

ELDER CARE TODAY AND TOMORROW

HEARING BEFORE THE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

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ELDER CARE TODAY AND TOMORROW

MONDAY, APRIL 27, 1998

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Columbus, OH.

The committee met, pursuant to notice, at 9:30 a.m., at the Ohio State University Fawcett Center, Columbus, OH, Hon. John Glenn, presiding.

Present: Senator Glenn.

WELCOME REMARKS FROM RICHARD SISSON, PH.D., INTERIM PRESIDENT, THE OHIO STATE UNIVERSITY, COLUMBUS, OH

Mr. SISSON. Welcome one and all. It is certainly a pleasure to have this distinguished group on the Ohio State University campus this morning. It is good also to see such a good turnout for this very important hearing. We are especially pleased to have our future university colleague and distinguished U.S. Senator, John Glenn, and Mrs. Glenn here today. Senator Glenn has the longest period—I don't know whether you know this or not, but the longest period of continuous service in the U.S. Senate of any Senator from Ohio in the 20th century. And we are all deeply proud of him. [Applause.]

We are all very excited about the impact that the Senator and Mrs. Glenn's presence on the campus will have on our students, but also on the furtherance of this university's participation in national debates on major issues of public policy and leadership.

We are very, very pleased that Dean Healy and Dr. Kantor and others from our university can contribute to this hearing from the university's perspective, but also from the broader perspective of science and the interests of the United States public policy.

Ohio State has a strong commitment to this important, this fundamental area of research and teaching, and this area and public policy generally is scheduled to be a growth industry at this university.

Thank you for bringing this important public event to Ohio State. It will, in retrospect, I am sure, be the first of a continuing series of symposia on matters of national and international public importance. We thank you for being here. We look forward to engaging in the discussion.

Thank you very much. [Applause.]

OPENING STATEMENT OF SENATOR JOHN GLENN

Senator GLENN. Thank you, Richard. I appreciate that welcome very much and appreciate the hospitality provided to me and the U.S. Senate Special Committee on Aging by Ohio State University.

I am grateful to everyone here at OSU, particularly to Dr. Bernadine Healy with me here this morning and members of her staff for their help in organizing this hearing and making the Fawcett Center available to us.

I want to welcome all of you to this hearing, which is entitled "Elder Care Today and Tomorrow."

It is a pleasure to be back at the Fawcett Center to hold this official hearing of the Senate Aging Committee, and this is an official hearing of the committee. It is one of the field hearings that we do from time to time in different parts of the country. I have held several of these in past years in different parts of Ohio, and I am glad to be having this one here this morning.

All of the testimony that we hear today and the information we receive will be made part of the official hearing record available to members of the Senate, their staffs, and anyone else, of course, who is interested in this particular subject.

The chairman and ranking minority member of the Senate Special Committee on Aging are very interested in today's hearing, and they are represented here by members of their staffs. Ms. Hope Hegstrom is the counsel to Senator Charles Grassley, who is chairman of the Aging Committee. Hold your hand up here, Hope. Mr. Ken Cohen is the minority staff director for Senator John Breaux, the ranking minority member. We welcome you both to Ohio and thank you for your assistance.

As we know—or you may not know—Americans are living longer and our population is aging. What you may not know is that the average life expectancy for someone born today is nearly 77. In 1900, the average life expectancy was 47. That shows an amazing leap forward in the last 100 years. I think you could go back to the time of the Caesars, and I know that gets a little too far back in aging for us to really comment about, but back then the life expectancy was in the mid-twenties. So it took about 1,900 years to get up another 20-some years, up to 47, and in the last 100 years, things have gone up far more than that, up to 76 and growing past that. I think it is almost 77 now. So the aging population is exploding.

Today there are some 34 million Americans aged 65 and older. That is nearly 13 percent of our population. By the year 2030, when the baby boomers, as they are called, start retiring, that number will be 70 million older Americans, or 20 percent of our population. If you project that on out, the demographic experts tell us that by the year 2050, just a few decades from now, we will have over 99 million Americans 65 and up if current trends continue. This is something that is very, very important.

The fastest-growing segment of our elderly population is the 85-plus group, something we wouldn't have thought possible just a few years ago. They will be the ones most likely to need some assistance to remain in their homes and in their communities.

As our population ages, we must develop and implement policies that will prepare our society for the changes we know are taking

place, and we must provide individuals with information they can use to improve the quality of their own lives.

Some people say, well, why don't families just take care of us. Our biggest caregivers are families, but we still have major problems. In our family, we are not unusual in that Annie and I are here in Ohio; we are in Washington most of the time, of course, with our duties there in the Senate. But our daughter lives in St. Paul, and our son and his family live in San Francisco. So we are not unusual in that we are spread out the length and breadth of this country. In the old days, families just took care of families and that took care of the problem of the aging, but we can no longer do that. Churches and other organizations can't always take up the slack in this area, and so we are left with public policy decisions about what happens. Our goal is to ensure that our increased years of life are years that are healthy and productive.

My personal interest in this particular subject pre-dates even my Senate election back nearly 24 years ago. Annie was asked to be the chairperson of Nursing Home Week here in Ohio. She spent a week and then went into a second week checking into some of the homes to see what the conditions were and stayed overnight. Some of the things that we found were good, and some were horrible in some of those places.

So when I got to the Senate, I asked to be on the Special Committee on Aging. I have been on it ever since.

On a different note, of course, the interest in aging and aging matters was one of the reasons I was selected to be part of the space program later this year, going up again in October. We may have time to talk a little bit about that at a later time. I am glad to do that, and from a personal standpoint, I am glad to be going up. But an even more exciting standpoint is the fact that the research I will be taking part in, doing some of it myself, some by the other astronauts on the flight, will contribute to this knowledge of aging and how we take care of ourselves. In other words, we are looking into areas of how you cut back some of these frailties of old age and areas that overlap between what happens to the younger astronauts up there and the things that happen as part of the natural process of aging right here on Earth.

I am also pleased to know that the research in which I will be involved, research developed by the National Institute on Aging and by NASA together, could help open the door to our understanding of the aging process and help reduce some of the frailties of old age. You couldn't have a better person to comment on some of these things and to be one of our witnesses this morning than Dr. Robert Butler, who is the founding director of the National Institute on Aging.

Bernadine Healy, of course, was the head of NIH, which has 20 institutes within it. Dr. Butler started back in 1975 and headed up the newly established, at that time, Institute on Aging, was its founding director, and is now head of the International Longevity Center dealing in these same subjects.

If my example at age—I will be 77 in October—can help inspire other older Americans to live life to the fullest and to keep themselves in shape and do things, that may be a side benefit out of this whole thing, too, that I am glad to be participating in.

We realize what is happening in our country that we are living longer and our population is aging, and now is the time to develop programs and policies to prepare for these changes, not wait until they present a crisis. And that is rather key. The timeliness of what we are doing this morning here I don't think could be over-estimated.

So let's make growing older a blessing by working together, out of concern and respect for one another, to make our increased years of life comfortable, affordable, and as rewarding as possible.

At today's hearing, we have two distinguished panels of witnesses. Our first panel will discuss aging research and geriatric training. That will be Dr. Butler and Dr. Healy here with me. Our second panel will discuss home and community-based care. I thank all of our participants for taking time from their busy schedules to join us today, and I look forward to hearing from them about the programs that are now in place and, more important, their recommendations for the future. That is the reason we are here, not just to pat ourselves on the back and say, yes, we are concerned. We want recommendations of how we can better deal with some of these problems in the future.

[The prepared statement of Senator John Glenn follows:]

PREPARED STATEMENT OF SENATOR JOHN GLENN

Thank you, Richard, I appreciate that welcome very much, and I appreciate the hospitality to me and the U.S. Senate Special Committee on Aging by the Ohio State University. I am grateful to everyone here at OSU, and particularly to Dr. Bernadine Healy and members of her staff, for their help in organizing this hearing and for making the Fawcett Center available to us.

I want to welcome each and every one of you to this hearing, entitled "Elder Care Today and Tomorrow." It is a pleasure to be back at the Fawcett Center to hold this official hearing of the Senate Aging Committee. All of the testimony we hear today, and the information we receive, will be made part of the official hearing record available to members of the Senate, their staffs and anyone else who is interested.

The Chairman and Ranking Minority members of the Senate Special Committee on Aging are very interested in today's hearing, and they are represented here by members of their staffs. Ms. Hope Hegstrom is the Counsel to Senator Charles Grassley, Chairman of the Aging Committee; and Mr. Ken Cohen is the minority staff director for Senator John Breaux, the ranking minority member. I welcome you both to Ohio and thank you for your assistance.

As we know, Americans are living longer and our population is aging. Average life expectancy for someone born today is nearly 77. In 1900, average life expectancy was 47. Today there are 34 million Americans aged 65 years and older. That's nearly 13 percent of our population. By the year 2030, with the retirement of the Baby Boomers, that number will be 70 million older Americans or 20 percent of our population. And the fastest growing segment of our elderly population is the 85-plus group, those most likely to need some assistance to remain in their homes and communities.

As our population ages, we must develop and implement policies that will prepare our society for the changes we know are taking place, and we must provide individuals with information they can use to improve the quality of their own lives. Our goal is to ensure that our increased years of life are years that are healthy and productive.

On a personal note, I am thrilled to have the opportunity to return to space, and I am enjoying the training leading up to my flight in October. I am also pleased to know that the research in which I am involved, research developed by the National Institute on Aging (NIA) and NASA, could help open the door to our understanding of the aging process. And if my example, at age 77, helps inspire other older Americans to live life to the fullest, well that would be an added benefit to my flight.

We realize what is happening in our country that we are living longer and our population is aging. Now is the time to develop programs and policies to prepare

for these changes, not wait until they present a crisis. Let's make growing old a blessing by working together, out of concern and respect for one another, to make our increased years of life comfortable, affordable and rewarding.

At today's hearing, we have two distinguished panels of witnesses. Our first panel will discuss aging research and geriatric training; and our second panel will discuss home and community-based care. I thank all of our participants for taking time from their busy schedules to join us today, and I look forward to hearing from them about the programs that are now in place and more important, their recommendations for the future. By acting now and by working together—government, the private and voluntary sectors and individuals—we can successfully meet the challenges presented by our longevity revolution.

By acting now and by working together—government, the private and voluntary sectors, and individuals—I believe we can successfully meet the challenges presented by our longevity revolution.

Just a couple of housekeeping details before we proceed to our first panel of witnesses. First, you were given comment sheets along with today's agenda. I believe more are available in the lobby area if you didn't get a copy. I hope you would use these sheets to share with me your views about today's hearing and the issues we are discussing. Your comments will be taken back, and we will make them a part of our hearing record.

Second, we also have cards with information about the Senate Special Committee on Aging. Included on those cards is the committee's Web page address where today's testimony is available. We put that out so we can reach a much wider audience than just those here today or just those who may be able to see a TV broadcast tonight. The comments today of all of our witnesses will be available on the Web page.

So with that, I would like to get on with our hearing here. Our first panel is made up, as I said already, of two outstanding leaders in the area of health research and medical education, Dr. Bernadine Healy and Dr. Robert Butler. I know we will learn a great deal from them about research aimed at ensuring a healthy old age and about preparing all health professionals to meet the particular needs and circumstances of the elderly.

