. Still, in 2003, 10.2 percent of the population 65 and older lived in poverty, and an additional 6.7 percent were near poor, with incomes between 100 percent and 125 percent of the federal poverty threshold (U.S. Census Bureau 2005).

Health Status

Average life expectancy increased from 47.3 years in 1900 to 76.9 years in 2000 (U.S. Census Bureau 2005).

There is less disability among older people today than there was 30 years ago, and many chronic ailments such as heart disease, lung disease, and arthritis are occurring an average of 10 to 25 years later than they did in the past (Kolata 2006).

About 80 percent of seniors have at least one chronic health condition and 50 percent have at least two. Between 1960-1962 and 2003-2004, the percentage of people age 65-74 who were obese rose from 18 percent to 35 percent (CDC 2003; Federal Interagency Forum on Aging-Related Statistics 2006).

Health Care Costs

Almost 40 percent of health care spending, about $735 billion annually, is incurred by people over age 65 (The Century Foundation 2006).

Among older Americans, almost 95 percent of health care expenditures are for chronic diseases (Merck and CDC 2004).

The aging of the population is only one factor contributing to rising health care costs. Projections for long-term Medicare spending through 2075 by the Congressional Budget Office indicate that "approximately 30 percent of that growth is due to society's aging; the remaining 70 percent is attributable to general growth in health care costs in excess of the rate of gross domestic product growth" (The Century Foundation 2006).

Health Insurance Coverage

Retiree health benefits are on the decline. Thirty-five percent of large firms offered retiree coverage in 2006, down from 66 percent in 1988 (The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2006).

Medicare, the federal health insurance program created in 1965 for the disabled and people age 65 and older regardless of their income or medical history, now covers nearly 43 million Americans (The Henry J. Kaiser Family Foundation 2006a).

Medicare pays for just over half (55.2 percent) of older Americans' health care costs. The Medicaid program pays 10 percent of older Americans' expenditures, private insurers pay for 12 percent, and older people cover one fifth (20.4 percent) of the cost of services themselves (Friedland and Summer 2005).

The proportion of older persons' income spent on health rose from 8.1 percent in 1997 to 9.9 percent in 2001. This proportion varies widely by socioeconomic and health status. Poor or near poor older people spend 21.5 percent of their income on health care costs (The Century Foundation 2006).

Prescription Drugs

People age 65 and older account for 34 percent of all prescriptions for medications (Merck Institute of Aging & Health and CDC 2004).

As of June 2006, the U.S. Department of Health and Human Services (HHS) reported that 22.5 million beneficiaries were enrolled in Medicare prescription drug plans. Based on HHS estimates, 4.4 million beneficiaries, or more than 10 percent of the Medicare population, had no prescription drug coverage in 2006 (The Henry J. Kaiser Family Foundation 2006b).

The drug benefit offers substantial premium and cost-sharing assistance for beneficiaries with low incomes and modest assets. HHS estimates that 3.1 million beneficiaries who are eligible for this assistance are not currently receiving it (The Henry J. Kaiser Family Foundation 2006b).

Long-Term Care

Nearly 79 percent of people who need long-term care live at home or in community settings. Most long-term care is provided by informal caregivers (Merck Institute of Aging & Health and CDC 2004, The Century Foundation 2006).

The value of services that family caregivers provide at no cost is estimated to be $257 billion a year (Merck Institute of Aging & Health and CDC 2004).

Excluding informal care, Medicaid is the largest source of funding for long-term care of the elderly. In 2004, Medicaid paid 35 percent of long-term care costs, while Medicare paid 25 percent, seniors paid 33 percent out of pocket, and private insurance paid 4 percent (The Century Foundation 2006).

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Kolata, Gina, "So Big and Healthy Grandpa Wouldn't Even Know You," *The New York Times*, July 30, 2006.

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U.S. Census Bureau, *65+ in the United States: 2005* (Washington, DC: 2005).

Recommended Reading

AARP Public Policy Institute, *The State of 50+ America* (Washington, DC: 2004). Available on-line at www.aarp.org/research/reference/statistics/aresearch-import-480-D18051.html.