I offer, as I said, a very special welcome to Dr. Butler. He has come in from New York just for today's hearing. For most of you, Dr. Butler probably doesn't need much of an introduction because I think probably more than any other individual in this country, and possibly throughout the world, Bob has been responsible for making us aware of the needs of the elderly and the challenges presented by our aging population. Dr. Butler is chairman now of the International Longevity Center, in New York City, and professor of geriatrics at the Henry L. Schwartz Department of Geriatrics and Adult Development at The Mount Sinai Medical School, where he founded the first Department of Geriatrics in a U.S. medical school in 1982. As I said, he was founding director of NIA and served there from 1975 to 1982.

In 1976, Dr. Butler won the Pulitzer Prize for his book "Why Survive? Being Old in America." Dr. Butler has been a friend and advisor to me throughout my years in the Senate, and I thank you, Bob, for participating in today's hearing. You and I jointly set up a couple of conferences years ago called "The Graying of Nations," when we were looking into some of these things and had people in from 20-some different countries. This was in the days of the Cold War, and yet the Russians—the Soviets, at that time—sent their

person who was responsible for overseeing all their research in geriatrics and so on. From China, Dr. Ma, I remember, came and showed that this is an increasing problem all over the world. So we have worked together for a long time.

Dr. Bernadine Healy became dean of the College of Medicine and Public Health here at Ohio State University in 1995. The college and OSU Medical Center comprise one of the Nation's most comprehensive and dynamic academic research and medical centers. Dr. Healy is the immediate past director of the National Institutes of Health, where she established the NIH Intramural Laboratory for Human Genetics and launched a 625 million national Women's Health Initiative to study the causes, prevention, and cures of diseases that affect women in particular.

So it is a real pleasure to have both of you here with me this morning and to be here through this morning as we get into our second panel also.

STATEMENT OF BERNADINE P. HEALY, M.D., DEAN OF THE OHIO STATE UNIVERSITY COLLEGE OF MEDICINE AND PUBLIC HEALTH

Dr. HEALY. Thank you, Senator Glenn, Mrs. Glenn, Mr. Sisson, and ladies and gentlemen. As you just heard from the chairman, at the turn of the last century, the life expectancy for Americans hovered around 47. You don't have to look beyond your own neighborhood—or even this room—to see the changing demographics at the close of this century. Life expectancy for Americans is moving towards 80, and for those who reach age 65, they have a very good chance of welcoming in their tenth decade. This has been a glorious time for those who are enjoying life beyond 50.

But the next century is destined to take these strides even further. We will surely see even more lengthening of life, perhaps to our biological lifespan of 100-something. But we will also see dramatic improvements in the quality of life of the elderly, in terms of both mental and physical well-being.

Contrary to what some pundits have said, medicine and medical research have always learned a lot from the study of one individual—one index case. One such case is that of Madame Jeanne Louis Calment of Arles, France, who died this past August at the age of 122.

Madame Calment became the world famous poster girl of dignified aging, living independently in her own home until the age of 110, largely because of her fit brain and her sturdy bones. At that point her physical frailty did finally force her into a nursing home. At the age of 115, she faced some of the common health problems of the elderly: she fractured two bones, her hearing and eyesight diminished, and her memory began to fail. Nonetheless, she rebuked anyone who mentioned that failing: "When you're 117, you see if you remember everything."

The secrets of her extraordinary longevity were the subject of much medical research and speculation. She ate pounds of chocolate, drank red wine almost every day, and she rode a bicycle until she was 100. Dr. Jean Marie Robine, a public health researcher who had studied her for many years gave his analysis of her longevity. He said, "I think she was someone who constitutionally and

biologically speaking, was immune to stress." Madame Calment was fond of saying, "If you can't do anything about it, don't worry about it."

Her sharp wit and her sense of humor were clearly her way of coping with the stress of aging and also the growing attention the world heaped upon her with each year, each additional year of her long life. To a visitor whose parting greeting to her after one of these scrutinies was, "Until next year, perhaps, Madame," Madame Calment turned and quickly retorted, "I don't see why not. You don't look so bad to me." [Laughter.]

This humor and ability to handle the stress undoubtedly helped to strengthen her immune system—which does decline with age. The entire field of psycho-neuro-immunology, developed in part by the pioneering work of Ohio State researchers Dr. Jan Kiecolt Glaser and Ron Glaser, is defining the critical mind-body connections between stress, the immune system, and health. Of course, one of the best stress relievers is humor, a sharp wit, and a good laugh.

So that longevity formula is well derived from our single case study of Madame Calment: a sage brain, a sturdy skeleton, and a funny bone. Indeed, what forces most elderly from independent living to dependence, from being vibrant parts of society to believing they are burdens to society, are their bones, their brains, and their attitude.

Musculoskeletal wellness has finally been recognized as a preventable and treatable issue for the elderly. Loss of height, fractured wrists and hips, curved spines, and atrophied muscles are not inevitable to aging. Deterioration of the skeleton through osteoporosis is preventable and may even be reversible. Non-invasive, quantitative technologies to monitor bone mineralization has enabled us to recognize bone loss even before any fractures occur. Arsenal of anti-osteoporosis medicine, including the estrogenic compounds for women, and for men and for women, the bisphosphonates, have arrived on the scene only in this past decade.

Research on the importance of calcium and vitamin D supplementation to bone health has led just this past year to increases in the National Academy of Sciences' recommended daily intake for elderly Americans for both of these nutrients. Work done by the National Institute of Aging has shown the role of walking and weight-bearing exercise in the over age 70 population for improving musculoskeletal function. We here at Ohio State, we have some leading research activities in this whole arena. Dr. Rebecca Jackson heads several studies on osteoporosis and, of course, heads our Women's Health Initiative, which is also looking at bone health and well-being. Dr. Velimir Matkovic has done years of NIH work on osteoporosis in the young as well as the old.

The brain is another target for ensuring happy longevity along with the bones. We all, I am sorry to say, have to resign ourselves to the fact that the intelligence quotient peaks, and then declines starting in our mid-twenties. By mid-life, IQ may be 30 to 40 percent of what it had been in our early twenties. Memory and abstract problem-solving particularly are the hardest hit. However,

on a brighter note, practical intelligence, moral reasoning, common sense, and wisdom do better with age, and are lasting.

But even brighter, we are learning that the relentless loss of memory and cognition is also by no means inevitable. Research on the female sex hormone estrogen has taught us a lot about brain structure and function. Indeed, estrogen—and, secondarily, testosterone, which, by the way, the brain converts to estrogen through a special enzyme—is clearly more than a sex hormone. It is more than a bone hormone. It is also a brain hormone. Estrogen improves short-term memory, and it also has been shown to do this in perimenopausal women and beyond.

Observational studies supported by the NIH have suggested that estrogen replacement therapy actually decreases the incidence of Alzheimer's and its severity if it occurs. Neurobiological studies have shown the potential benefit this hormonal intervention has with regard to the growth of neurons and dendrites and also overall neuronal health. We are looking at an era in which we believe in neuronal plasticity, which in simple terms means the adult brain can rewire itself. Here at Ohio State, with Dr. Graham Stokes and other colleagues working in the neuroscience area, we believe they are part of this important research.

One approach to brain health, however, that is all too often missed is extraordinarily simple. It is called exercise. We know about exercising our bodies to promote physical wellness, but exercising our minds just as surely contributes to mental wellness. Several studies have noted that a lower education level and not keeping one's mind active contributes to Alzheimer's disease, but also contributes to cognitive decline.

By the way, what do we mean by mental exercise? It means reading, writing, using computers, participating in book clubs, doing crossword puzzles and word games, playing cards and chess, enjoying stimulating conversation or challenging hobbies. These factors are often lacking, sadly, in retirement or institutional environments, things that I know Dr. Kantor will address.

The full range of preventive strategies to keep our cardiovascular system healthy become critical to our aging population. It is not just that heart attacks are still the number one killer of elderly Americans, but that stroke all too often devastates the brains of previously fit elderly. Although stroke is declining in America, the most debilitating kinds of stroke are increasing in the elderly. The long-term debilitating kinds of stroke all too frequently means loss of independence and nursing homes, and, sadly, that often means maintenance and not rehabilitation.

Other brain factors also are critical to happy longevity. Age-associated changes in sensory function, which includes hearing and vision, are a major source of decreased quality of life. Certainly, sensory problems predispose to falls, medication error, and nutritional problems. Research on multiple sensory deficits—prevention and treatment—is a critical part of the aging agenda.

In this context, we have finally awakened to the importance of sleep disorders. Some 60-plus million Americans face sleep problems, and the majority of our 33 to 35 million elderly Americans struggle with these on a regular basis. The National Institute of Aging has a multi-pronged approach to dealing with sleep problems

and, in particular, is conducting studies on melatonin, the hormone that rises in the night, contributes to sleep, and is a critical part of setting our biological clocks.

As we look ahead to a world in which we will see not 60,000 but 600,000 centenarians, and in which those over 75 will be roughly one-quarter of our population, the challenge for all of us is to prepare now, whatever our age, to be one of those who ages well. Happy longevity has three parts: first, preventing disease and disability from taking hold; second, maintaining active minds and sturdy bodies; and, third, keeping productively engaged in the personal and social relationships and the day-to-day challenges of everyday life, the right attitudes.

It actually sounds simple, but it takes a national resolve as well as a personal devotion. In that context, Senator Glenn, I believe that your forthcoming journey into space—in which you will study muscle and bone loss, sleep disturbances, and cardiovascular and immunological changes that are common to both aging and space flight—will inspire all Americans, young and old. It will also redefine “senior citizen” for the entire world.

The Russian Space Agency Chief, Yuri Koptev, recently commented on your October reentry into space by noting that the Russian space program has cosmonauts who have reached their seventies, but none are in good health. He said, “We envy you [Americans] for having older people in such condition.”

Senator Glenn, we see you not as an exception, not as an isolated case report, but as the index case of what elderly in America is all about. [Applause.]

[The prepared statement of Dr. Healy follows:]

Elder Care: Today and Tomorrow
U.S. Senate Special Committee on Aging
with Senator John Glenn
April 27, 1998
Bernadine Healy, MD
A Sage Brain, A Sturdy Skeleton, and a Funny Bone
Lessons on Aging Today and Tomorrow

At the turn of the last Century, the life expectancy for Americans hovered around 47. You don't have to look beyond your own neighborhood -- or even this room -- to see the changing demographics at the close of this century. Life expectancy for Americans is moving towards eighty, and for those who reach age 65, they have a very good chance of welcoming in their tenth decade. This has been a glorious decade for those who are enjoying life beyond fifty.

But the next Century is destined to take those strides even further: We will surely see even more lengthening life --- perhaps to our biological lifespan of 100-something. And we will also see a dramatic improvement in the quality of life of the elderly, in terms of both mental and physical well being.

Contrary to what some pundits have said, medicine and medical research have always learned a lot from the study of one individual -- one index case. One such case is that of Madame Jeanne Louise Calment of Arles, France, who died this past August at the age of 122.

Madame Calment became the world famous poster girl of dignified aging, living independently in her own home until age 110, largely because of her fit brain and her sturdy bones. At that point her physical frailty forced her into a nursing home. At age 115 she faced common health problems of the elderly -- she fractured two bones, her hearing and eyesight dwindled, and her memory began to fail. Nonetheless, she rebuked anyone who mentioned that failing: "When you're 117, you see if you remember everything!" she said.

The secrets of her extraordinary longevity were the subject of much medical speculation: she ate pounds of chocolate, drank red wine almost every day, rode a bicycle until she was 100. Dr. Jean Marie Robine, a public health researcher who had studied her longevity and overall well-being, gave his analysis: "I think she was someone who constitutionally and biologically speaking, was immune to stress. Madame Calment was fond of saying "If you can't do anything about it, don't worry about it."

Her sharp wit and sense of humor were clearly her way of coping with the stress of aging and the growing attention the world heaped upon her with each and every added year of life. To a visitor whose parting greeting to her was "Until next year, perhaps," Madame Calment responded to her visitor. "I don't see why not! You don't look so bad to me."

This humor and ability to handle stress undoubtedly helped to strengthen her immune system -- which declines as we age. The entire field of Psycho-Neuro-Immunology, developed in part by the pioneering work of Ohio State Researchers Drs. Jan Kiecolt Glaser and Ronald Glaser, is defining the critical mind-body connections between stress, the immune system and health. And, of course, one of the best stress relievers is humor, a sharp wit and a good laugh.

So, that longevity formula is well derived from our single case study of Mme. Calment: a sage brain, a sturdy skeleton, and a funny bone. Indeed what forces most elderly from independent living to dependence, from being vibrant parts of society to believing they are burdens to society -- are their bones, their brains, and their attitude.

Sturdy Bones:

Musculoskeletal wellness has finally been recognized as a preventable and treatable issue for the elderly. Loss of height, fractured wrists and hips, curved spines, and atrophied muscles are not inevitable to aging. Deterioration of the skeleton through osteoporosis is preventable and may even be reversible. Non-invasive, quantitative technologies to monitor bone mineralization has enabled us to recognize bone loss before fractures occur. Arsenal of anti-osteoporosis medicines-- including estrogenic compounds for women, and for men and women, the bisphosphonates, have arrived on the scene in the past decade. Research on the importance of calcium and vitamin D supplementation to bone health has led, this past year, to increases in the National Academy of Sciences recommended daily intake for elderly Americans for both of these nutrients. Work done by the National Institute of Aging has shown the role of walking and weight bearing exercise in the over 70 age group for improving musculoskeletal function.

I am pleased that here at Ohio State we have some leading research activities in musculoskeletal health. Dr. Rebecca Jackson heads several important NIH funded activities in osteoporosis as well as the Women's

Health Initiative that looks at the well-being of women in the last half of their adult life, including bone health. Dr. Velimir Matkovic NIH work in osteoporosis has shown us that you are never too young to focus on building your bone strength for a long life.

Healthy Brain:

The brain is the other target for ensuring happy longevity. We all have to resign ourselves to the fact that the intelligence quotient (I.Q. as measured by standardized tests) peaks -- and then declines starting in our mid twenties. By mid-life, I.Q. may be 30-40% of what it had been, decreasing from there. Memory and abstract problem solving abilities are hardest hit. However, on a brighter note: practical intelligence, moral reasoning, common sense and wisdom, do better with age, and are lasting.

And even brighter, we are learning that the relentless loss of memory and cognition is also by no means inevitable. Research on the female sex hormone estrogen has taught us a lot about brain structure and function. Indeed estrogen -- and secondarily testosterone which the brain converts into estrogen -- is more than a sex hormone, and more than a bone hormone, it is also a brain hormone. Estrogen improves the short-term failings of memory that occur in the perimenopausal period and beyond. Observational studies supported by the NIH have suggested that estrogen replacement therapy is associated with less and milder Alzheimer's disease among elderly women. Neurobiologic studies reinforce the potential for beneficial hormonal interventions, based on laboratory findings demonstrating that estrogen influences the growth of axons and dendrites -- suggesting its possible role in neuronal plasticity. In simple terms, the adult brain can rewire itself. Many studies underway here at Ohio State are looking specifically at how the central nervous system repairs itself.

One approach to brain health that is all too often missed is extraordinarily simple: exercise. We know about exercising our bodies to promote physical wellness, but exercising our minds just as surely contributes to mental wellness. Several studies have noted that a lower education level is a risk factor for Alzheimer's diseases or even lesser forms of cognitive decline. What do we mean by mental exercise? It means reading, writing, using computers, participating in book clubs, doing crossword puzzles or word games, playing cards or chess, enjoying stimulating conversation, or challenging hobbies. These factors are often lacking in retirement or in institutional environments.

The full range of preventive strategies to keep our cardiovascular system healthy become critical to our aging population. It is not just that heart attacks are still the number one killer of elderly Americans, but that stroke all too often devastates the brains of previously fit elderly. Although stroke overall is declining, the most debilitating kinds of stroke are increasing in the elderly. The long term debilitating sequelae of stroke all too frequently means loss of independence and nursing homes -- and all too often that means maintenance and not rehabilitation.

Other brain factors also are critical to happy longevity. Age associated changes in sensory function which includes hearing and vision, are a major source of decreased quality of life. Sensory impairment can lead to loss of independence, social isolation, and the inability to keep the rest of the brain healthy and functioning. Sensory problems predispose to falls, medication errors and nutritional problems. Research on multiple sensory deficits -- prevention and treatment -- is an expanding and important area of emphasis.

And in this context, we have finally awakened to the importance of sleep disorders. Some 60-plus million Americans face sleep problems, but they are particularly concentrated in the population over 50. In fact the majority of the elderly population have sleep problems which may relate to alterations in the biological clock of the aging brain. The National Institute of Aging is conducting studies on melatonin, a brain hormone that influences our biological clocks. Melatonin rises in the darkness of the night and induces sleep. Since melatonin production declines with age, changes in the part of the brain that produce this hormone may explain some of the insomnia common among the elderly.

Right Attitude:

As we look ahead to a world in which we will see not 60,000 but 600,000 centenarians, and in which those over 75 will be one quarter of our population, the challenge for us all is to prepare now, whatever our age, to be one of those who ages well. Happy longevity has three parts: first, preventing disease or disabilities from taking hold; second, maintaining active minds and sturdy bodies; and third, keeping productively engaged in the personal and social relationships and the day to day challenges of every day life.

It actually sounds simple -- but it takes a national resolve as well as a personal devotion. And in that context, Senator Glenn, I believe that your forthcoming journey into space --- in which you will study muscle and

bone loss, sleep disturbances, and cardiovascular and immunological changes that are common to both aging and space flight --- will inspire all Americans, young and old. It will also redefine "Senior Citizen" for the world.

The Russian Space Agency Chief, Yuri Koptev recently commented on your October reentry into space by noting that the Russian space program has cosmonauts who have reached their 70's -- but none are in good health. He said "We envy you (Americans) for having older people in such condition."

Senator Glenn, we see you not as an exception, not as an isolated case report, but as the index case of what elderly in America is all about.

Senator GLENN. If Dr. Butler would go ahead with his presentation now, then we can have a discussion here of both of the presentations. Dr. Butler.

STATEMENT OF ROBERT N. BUTLER, M.D., CHAIRMAN AND CEO, INTERNATIONAL LONGEVITY CENTER

Dr. BUTLER. Thank you very much, Senator Glenn. In a way, this is a sentimental journey for me because I think it was about 20 years ago that we were here in this auditorium devoting a hearing to women and, I must say I congratulate Dr. Healy that since that time, through her, there has been the initiation of the very important Women's Health Initiative at the National Institutes of Health. I said sentimental journey, but, Senator Glenn, I do think that a gerontologist/geriatrician should be accompanying you into outer space. [Laughter.]

I am still trying.

I think it is very important to note that we not only have this remarkable revolution in longevity, but that we dare not simply sit back and congratulate ourselves on this unprecedented, dramatic change. We must seek to improve the quality of life, and it is very encouraging that there have been distinct drops in disability rates despite the aging of the population, not only in the United States but the reports from Japan and Sweden are confirmatory.

But I want to particularly address two major initiatives which I think are very important to our country, to our own people, not only to older persons but to all who would expect to grow old. But before I speak about those two matters, one being the development of geriatrics in American medical education and the development of a new initiative at NIH that focus upon frailty and dementia, I would like to congratulate the State of Ohio, which historically has often been in the lead in developing support for the development of geriatrics and in the forefront in medical, social, and behavioral aspects of aging research through its many fine academic and medical institutions.

But I do want to focus on the national and international aspects. On the national level, we must dramatically boost the budget of the National Institute on Aging and the National Institutes of Health. We have to prepare for that day when the baby boomers reach Golden Pond, which is just around the corner when, as already mentioned, 20 percent of the population will be over 65.

On both sides of the political aisle today in Washington, there is increasing interest in doubling the National Institutes' budget up to 26 billion. The rewards would be enormous.

It has been determined, for example, that \$1 invested in research can yield \$13 in savings. The simplest example often cited that is really relevant to geriatrics is that of the discovery of the polio vaccine. The expense of a "halfway" technology—the iron lung—was brought to an end when basic science was translated into a vaccine. Spring no longer brings the threat of an outbreak of polio. We no longer have the phenomenon of parents terrified at the thought of letting their kids into a swimming pool because of the fear of contagion. We now have the potential to make Alzheimer's disease the "polio of geriatrics" and dramatically reduce the number of persons in nursing homes.

But beyond Alzheimer's disease, we must address the range of ailments that affect older persons. I suggest not only doubling the support of the National Institute on Aging, but the introduction of an NIH/NIA trans-initiative. Every institute at the NIH has a component that bears on the frailty of the older population, whether it is secure bones or vision or hearing, as Dr. Healy pointed out. Opportunities to measure the performance of research through such an opportunity has great promise. To those who may wonder if NIH-wide initiatives work, I would point out that the initial Alzheimer's disease research effort involved four of the National Institutes of Health with the National Institute on Aging as the lead agency. Before the initiative, we knew precious little about Alzheimer's disease. People didn't even know of its existence. It has become a household word. Today there is a growing body of knowledge as to its pathology and even possible interventions, both preventive and therapeutic.

We cannot only be interested in research. We must ensure adequate funding to guarantee well-trained doctors and their colleagues in nursing and social work, physical therapy, and other allied health professions.

In Great Britain, every medical school has a Department of Geriatrics. Despite the fact that last year 6.8 billion was spent under Medicare's graduate medical education program in direct and indirect costs, precious little went to the advancement of geriatrics.

Of course, quite understandably, GME funds did support and should support training in various medical specialties. The fact is that geriatric training support, however, did not begin until the 1980's, and then only minimal support was provided for fellowships.

I would like to propose that everyone of our 140 allopathic and osteopathic medical institutions have the funding of a special allocation of graduate medical education monies to support the creation of 20 FTE's—full-time equivalents—at each one of the medical schools, because we have learned now that by having 20 such individuals in a faculty, it is possible to mainstream or integrate training in undergraduate, postgraduate, and continuing medical education. That would add up to about 3,000 doctors. There are 650,000 doctors in the United States, so this is basically a very modest program, but it would make possible for our country the development of first-rate teaching in geriatrics.

My own view has never been that we should have a new, possibly expensive practice specialty of geriatrics; rather, it has been my view that we need to have the teachers, the innovators, the leaders, to ensure us of the fact that everyone practicing—primary care doctors and specialists—would have the knowledge about the very special characteristics of growing old and the special problems of aging so that we could be assured, whatever doctor we went to, that we would have the best of care.