In this report AARP examines the well-being of Americans age 50 and older in terms of 20 indicators reflecting key dimensions of well-being, economics, health, lifestyle, independent living, and long-term care. Although the report shows favorable trends on almost all measures over the past decade, the 50 plus population has not fared as well in the near term, doing worse on all but 2 of the economic and health indicators analyzed, and declining on 10 of 15 indicators of well-being overall.

Burke, Shelia P., Judith Feder, and Paul N. Van de Water, eds., *Developing a Better Long-Term Care Policy: A Vision and Strategy for America's Future* (Washington, DC: National Academy of Social Insurance, 2005). Available on-line at www.pascenter.org/publications/publication_home.php?id=268.

This report focuses on developing a vision of a better, more responsive long-term care system and the policies to promote it, as well as developing a strategy to put long-term care on the national policy agenda. The current long-term care system falls far short of meeting reasonable expectations for its performance. Achieving a long-term care system that meets individual needs and distributes costs equitably, the report concludes, will require greater federal involvement and financing. The report is the final product of the National Academy of Social Insurance's study panel on long-term care.

Cohen, Gene D., *The Mature Mind* (New York, NY: Basic Books, 2005).

Drawing on the latest studies of the aging brain and mind, Gene Cohen debunks the myth of aging as an inevitable decline of body and mind. He introduces the concept of developmental intelligence, a maturing synergy of cognition, emotional intelligence, judgment, social skills, life experience, and consciousness. Drawing on the results of two groundbreaking studies, Cohen illustrates that the years after age 65 are anything but retiring, and that creativity, intellectual growth, and more satisfying relationships can blossom at any age.

Freedman, Marc, *Prime Time: How Baby Boomers Will Revolutionize Retirement and Transform America* (New York, NY: Perseus Books Group, 1999).

Marc Freedman predicts that a new kind of aging will bring new life to America. *Prime Time* highlights initiatives that tap retirees for such roles as foster grandparents and volunteers at free medical clinics. The book also profiles people who are now reaping the benefits of remaining socially productive. Freedman takes issue with the notion that old boomers will be a burden on the nation's health care and Social Security systems. Instead, they will be the largest, best-educated, and healthiest group of retirees ever.

Friedland, Robert B. and Laura Summer, *Demography is Not Destiny, Revisited* (Washington, DC: Georgetown University Center on an Aging Society, 2005). Available on-line at www.cmwf.org/usr_doc/789_friedland_demographynotdestinyII.pdf.

This report provides a framework and basic data on the U.S. population and the challenges presented by an aging society. It also examines public policies that encourage and facilitate education, basic research, and how the application of promising technologies can enhance the well-being of current and future generations of older people.

Grantmakers In Health, *Implementing the Medicare Prescription Drug Benefit*, Issue Focus, *GIH Bulletin*, April 3, 2006 (Washington DC: April 2006). Available on-line at www.gih.org/usr_doc/Issue_Focus_4-03-06.pdf.

On January 1, 2006, Medicare prescription drug coverage became available to the program's 43 million beneficiaries. To receive the coverage, however, beneficiaries must actively opt in to Medicare Part D by selecting a prescription drug plan (PDP). Seven and a half million dual eligibles, Medicare beneficiaries receiving drug coverage through Medicaid, were assigned to Medicare PDPs on January 1st.

Grantmakers In Health, *New Choices and Hard Decisions: Helping Seniors Navigate Medicare*, Issue Focus, *GIH Bulletin*, May 3, 2004. Available on-line at www.gih.org/usr_doc/Helping_Seniors_Navigate_Medicare.pdf.

Educating seniors on the changes to the Medicare program has been a challenge for both the public and private sectors. Reaching the nation's 41 million Medicare beneficiaries — 35 million of whom are over the age of 65 — will require a mix of customized, one-on-one assistance and broad education campaigns. This Issue Focus proposes that providing information and referral services for seniors and their families is an area ripe for foundation work, and outlines a number of opportunities for grantmakers.

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Grantmakers In Health, *Long-Term Care Quality: Facing the Challenges of an Aging Population* (Washington, DC: 2001). Available on-line at www.gih.org/usr_doc/53838.pdf.

For all the sophistication of our health care system, the U.S. does not have a highly developed and supportive long-term care network that takes good care of its elderly. This Issue Brief offers an overview of the primary factors influencing the quality of long-term care services, including demographics, service providers, financing, and policy and regulation. It also profiles innovative grantmaker programs.