Population aging is international. We are experiencing a world-wide revolution in longevity. Already, 60 percent of the older persons in the world live in the developing world. In China, for example, there are 100 million people over 60. We have about 44 million. Sweden has a much higher percentage of older people than we do. While there are those who are worried about Social Security and

Medicare costs, the truth is that the sky is not falling in, either in China or in Sweden. However, we do have to be mindful of the extent to which our country, although possessing the leadership in research, has not done quite as well in the delivery of services.

In the Netherlands, Germany, and Japan, for example, they are already beginning to move rapidly in the formulation of effective long-term care arrangements, meaning a continuum of care that involves acute care, chronic care, long-term care, assisted living, all the way up to palliative care and to hospice care.

We must develop longevity science. We must develop well-trained cadres of outstanding leaders.

I am also submitting for the record a variety of tables which I hope will help bring further illumination to the very special situation that older Americans face, and that really means families of older Americans as well. The slides show us the demography, the dependency ratio, the extraordinary life expectancy, the very special issues that women face since women make up over 70 percent of those who are in nursing homes, and unfortunately are the ones that are often vulnerable to poverty, hospitalization, institutionalization, and isolation. We have to be sensitive to the fact that any cuts that might be forthcoming in Medicare and Social Security disproportionately and adversely affect the women of our society, women who may, with their husbands, be provident and saved all their lives, but in that long period of time that constitutes increasingly the period of late life, they may be left devastated.

We have lead time—not much, but we do have lead time. We must move rapidly if we are to advance aging research and geriatric training programs in Ohio and in the Nation. Obviously, we cannot suddenly cure Alzheimer's disease and prevent dementia. We cannot overnight create nurses, physicians, and social workers trained in geriatrics. But if we act now, and if we act imaginatively and forcibly, we can do so much to make it possible for the American family, for future older Americans, to enjoy not only a longer life but one of high quality, one of distinction.

I will close by saying that I don't think any one of us and any of our grandchildren will want to look at the later years in the same way after Senator Glenn returns to Earth, because that is going to change the whole imagery, the wonderful imagery of growing older in America.

Thank you. [Applause.]

[The prepared statement of Dr. Butler follows:]

TESTIMONY
by
Robert N. Butler, M.D.
CEO and President
International Longevity Center
and

Professor of Geriatrics
Henry L. Schwartz Department of Geriatrics
Mount Sinai Medical Center, New York

FIELD HEARING OF THE
U.S. SENATE SPECIAL COMMITTEE ON AGING

ELDER CARE TODAY AND TOMORROW
Columbus, Ohio
Monday, April 27, 1998

We cannot simply sit back and congratulate ourselves on the dramatic, unprecedented increase in longevity that has come about in this century, in our country and throughout the world. We must plan to reduce the concomitant frailty and dementia that all too frequently accompany old age and compromises older people's quality of life. On the positive side, we can report that there have been significant drops in disability rates over the last two decades, but growing numbers of older persons continue to suffer - at home, in the community and in nursing homes.

Major new initiatives must be developed to support research in aging and longevity. Furthermore, every doctor must be trained, whether in primary care or in specialty medicine, to have a broad but focused understanding of the specific issues that affect older persons.

Historically, the State of Ohio has contributed significantly to training medical students and physicians in geriatrics through a state program that has assisted its medical schools. Ohio is also famous for advancing knowledge about the medical, social and behavioral aspects of aging throughout its many fine academic and medical institutions.

Today, I want to focus on the national and international aspects. On the national level, we must dramatically boost the budget of the National Institute on Aging and the National Institutes of Health. Indeed, there has been much discussion on both sides of the political aisle about doubling the NIH research budget. And why not? Health is critical to all of us, from childhood to old age. Even at 26 billion dollars a year, the NIH budget would be modest compared to many public expenditures, and the rewards are enormous. It has been determined that one dollar invested in research can yield thirteen dollars in savings. The simplest example often cited that is relevant to geriatrics is that with the discovery of the polio vaccine, the expense of a "halfway" technology - the iron lung - was brought to an end. Spring no longer brings the threat of an outbreak of polio. We no longer have the phenomenon of parents terrified at the thought of letting their kids into the swimming pool because of the fear of contagion. We have the potential to make Alzheimer's disease the "polio of geriatrics" and empty our nursing homes.

Beyond Alzheimer's, we must also address the range of ailments affecting older people. I suggest not only doubling the support of the National Institute on Aging, but the introduction of an NIH/NIA-wide initiative. Every institute at the NIH has a component that bears on the frailty of the aging population, whether it is hearing loss, stroke, arthritis or incapacitating heart disease. By virtue of undertaking an NIH-wide initiative, with the National Institute on Aging as its lead agency, opportunities to measure performance of the research arm of the enterprise would also be facilitated. To those who may wonder if NIH-wide initiatives work, I would point out that the initial Alzheimer's disease research effort involved four of the National Institutes of Health with the National Institute on Aging as the lead agency. Before the initiative, we knew precious little about Alzheimer's disease. Today, there is a growing body of knowledge as to its pathology and possible preventive and therapeutic interventions.

We cannot only be interested in research. We have to ensure adequate funding to guarantee well-trained doctors and their colleagues in nursing and social work, physical

therapy and other allied health professions in geriatrics. Despite the fact that last year 6.8 billion dollars was spent under Medicare's graduate medical education program in direct and indirect costs, precious little went to the advancement of geriatrics. (Of course, quite understandably, GME funds did support training in various medical specialties. The fact is that geriatric training support did not begin until the 1980s and then only minimal support was provided.) Fellowships are supported to some degree, but no umbrella initiative exists to ensure that skilled faculty will be available to lead the development of geriatrics in its training in the 140 allopathic and osteopathic medical schools. Contrast this with Great Britain, where every medical school has a department of geriatrics. We have but three: one at the Mount Sinai School of Medicine, and two fledgling programs, supported initially by the Donald W. Reynolds Foundation at the Universities of Arkansas and Oklahoma Schools of Medicine. Individual and foundation philanthropy is very important, but it is not enough to meet this major national need. That is why at this time an effort should be made by Congress to set aside a specific amount from the 6.8 billion dollar Medicare GME money for the purpose of developing the field of geriatrics. It should be put on a fast track.

Population aging is international. We are experiencing a world wide revolution in longevity. Already, 60 percent of the world's population over 60 lives in the developing world. After the beginning of the next century it will be 80 percent. The percentages rise dramatically within the industrialized nations, Europe having the oldest population, Japan moving the most rapidly, and America right behind. We will have 20 percent of our population over 65 when the baby boomers reach Golden Pond, between the years 2020-2030.

The Netherlands, Germany and now Japan, despite its economic problems, have developed long-term care insurance. Japan is also developing a major research entity - the National Center of Longevity Science - which may prove competitive with our own NIA.

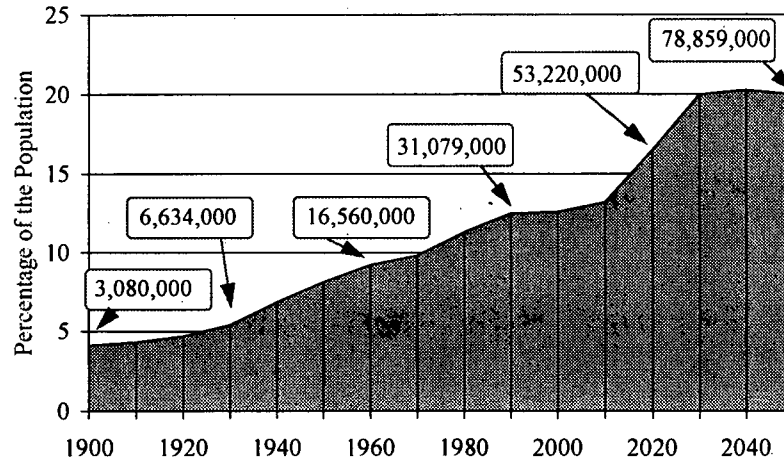
We have some lead time, but not much. We must move rapidly if we are to advance aging research and geriatric training programs in Ohio and in the nation. We cannot suddenly cure Alzheimer's disease and prevent dementia. We cannot, overnight, create physicians well-trained in geriatrics. Clearly, we have to act now.

* * *

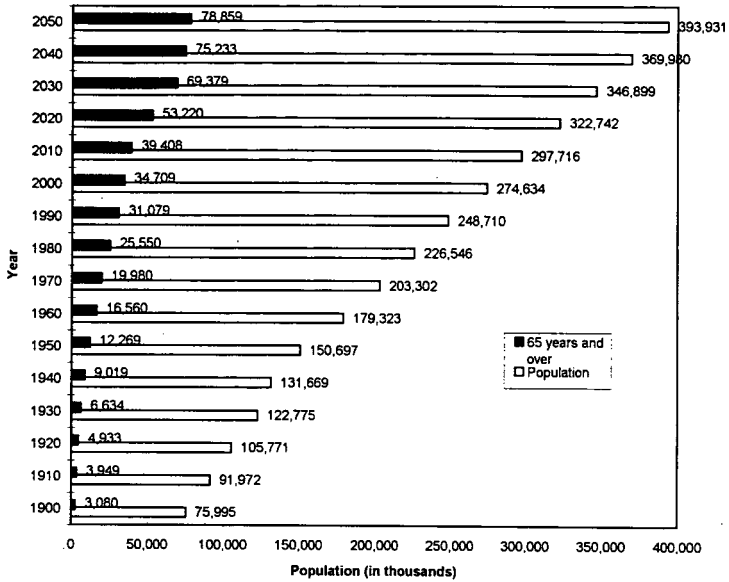
Handouts will be provided.

Percentage of the U. S. population age 65 and older from 1900 to 1990, with projections for 2000 to 2050.

Adapted from: U. S. Bureau of the Census (1996).



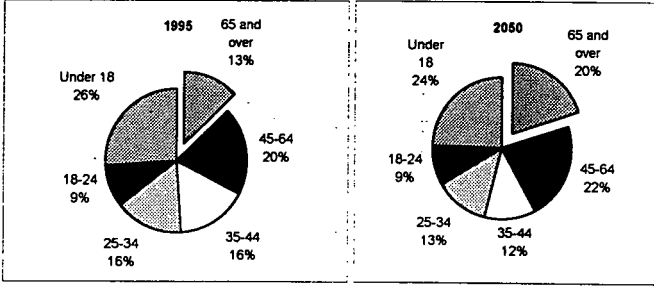
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U. S. population age 65 and older compared to total U. S. population from 1900 to 1990, with projections for 2000 to 2050

Source of data: U. S. Bureau of the Census (1996)

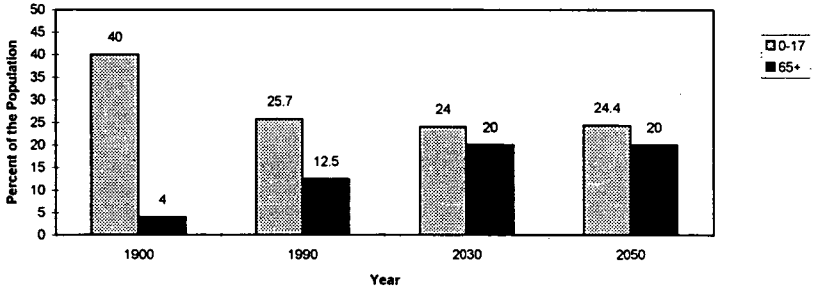
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Age distribution of total population of the U. S. in 1995 compared to projections for the year 2050

Source of data: U. S. Bureau of the Census (1996)

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Actual and projected distribution of children and the elderly in the population: 1990-2050.
Adapted from: U.S. Bureau of the Census (1996).

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"Dependency ratio": comparison of numbers of persons under 18 and over 65 (the "dependents") to the middle generations (the "workers").

Year	Number of Persons Under Age 18 Per 100 Persons Age 18 to 64	Number of Persons Age 65+ Per 100 Persons Age 18 to 64	Total Number of "Dependents" Per 100 "Workers"
Estimates			
1900	72.6	7.3	79.9
1910	65.7	7.5	73.2
1920	64	8	72
1930	58.6	9.1	67.7
1940	48.8	10.9	59.7
1950	51.1	13.4	64.5
1960	65.3	16.9	82.2
1970	61.1	17.6	78.7
1980	46.2	18.7	64.9
1990	41.7	20.3	62
Projections			
1995	42.8	20.9	63.7
2000	41.8	20.5	62.4
2010	39	21.2	60.2
2020	40.4	27.7	68.2
2030	43	35.7	78.7
2040	43.1	36.6	79.7
2050	43.9	36	79.9

Source: U.S. Bureau of the Census (1996).

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Life expectancy at birth and age 65 by race and sex: 1900-1995

YEAR	<u>ALL RACES¹</u>			<u>WHITE</u>			<u>BLACK</u>		
	BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE
At birth									
1900 ^{2,3}	47.3	46.3	48.3	47.6	46.6	48.7	33 ⁴	32.5 ⁴	33.5 ⁴
1950 ³	68.2	65.6	71.1	69.1	66.5	72.2	60.7	58.9	62.7
1960 ³	69.7	66.6	73.1	70.6	67.4	74.1	63.2	60.7	65.9
1970	70.8	67.1	74.7	71.7	68	75.6	64.1	60	68.3
1980	73.7	70	77.4	74.4	70.7	78.1	68.1	63.8	72.5
1985	74.7	71.1	78.2	75.3	71.8	78.7	69.3	65	73.4
1990	75.4	71.8	78.8	76.1	72.7	79.4	69.1	64.5	73.6
1995 **	75.8	72.5	78.9	76.5	73.4	79.6	69.6	65.2	73.9
At 65 years									
1900-1902 ^{2,3}	11.9	11.5	12.2	*	11.5	12.2	*	10.4	11.4
1950 ³	13.9	12.8	15	*	12.8	15.1	13.9	12.9	14.9
1960 ³	14.3	12.8	15.8	14.4	12.9	15.9	13.9	12.7	15.1
1970	15.2	13.1	17	15.2	13.1	17.1	14.2	12.5	15.7
1980	16.4	14.1	18.3	16.5	14.2	18.4	15.1	13	16.8
1985	16.7	14.5	18.5	16.8	14.5	18.7	15.2	13	16.9
1990	17.2	15.1	18.9	17.3	15.2	19.1	15.4	13.2	17.2
1995 **	17.4	15.6	18.9	17.6	15.7	19.1	15.6	13.6	17.1

Source: National Center for Health Statistics (1995). Trends in the health of older Americans: United States, 1994. Series 3: Analytical and epidemiological studies. No. 30. DHHS Publication No. (PHS)95-1414. Hyattsville, MD: DHHS.

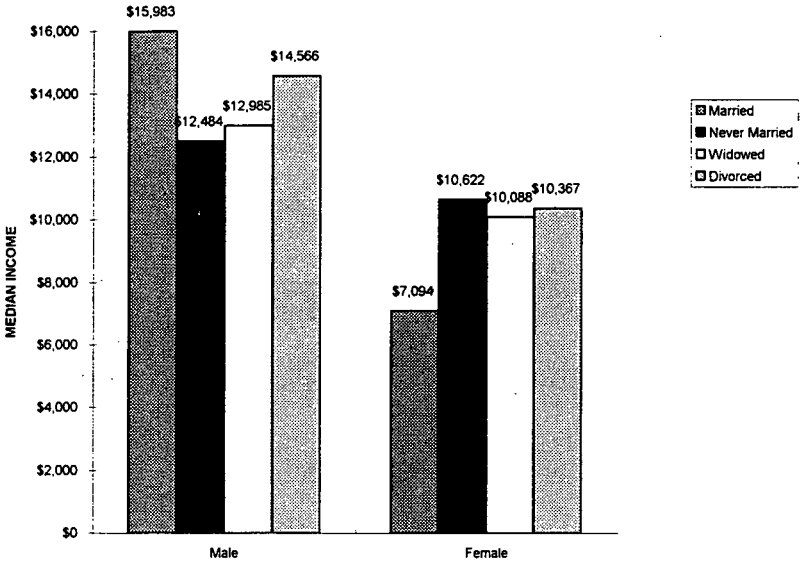
** Source for 1995 data: National Center for Health Statistics, unpublished data.

¹ Data includes races other than white and black

² Death registration area only. This area increased from 10 states and the District of Columbia in 1900 to the coterminous U. S. in 1933.

³ Includes deaths of nonresidents of the United States.

⁴ Figure is for "all other" population.

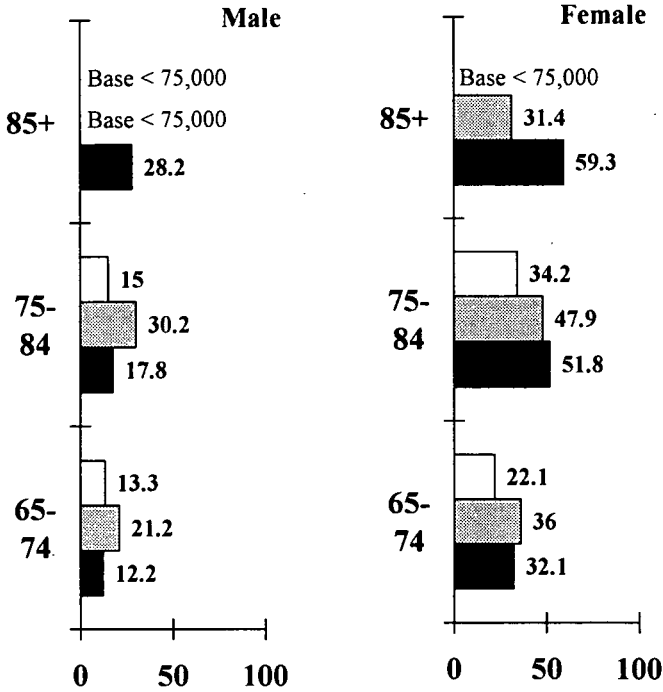


Median income of persons age 65 and older by sex and marital status: 1994.

Source: U.S. Bureau of the Census (1994), Current Population Survey, unpublished data.

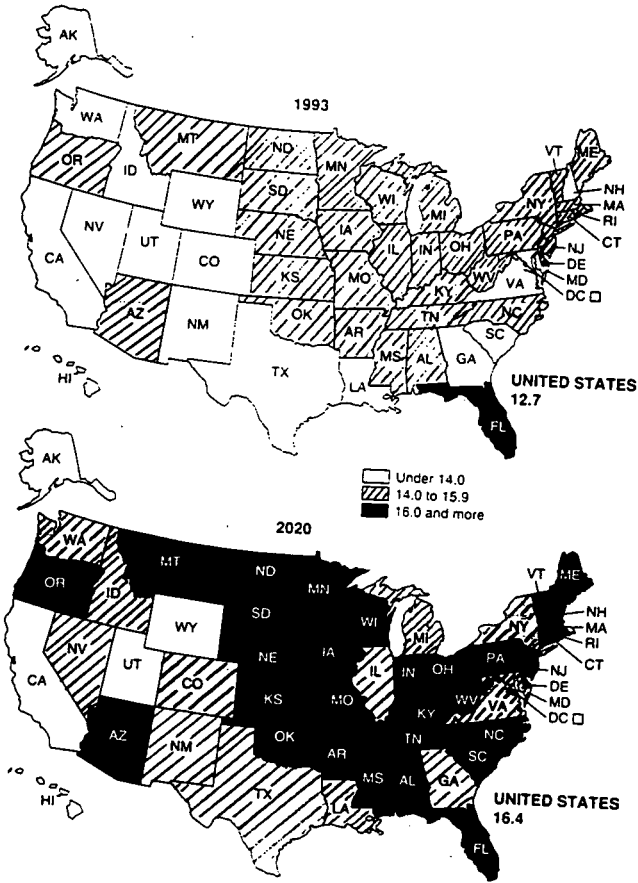
Percent of persons age 65 and over living alone by age, sex, race and Hispanic origin: 1993.

Source: U. S. Bureau of the Census (1996).



- Hispanic Origin (may be of any race)
- ▨ Black
- White

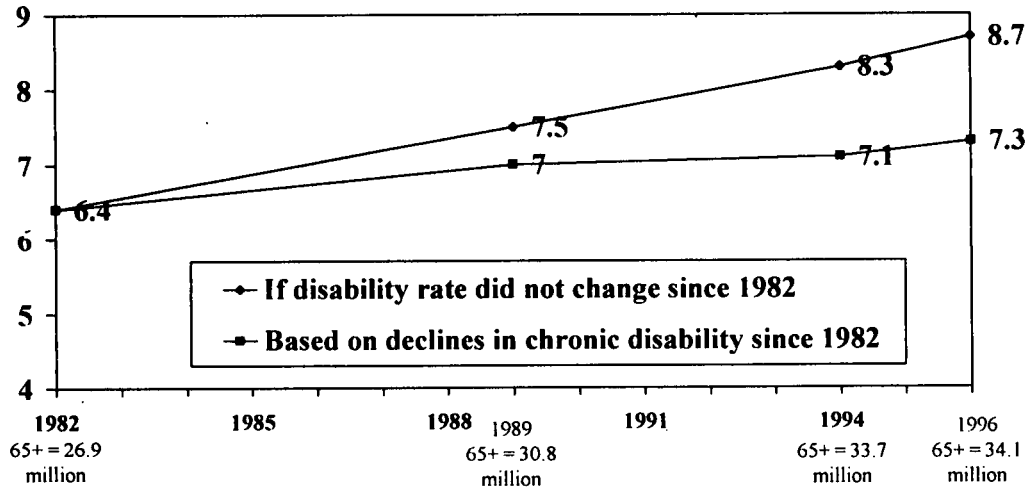
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Percent of total state population aged 65 and older in 1993 and projections for 2020

Source: U. S. Bureau of the Census (1996). 65+ in the United States. *Current population reports, special studies*, Series P-23, No. 190. Washington, DC: U. S. Government Printing Office.

Number of chronically disabled Americans aged 65 and over (in millions)



Source: Manton, et. al. (1997, March). Chronic disability trends in elderly United States populations: 1982-1994. *Proc. Natl. Acad. Sci. USA*. 94: 2593-98.

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Educational Attainment of Older People in The U. S.

- The percentage of older persons who have completed high school rose from 28% in 1970 to 60% in 1993.
- In 1993, almost 12% of older persons attained a bachelor's degree or more.

However, education levels vary considerably by race.

In 1993:

- 16% of whites age 65-74, and 29% of whites age 75 and older never attended high school.
- 38% of Hispanics age 65-74, and 71% of Hispanics age 75 and older never attended high school.
- 58% of blacks age 65-74, and 61% of blacks age 75 and older never attended high school.
- 63% of older whites completed high school compared to only 33% of older blacks, and 26% of older Hispanics.
- Only 6% of older blacks attained a bachelor's degree or more, compared to 13% of older whites.