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Iezzoni, Lisa I., *When Walking Fails: Mobility Problems of Adults with Chronic Conditions* (Berkley, CA: University of California Press, 2003).

Roughly one in ten adult Americans find their walking slowed by progressive chronic conditions like arthritis, back problems, heart and lung diseases, and diabetes. In book, Lisa Iezzoni describes the personal experiences of and societal responses to adults whose mobility makes it difficult for them to live as they wish because of physical and emotional conditions, as well as persisting societal and environmental barriers. Iezzoni explains who has mobility problems and why; how mobility difficulties affect people's physical comfort, attitudes, daily activities, and relationships with family and friends throughout their communities; strategies for improving mobility; and how the health care system addresses mobility difficulties, providing and financing services and assistive technologies.

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The Henry J. Kaiser Family Foundation, *Medicare Chart Book 2005* (Menlo Park, CA: 2005). Available on-line at www.kff.org/medicare/7284.cfm.

This resource features more than 80 charts and tables with detailed information about the Medicare program and the 42 million seniors and younger people with disabilities who rely on Medicare for health insurance coverage. It covers a wide range of relevant data, including state-by-state information when available, such as benefits and utilization, supplemental insurance coverage, out-of-pocket spending, and financing and future projections for the Medicare program.

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Mockenhaupt, Robin E., Jane Isaacs Lowe, and Geralyn Graf Magan, "Improving Health in an Aging Society," in Stephen L. Isaacs and James R. Knickman eds., *The Robert Wood Johnson Anthology: To Improve Health and Health Care, Volume IX* (San Francisco, CA: Jossey-Bass, 2006). Available on-line at www.rwjf.org/files/publications/books/2006/chapter_02.pdf.

In this chapter of *The Robert Wood Johnson Anthology: To Improve Health and Health Care*, Volume IX, the authors suggest the nation's aging population presents a unique opportunity. They set the foundation's work in aging into a context of what society needs to do to promote the health and well-being of older adults. The chapter presents five propositions about how people can age in a healthy way. For each proposition, the authors present the research supporting the proposition and then discuss the relevance of foundation-supported programs. The authors also review the successes and failures of a broad range of initiatives and suggest future paths that the foundation might take.

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Novelli, Bill and Boe Workman, *50+: Igniting a Revolution to Reinvent America* (New York, NY: St. Martin's Press, 2006). Available on-line at www.aarpmagazine.org/books/fifty_plus.html.

In this book AARP CEO Bill Novelli challenges the retirement-age generation to come together and grasp the unique opportunity that faces them to transform society. Novelli identifies several opportunities for this generation including transforming health care, reinventing retirement, revolutionizing the workplace, building livable communities, and leaving a lasting legacy.

Prevratil, Joseph, "Taking Action in Aging Issues: Creating an Agenda, Finding Common Ground" Views from the Field, *GIH Bulletin*, June 2, 2000.. Available on-line at www.gih.org/usr_doc/Aging_Issues.pdf.

This Views from the Field article by Joseph Prevratil of the Archstone Foundation explores intersections between health and aging that could benefit from funder collaboration, including environment, disability, family caregiving, civic engagement, elder abuse, exercise and wellness, and workforce development.

Schoenborn, Charlotte A., Jackline L Vickerie, and Eve Powell-Griner, "Health Characteristics of Adults 55 Years of Age and Older: United States, 2000-2003," *Advance Data from Vital and Health Statistics No. 370* (Hyattsville, MD: National Center for Health Statistics, 2006). Available on-line at www.cdc.gov/nchs/data/ad/ad370.pdf.

The U.S. Centers for Disease Control and Prevention highlights the health characteristics of four age groups of older adults in this report: those 55 to 64 years, those 65 to 74 years, those 75 to 84 years, and those 85 years and over. The report provides estimates by sex, race and Hispanic origin, poverty status, health insurance status, and marital status.

Rowe, John W., and Robert L. Kahn, *Successful Aging* (New York, NY: Random House, 1998).

In this groundbreaking book John Rowe and Robert Kahn argue that aging does not have to be a painful process of debilitation. Their research shows that the influence of genetics shrinks proportionately as you get older, while social and physical habits become increasingly integral to your mental and physical health. The 10 years worth of research cited in *Successful Aging* reveal stunning facts about health in later life.