Source: U. S. Bureau of the Census (1994)

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Aging is a women's issue

Women...

- live 7 years longer than men on average
- need Medicare 7 years longer
- have more chronic illness and disability
- occupy over 70% of nursing home beds

* * *

- One-third of older women live alone.
- Many live in poverty and never retire.
- Many are not “financially literate.”

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7 Deadly Myths

1. Older people receive heroic, high-tech treatments at the end of life.
2. Most older people die in hospitals.
3. Aggressive hospital care for older people is futile and a waste of money.
4. Living wills or advance directives would solve all dilemmas about care at the end of life.
5. Limits on Medicare at the end of life would save money.
6. Population aging is the main reason for rising health care costs.
7. Population aging will bankrupt the nation.

Source: Alliance for Aging Research (with support from the Project on Death in America of the Open Society Institute and the Retirement Research Foundation).

ILC-US

Senator GLENN. Thank you, Bob. Thank you very much. Dr. Healy, you mentioned the mental attitude of—what was her name?—Jeanne Louis Calment, Madame Calment, who lived to be 122. I was thinking they attribute the statement, I think, to Satchel Paige, a legendary baseball player, who said, "It is just mind over matter. If I don't mind, it don't matter." [Laughter.]

I thought that was a pretty good attitude to have toward things. The things you can do something about, do it. If you can't, well, don't let it wreck your life in other ways, too.

Dr. Healy, we have mentioned several times here that women live longer than men. You have taken the initiative, when you were head of NIH, of triggering off a whole new program on women's health. Could you comment a little bit about that, tell us a little about it? Because I think that is a great program.

Dr. HEALY. Well, as you mentioned, Senator, as people get older, women start to predominate. The sad news, of course, is men don't live as long as women, but the bad issue for women is that though they do live 8 years longer, on average, but so often with chronic debilitating diseases that generally start to pile up on them after age 60.

We initiated the Women's Health Initiative back when I was at NIH. The trial is just about winding down. I am pleased to say Ohio State was one of the 40 sites nationally, and the focus of that study was to look at women from age 50 right on through their 80's and to look at cardiovascular diseases, to look at cancer risks, to look at their bone health, their psychological health and well-being, and interventions including nutritional interventions as well as estrogen.

This particular study will start to be gathering information and producing knowledge hopefully within the next few years so that virtually every woman on this planet today will benefit from this particular study of women in the last half of the adult life.

Senator GLENN. It is a great initiative.

Dr. Butler, you look at aging with an international perspective. You are head of the International Longevity Center. In some other cultures, women are the people out gathering the firewood and doing the tough work. Is the aging of women and their living longer, is that the same in other countries as it is here, a general worldwide problem? Or is that particularly applicable just here in this country?

Dr. BUTLER. In many ways, the face of aging is a woman's face everywhere in the world. However, we do in the industrialized nations enjoy greater life expectancy for women than, of course, is true in some other nations. In Africa, for example, the sub-continent of India, parts of Latin America don't enjoy quite the same life expectancy. If you look at Uganda, for example, neither men nor women do. So there is that difference, and certainly the educational level of women in Europe and the United States is so superior and their opportunities are so much greater than is true in some of the developing world where their chance of realizing a high quality of life and having the financial means and health is much reduced.

Senator GLENN. Thank you.

Dr. Healy, Dr. Butler has given us two specific recommendations regarding the NIH: doubling the funding for NIH—and that is a big order—and calling for NIH/NIA initiatives—since every institute has a component affecting the elderly. I think that is something most people don't realize, the overlapping nature of these things with the different institutes.

You ran that whole operation there as past director. Could that much money be used—let's say I propose that. Is this something that should be phased in over a 3- or 4-year period of time? I think sometimes in this country we tend to think that if we just throw money at it, we will solve the problem, and that isn't always the case. We don't necessarily have the number of experts or the people to take advantage of that properly and get the best bang for every taxpayer dollar spent.

Do you favor his general approach? How would you administer that if you were back at NIH again?

Dr. HEALY. I think the notion of doubling the NIH budget over the next 5 years is a reasonable one because we have such a sturdy platform. We have 1,200 institutions around the country, thousands and thousands of investigators that are doing relevant work so that people can be served in this country. I think that it can be absorbed and very wisely invested in the present greatness of American science and American biomedical research.

Thirty years ago maybe we couldn't have done it quite effectively, but I think we can today, Senator. There are untold important experiments and discoveries that need to be made that are not being done today because of limited resources.

Senator GLENN. Money keeps cropping into this, and it has to, of course, when you are talking about any Government program. I would appreciate your comments on care at the end of life because I think—I don't remember the exact figure—something like 60 percent or two-thirds of Government funding spent on the elderly is spent in the last—what is it?—the last 18 months of life. The figures are of that nature, anyway.

We in this country, almost more than any place else, take extraordinary heroic measures trying to keep people alive, with tubes and so on. Some people take that in their own hands. I can remember when my dad was dying of cancer. This is back many years ago now. He didn't want to die in a hospital with all the tubes in him, and he made us—it was one of the toughest conversations I remember having, once when I was home on leave from the Marine Corps. My dad said when the time comes, he wanted to die at home. He wanted me to sit down and promise that we wouldn't go through all sorts of heroic things just trying to keep him alive for what would be another three months or something like that. That was one of the toughest promises I ever made. But that is where he died, at home.

Now, we tend too often not to go that route. We spend huge amounts of money keeping people alive for what usually turns out to be not a solution to their problems and another decade or two of life, but at best, a few more months.

The reason I bring this up and ask you about it, too, is you are faced with this in what kind of instruction you give or what kind of discussions you have with your med students here. You probably

have some med students here—I don't know whether any are in the audience now. How do you handle this on a med school basis? What do you think we should be doing to ensure the most appropriate type care? Do we need to do more to ensure that patients' wishes about their own end-of-life care are adhered to? What do you teach your students?

Dr. HEALY. I am sure Dr. Butler knows this. We always remind them that throughout most of the world, death is inevitable, but in the United States, death is an option. Certainly does come into play in most of our heroic acts on behalf of our patients and the patients we serve.

But I think that as we treat more and more acute illnesses and they become chronic illnesses, our focus is on responding to the chronic illnesses that can, in dealing with them, make people's quality of life important. I think as Dr. Butler stressed, we are not just looking at lengthening life. We are looking at quality of life. Ninety-five percent of the elderly in this country do live independently, do live outside a nursing home. Our goal is to prevent the disabilities, and those investments are the right investments.

With regard to our students, we have instituted many changes in the curriculum, the so-called DOC-3 curriculum, which look at differentiating care of chronic illness. It is no longer just the emergency room trauma, but it is dealing with the chronic illnesses, osteoporosis, chronic heart disease, stroke. These are the things that our students must be prepared to deal with in the next century much more than the doctors of this past century have had to do.

Senator GLENN. Dr. Butler.

Dr. BUTLER. I would like to respond to that, too. Dr. Healy, of course, expresses it ideally, but we do know from a recent study—which I would like to submit for the record called "The Seven Deadly Myths: The Truth about the High Cost of Dying in America"—while it is true that from time to time foolishness prevails, by and large the issue is the high cost of the last year of life is also because people are much sicker in the last year of life. We don't have yet such brilliant means of differentiating those who are going to survive and those who will die. In the course of our evaluation, we have found that it is not the case that, in fact, people as they get older are simply given more heroic treatments. While it can happen, it is not a generalization, and that, in fact, there is a drop in the actual per capita expenditure for people advanced in age, both in the hospital and in medical practice.

So without taking too much time, if I may, I will submit that for the record.

[The information follows:]

7
SEVEN
Deadly
MYTHS

Uncovering the Facts
About the High Cost of
the Last Year of Life

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~~SEVEN DEADLY MYTHS~~

The Truth About the High Cost of Dying in America

Popular comedian Al Franken joked recently that huge savings in federal spending could be achieved with a single stroke from both Medicare and NASA. Franken set up his audience by noting that 30% of Medicare costs are incurred by people in the last year of their lives, and that NASA spends billions on astronaut safety.

"Why not shoot the elderly into space?," he suggested to howls of laughter. "Think of how many more manned space explorations NASA could fund if they didn't have to worry about getting the astronauts back?"

Advocates for the elderly might cringe at Franken's joke, thinking it tasteless or even offensive. But he is certainly not alone in drawing dubious conclusions about the health costs older Americans incur at the end of life. It has become commonplace for politicians, news commentators, ethicists and economists to use – and misuse – available data about the high cost of medical care at the end of life in the United States. Misuse of the data has helped conjure an image of futile, yet expensive, high technology treatments being lavished on the very old who, it is reasoned, are going to die anyway. The health care debate is haunted by a harrowing image of very old men and women hooked up to beeping, wheezing life support machines monitored by physicians and hospital workers heedless of the costs and insensitive to individual human suffering. This picture lies at the heart of the debate over such diverse issues as Social Security, Medicare costs, physician-assisted suicide, health care rationing and medical research priorities.

This report shows that picture is based more on fiction than fact. But powerful misconceptions can influence health care policies in ways quite damaging and even dangerous to the proposition that Americans of all ages need and deserve high quality and appropriate levels of health care.

The Alliance for Aging Research set out to test some misconceptions surrounding the financial and medical impact of older Americans during their last months of life. This report presents the results. It is not an original research study but a comprehensive, independent review of the most current Medicare data, medical literature, and statistical evidence available on the subject. It is intended to clarify key aspects of the discussion of aging and cost of dying in America.

The Alliance for Aging Research has produced this report with the assistance of a nationally recognized and specially selected panel of advisors, drawn from the fields of health care, public policy, philosophy, ethics and medical economics. These experts came to this project holding a wide spectrum of views and opinions about the end of life. They came away convinced that the following seven deadly myths need to be exposed and eliminated from the national debate:

Myth #1: It is common for older people to receive heroic, high-tech treatments at the end of life.

In Fact: Only a fraction of people over age 65 receive aggressive care at the end of life, and the older people are the less likely they are to receive aggressive care when dying.

Myth #2: The majority of older people die in hospitals.

In Fact: The majority of older people do not die in hospitals, and the older people are the more likely they are to die in nursing homes.



Myth #3: Aggressive hospital care for the elderly is futile; the money is wasted.

In Fact: Many older people who receive aggressive care survive and do well for an extended period.

Myth #4: If all elderly patients had living wills or other kinds of advance directives, it would resolve dilemmas of how aggressively to provide care.

In Fact: Even when patients have advance directives, they often have little impact on or relevance to end-of-life decision making.

Myth #5: Putting limits on health care for the very old at the end of life would save Medicare significant amounts of money.

In Fact: Limiting acute care at the end of life would save only a small fraction of the nation's total health care bill.

Myth #6: The growing number of older people has been the primary factor driving the rise in America's health care expenditures over the past few decades.

In Fact: Population aging does not so far appear to be the principal determinant of rising health care costs.

Myth #7: As the population ages, health care costs for the elderly will necessarily overwhelm and bankrupt the nation.

In Fact: Population aging need not impose a crushing economic burden, especially if we start now to conduct the necessary research and develop policies on health care at the end of life.

The facts are summed up in the words of Dr. Gene Cohen, a prominent geriatrician, former acting director of the National Institute of Aging and panel chairman for this report: "The empirical data, in summary, offer little support for the politics of blame. It appears that age alone is not a reliable predictor of medical care outcomes or expenditures, nor is health care at advanced ages usually characterized by recourse to futile and expensive technologies. Clearly some common assumptions about health care costs and the elderly should be labelled 'myths' and removed from consideration."

This report concludes with recommendations made by the independent panel of experts and endorsed by the Alliance. The recommendations include calls for stepping up research on supportive care at the end of life, including studies into expanding hospice care and developing meaningful advance directives; methods to improve communication between critically ill older patients, their families and physicians; and increased emphasis on teaching geriatrics and pain management in all U.S. medical schools.

The aging of America's population, though often viewed in the negative, is in fact one of the great success stories of the 20th century. The likelihood that most of us will enjoy many decades of healthy and productive life beyond childhood and youth is the achievement of a good and just society. The greater numbers of people who live into and beyond their 80s and 90s, also raise the stakes we all have in achieving a good death when the time comes. The purpose of this report is to expose and defuse myths about the cost of dying among older Americans and to clear the way for reasoned consideration of the real questions – economic, social, and ethical – that surround health care in the last year of life.

MYTH I

It is common for older people to receive heroic, high-tech treatments at the end of life.

Fact: Only a fraction of people over age 65 receive aggressive care at the end of life. The older people are, the less likely they are to receive aggressive care when dying.

A terminally ill 90-year-old lives out his last weeks connected to tubes and a ventilator, his dying prolonged by a health care system infatuated with technology and insensitive to human suffering. This is a familiar image, one that haunts many people on a personal level and appears often in media coverage of death and dying.

It is an easy step from this image to the assumption that high-tech, senselessly prolonged death is common in old age and that it is a major reason for rising Medicare costs. But are such deaths common? There are various ways to measure the aggressiveness of care, and all cast doubt on this assumption.

One measure of the aggressiveness of care is cost. Data from the Health Care Financing Administration show that about six to eight percent of Medicare enrollees die each year, and they account for about 27 to 30 percent of annual Medicare expenditures.^{1,2} About half of Medicare costs in the last year of life are incurred in the last 60 days and about 40 percent in the last 30 days.³ These figures have strengthened the belief that intensive, futile hospital care for the elderly is common.

But a closer look at the Medicare data show otherwise. While hospital care at the end of life does account for a large portion of Medicare costs, spending for aggressive care is not a major component of these costs. In fact, only about three percent of Medicare beneficiaries who die incur very high costs, of the kind that suggest aggressive care.⁴ In 1990, the Congressional Research Service reviewed existing studies and concluded that "analysis of expenditure patterns lends little support to the assertion that high-technology medical care for the terminally ill contributes disproportionately to expenditures for those who die or to the argument that overall spending at the end of life is inordinately high and could be reduced."⁵

Some of the most recent data on this issue come from a long-term study of treatments and decision-making for seriously ill, hospitalized patients, called SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment). The largest study ever to look at the care of critically ill and dying patients, SUPPORT has collected data over a period of five years on 9,105 adults hospitalized with one or more of nine life-threatening diagnoses in five medical centers across the country. This study found that patients over 80 years of age are less likely to undergo three procedures representing aggressive care – major surgery, dialysis, and right heart catheter placement – than patients under 50.⁶ By a second measure – the overall intensity of care – older SUPPORT patients also received less aggressive, high-tech care.

In fact, older patients may receive less aggressive care even when severity of illness and prior functional status are comparable to those of younger patients. One SUPPORT analysis found that "do not resuscitate" orders were written earlier (in the course of the study) for patients age 75 and older regardless of prognosis.⁷ These findings suggest, as the researchers note, that "physicians may be using age in a way that is inconsistent with the reported association between age and survival."

Other researchers have looked at the question of age and aggressiveness of care from different perspectives and come up with similar conclusions. A study of Massachusetts hospital patients found that those age 90 and above tended to have conditions that involved less acute care than people in their

sixties.⁸ And regardless of diagnosis, the oldest people in this study had lower rates of aggressive care than people age 60 to 69. For example, they had lower ancillary charges (charges other than those for the hospital room, such as use of the operating room and radiology services). In addition, people age 80 and older in this study were less likely to be admitted to teaching hospitals and more likely to enter lower-cost community hospitals.⁹ Again it appears, as the SUPPORT researchers noted, that some informal age-based rationing of hospital care is in effect.

Estimated Total Costs and Length of Stay According to Age Group in Nonteaching vs. Teaching Hospitals

Age Group, y	Nonteaching Hospitals		Teaching Hospitals		Difference in Mean Total Cost Between Hospitals, %
	Mean Total Costs, \$	Mean Length of Stay, d	Mean Total Costs, \$	Mean Length of Stay, d	
60-69	6030	7.0	10524	7.8	42.7
70-79	6406	8.3	11542	9.2	44.5
80-89	6177	9.4	9499	9.5	35.0
90-99	5616	9.5	7338	9.0	23.5
>100	5330	9.8	6198	8.3	14.0

Average Estimated Total and Ancillary Costs per Discharge to Age Group and Survivor Status at Discharge*

Age Group, y	Decedents			Survivors		
	n	Total Costs, \$	Ancillary Costs, \$	n	Total Costs, \$	Ancillary Costs, \$
60-69	7387	16886	9463	201939	6981	3705
70-79	13467	14917	8059	241820	7163	3470
80-89	12887	10557	4654	157481	6492	2622
90-99	4050	6977	2737	34866	5784	2044
>100	145	6523	1660	857	5313	2499

*P<.0001 for differences between decedents and survivors for both total and ancillary costs, except for the age group of 100 or more years. Source: Paris TT and Wood ER (1996) Acute Care Costs of the Oldest Old. *Archives of Internal Medicine*. 156:759.

Functional Status vs. Age

Who does receive aggressive, high-technology care at the end of life? A study of 261 patients in a group practice in Palo Alto, California, showed that high-tech care more often went to people with good functional status (ability to carry out basic activities such as dressing and bathing) 12 months prior to death. In other words, quite reasonably, aggressive care was going to "the kind of patients a physician would not feel justified in not treating aggressively."¹⁰

Although total expenses did not differ substantially for the different functional groups in this study – the unimpaired, partially impaired, or totally impaired – costs by type of service did differ strikingly. Regardless of age, average hospital expenses were much higher for the unimpaired (\$18,000) than for the totally impaired (\$3,000) and the partially impaired (\$11,600). Physician costs for the totally impaired were about one-third those for the unimpaired. On the other hand, nursing home and home health care costs were sharply higher for the totally impaired than the unimpaired, offsetting their lower hospital and physician costs.¹¹

Finally, there is no evidence that aggressive care at the end of life is increasing. On the contrary, the proportion of total Medicare dollars spent for individuals in their last year of life has remained stable, according to a study that traced costs from 1976 to 1988.¹² Payments for care in the last two months of life also remained the same, proportionally, throughout the period of the study.

These findings suggest that physicians and hospitals are not blindly ordering heroic measures to prolong dying, despite the popular misconception. It appears that the more crucial issues for policy makers centers on supportive care for the elderly who are close to death. How can physicians determine when such care is appropriate, how and where should that care be provided, and who should pay for it?

MYTH 2

The majority of older Americans die in hospitals.

Fact: The majority of older Americans do not die in hospitals and the older people are, the more likely they are to die in nursing homes.

There is a widespread perception that one reason for the high cost of dying in the United States is that the vast majority of elderly people die in hospitals. The data, however, show otherwise. Data from the National Center for Health Statistics (NCHS) for 1994, the most recent year for which there are data, demonstrate that fewer than half of the deaths among people 65 and older occurred in hospitals. More than half of these deaths occurred in nursing homes or residences.

The trend, moreover, appears to be toward less hospital care for the dying as age increases, in contrast to the popular assumption. The NCHS data on place of death shows a sharp drop in hospital deaths after age 84 and a steady increase in the nursing home as place of death after age 65.

Hospital costs may also decline with age, according to some data. SUPPORT researchers, looking at more than 4,000 adult patients in five medical centers across the country, found that patients 80 and older had estimated hospital costs that were on the average \$7,161 lower than those for patients under 50.¹³ The same trend is apparent in patients 65 and older; in this age group, Medicare payments in the last year of life fall as age at death increases.¹⁴ Similarly, a study of Massachusetts acute care hospitals in 1992 and 1993 found that hospitalization costs peaked between the ages of 70 and 79 and then fell with increasing age. Among those who died in the hospital, costs peaked even earlier, in the 60 to 69 year age group.

The Survey of the Last Days of Life, conducted by the National Institute on Aging, suggests that most older people spend the majority of their last 90 days of life outside of hospitals, although about half transfer to a hospital in the last week or two of life.

Acute vs. Supportive Care

Studies of Medicare costs at the end of life are limited by and large to hospital and physician costs. To estimate end of life costs outside hospitals, several researchers have attempted to look at all health care usage and costs for terminal care. Their findings merit close attention because they show hospital use declining with age, while the use of nursing home and home health care rises dramatically.

The Survey of the Last Days of Life, conducted by the National Institute on Aging, suggests that most older people spend the majority of their last 90 days of life outside of hospitals, although about half transfer to a hospital in the last week or two of life.^{15,16} This study of more than 4,000

deaths in Fairfield County, Connecticut, also found that the number of days that elderly persons spent in nursing homes in the last 90 days of life increased dramatically with age.¹⁷

Researchers have also looked at nursing home costs. The study of 261 patients in Palo Alto, found that nursing home and home health care costs increased sharply after age 80, even as hospital costs dropped by 50 percent.¹⁸ Likewise, a 1988 study of 4,349 Medicare and Medicaid beneficiaries in Monroe

County, New York, found that the percentage of Medicare and Medicaid expenses for nursing home care rose sharply with age from 24 percent for the "young old" (65 to 74) to 62 percent for the "oldest old" (85 and over).¹⁹

The National Mortality Followback Survey of 1986 showed that among the 1.5 million people age 65 and older who died that year, 35 percent had a nursing home stay in their last year of life. The percentage rose with increasing age, from 16 percent of the young old, to 58 percent of the oldest old. The length of stay in nursing homes likewise increased with age.²⁰ Based on these figures, one researcher has estimated that nursing home costs equal or exceed the decline in hospital and physician costs.^{21,22} Clearly, the main focus of research and debate should be on supportive care for the elderly, rather than acute, hospital care.

One kind of supportive care covered by Medicare is provided through hospice services. However, Medicare pays for hospice care only when patients have a life expectancy of less than six months according to their physicians' estimate. In part because of the difficulty of estimating life expectancy, most patients with illnesses that result in death never use Medicare's hospice benefits or use them only shortly before death. Most hospice users are those with advanced cancers for whom life expectancy is easier to estimate.

The current debate on physician-assisted suicide reflects the urgent need for research and training on supportive, or palliative, care. Underlying this debate is the false assumption that suicide is the only practical alternative to the pain, indignity, and depression that too often accompany death from chronic diseases. However, we already know how to alleviate this suffering in many cases and to "make dying a comfortable, worthy part of a full life."²³

What needs to be done now is to extend this knowledge to all dying patients. Very few physicians currently receive training in end of life, palliative care, for instance, and many patients do not benefit from the aggressive management of pain that is possible and recommended.²⁴ Recently a group of 40 prominent health care organizations issued a declaration of principles for measuring quality of care at the end of life, including aspects of care such as relief of physical and emotional symptoms, support of function and autonomy, and advance care planning.²⁵

Clearly, the most critical policy issue in end of life care ought not to be whether physician-assisted suicide is a constitutional right. Rather, the most important issue is how to improve supportive care for people with critical illnesses that will result in death. What are the elements of good supportive care? How will we measure and pay for it? And what will be the impact of the growing numbers of elderly on supportive care services?

Hospital costs may also decline with age, according to some data. Researchers, looking at more than 4,000 adult patients in five medical centers across the country, found that patients 80 and older had estimated hospital costs that were on the average \$7,161 lower than those for patients under 50. The same trend is apparent in patients 65 and older; in this age group, Medicare payments in the last year of life fall as age at death increases.

MYTH 3

Aggressive hospital care for the elderly is futile; the money spent is wasted.

Fact: Many older people who receive aggressive care survive and do well for an extended period.

One of the most common myths surrounding health care in old age is that aggressive treatment is too often "wasted" on patients who, because of age, cannot benefit from it. The facts are that 1) many older people do benefit from aggressive care and 2) that age alone is not the major determinant of who will benefit.

The benefits of aggressive care for the elderly are demonstrated by Medicare data showing that among beneficiaries who incur high costs, there are about as many who survive as who die in the course of a calendar year. For instance, among those who cost Medicare more than \$20,000 in 1978, 24,000 died and 25,000 survived in that year.²⁶ In four other years, the percent of Medicare enrollees who incurred the highest costs were divided about equally between those who survived and those who died in the course of the year.²⁷

These data suggest, retrospectively, that high-cost (or aggressive) care has benefits for people age 65 and over about half the time, if one accepts survival as an indication of benefit. The figures also imply that if it were possible, prospectively, to identify persons who would benefit and persons who would not benefit from aggressive care, physicians and patients together could choose care accordingly.

At present, physicians do not have a reliable way to predict the outcome of treatment in elderly patients or, with the exception of terminal cancer, to predict how long a patient has to live with much accuracy.

This idea, however, leads to one of the crucial problems in decision making at the end of life: the difficulty of predicting which patients will survive and which will die. At present, physicians do not have a reliable way to predict the outcome of treatment in elderly patients or, with the exception of terminal cancer, to predict with much accuracy how long a patient has to live. Even the use of complex scoring formulas that take many factors into account fail to yield precise predictions of life expectancy in critically ill patients. The best known of these, the APACHE

model (Acute Physiology, Age, Chronic Health Evaluation), has improved the accuracy of predictions in groups of patients but has not proved useful in predicting which individual patients will die.²⁸

In one of the SUPPORT studies, the researchers found that seven days before death, patients had a median 51 percent likelihood of surviving two months, according to SUPPORT's own prognostic model.²⁹ Even one day before death, the median likelihood of surviving 2 months was 17 percent.

"While a prognosis of 50 percent for two months is a very serious prognosis," these researchers write, "it is not clear that the public means to categorize persons who still have a 'fifty-fifty' chance to live two months as 'terminally ill' and certainly not as 'imminently dying'."

Proportion of SUPPORT patients by disease who would be included in a "terminally ill" population as defined by two thresholds, and the rates at which they die within one and within twelve months.

Disease	N	< 50% survival (6 mo.)		< 20% survival (6 mo.)			
		N	% alive 1 mo.	% alive 12 mo.	N	% alive 1 mo.	% alive 12 mo.
ARF/MOSF	3515	1333	49	26	458	28	12
COPD	967	164	62	25	39	49	15
CHF	1387	125	70	28	25	32	4
Cirrhosis	508	186	47	23	70	20	13
Coma	596	478	23	13	252	13	6
Colon Ca	512	157	70	19	54	53	14
Lung Ca	908	657	68	13	197	44	3
MOSF/Ca	112	593	41	13	285	26	4

Source: Lynn J et al. (1996) Defining the "Terminally Ill": Insights from SUPPORT, *Duquesne Law Review*. 35: 311-36.

**Age alone is not a
good basis for
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to predict.**

Compounding the problem of prognosis was the markedly different likelihood of surviving two months that emerged for different illnesses and conditions in this study.

One clear fact that does emerge from studies of prognostic models is that age alone is not a good predictor of whether treatment will be successful. Both the APACHE III and the SUPPORT model include age as one prognostic element, along with physiologic and other variables. In neither case does age appear to play a major role, compared to other variables.^{30,31}

In summary, the common assumption that intensive care for the elderly is futile is not borne out by the evidence. Age alone is not a good basis for making prognoses, and the outcome of aggressive treatment is hard to predict. One of the pressing needs in end of life care is the development of better models to enable physicians to give patients and their families reliable prognoses and particularly to let them know when further aggressive treatment will indeed be futile.

MYTH 4

If all elderly patients had living wills or other kinds of advance directives, it would resolve dilemmas of how aggressively to provide care.

Fact: Even when patients have advance directives, they often have little impact on or relevance to end of life decision making.

Faced with medicine's increasing ability to save and prolong lives with high-technology care, many people have turned to advance directives, such as living wills, to guide decisions about use of such care in the event they are unable to make these decisions themselves near death. The Patient Self Determination Act (PSDA) of 1990 mandated that health care institutions inquire about and document existing advance directives at the time of hospital admission.

A TYPICAL LIVING WILL

I, (name), being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have in incurable injury, disease or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

Have advance directives fulfilled their promise? Not so far, say researchers who have identified at least three barriers to their use.

One of these barriers appears to be that advance directives are still not well integrated into our health care system. Despite the PSDA's passage, living wills, durable powers of attorney for health care, other kinds of instructions, and "do not resuscitate" orders often do not find their way into patients' medical records.³² This is not to say that the PSDA has not had any effect - SUPPORT researchers found that following passage of the bill, documentation of existing advance directives in seriously ill patients' medical records rose from six to 35 percent of records. An education and communication effort at the time of hospital entry further boosted this rate.

However, even when advance directives and "do not resuscitate" orders are placed in medical records, they appear to have little impact on care. SUPPORT researchers found, for example, that patients' preferences regarding cardiopulmonary resuscitation (CPR) often were not translated into practice. Among those who said they preferred not to have CPR, nearly half did not have "do not resuscitate" orders written

for them.³³ An intensive educational effort to improve communication between patients, families and physicians made little or no difference in this and other indications of the impact of advance directives.

A second barrier to the use of advance directives may be their lack of specificity. SUPPORT researchers, analyzing the content of 688 directives in five hospitals, found that the great majority used only the general language found in standard living wills, i.e. a statement that the patient prefers not to prolong dying through artificial means.³⁴ Only 90, or 13 percent, went beyond the general statement. Just 36 had specific instructions about the use of life-sustaining treatment and only 22 of these referred to the patient's current situation.

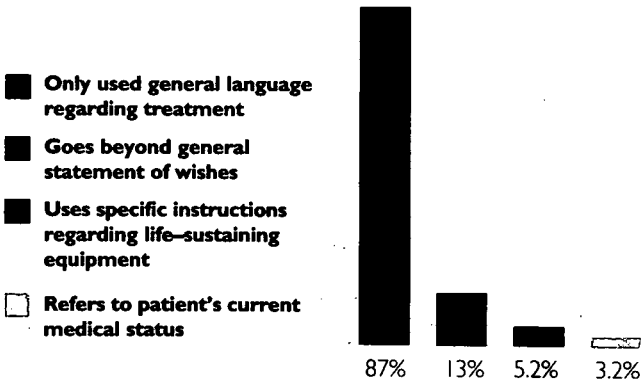
A general statement about not prolonging death may be of little use in today's health care environment. "What is ordinarily at stake for very seriously ill patients is not whether efforts to prolong life should ever cease, but exactly which efforts and when," SUPPORT researchers conclude.

A third and related barrier to the effectiveness of advanced directives is the clinical problem already mentioned – the difficulty of predicting when a given patient is near the end of life. Most advance directives embody the concept of not using life-sustaining measures when they would be futile. When physicians cannot predict futility, however, such instructions offer little guidance.

The issue, in other words, is complex. Simply getting more patients to write advance directives, even getting more hospitals to incorporate them into patient records, may have little impact in the face of these other barriers. One key focus for research and debate is how to craft advance planning that can make a difference in a patient's experience. In addition, research is needed on systemic hospital changes that could help older patients and their families make informed decisions and specific plans concerning the aggressiveness of care during critical illness.

Language Specificity as Barriers to the use of Advance Directives.

A total of 688 advance directives in five hospitals were reviewed.



Source: Teno JM et al. (1997) Do Advance Directives Provide Instructions That Direct Care? *Journal of the American Geriatrics Society*, 45:508-512.

MYTH 5

Putting limits on health care for the very old at the end of life would save Medicare significant amounts of money.

Fact: Limiting acute care at the end of life would save only a small fraction of the nation's total health care bill.

Even if physicians and hospitals could predict which patients were near death, limiting acute care would not save the amount of money that many people assume.

Consider Medicare expenditures at the end of life. It is a widely publicized finding that they consistently account for 27 to 30 percent of all Medicare expenditures.³⁵ But a closer look at the figures shows that an extremely small fraction of beneficiaries have high costs – the kind that suggest aggressive care. Moreover, eliminating care for these few high-cost users would save the country relatively few dollars.

For instance, only about three percent of older persons who died in 1978 cost Medicare more than \$20,000, and they accounted for only six-tenths of one percent of the nation's total health care costs.³⁶ Similarly, if care had been cut off to the 3.5 percent of Medicare patients who were high-cost users in 1993 and who died in that year, national health care costs would have fallen only slightly, from \$900 billion to \$895 billion. The savings would have amounted to one-half of one percent of total U.S. health care expenditures for that year.³⁷

Even if physicians could provide reliable prognoses and did curtail acute care for all persons with a very short life expectancy, it is not clear that society would save large amounts of money. Several studies suggest that the cost of hospice and other forms of supportive care can largely make up for savings in acute care.³⁸ According to one rough estimate, if society did limit aggressive care for all persons 65 and older who died, while implementing advance directives and using hospice care, the savings would amount to only 6.1 percent of annual Medicare expenditures and less than one percent of total national health care expenditures.³⁹

To sum up, aggressive care for the elderly at the end of life does not appear to be a major item in the nation's health care bill nor a potential area for large savings. While we need more information and better policies to guide appropriate end of life care, we cannot assume that simply by limiting aggressive care we could resolve America's problem of spiraling health care costs.

For instance, only about three percent of older persons who died in 1978 cost Medicare more than \$20,000, and they accounted for only six-tenths of one percent of the nation's total health care costs.

"Moreover, eliminating care for these few high-cost users would save the country relatively few dollars."

MYTH 6

The growing number of older people has been the primary factor driving the rise in America's health care expenditures over the past few decades.

Fact: Population aging does not so far appear to be the principal determinant of rising health care costs.

Health care costs in the United States have risen sharply in the past three decades not only in actual dollars but also as a proportion of the gross national product. It is easy to jump to the conclusion that this rise stems primarily from the graying of America, because the elderly on average spend more on health care than the nonelderly.

But a close look at the reasons for rising health care costs shows something different. One analysis has shown that between 1973 and 1983, general price inflation accounted for about 60 percent of the growth in national health expenditures, while inflation specific to the health sector of the economy was responsible for another 10 percent.⁴⁰ In the following ten years, 1983 – 1993, general inflation accounted for about 40 percent of the rise in national health expenditures, and sector-specific inflation for about 20 percent. Population and other factors remained relatively constant, according to this study.

To measure the effect of aging, the same analysts developed indexes of use per capita and cost per use for most of the components of personal health care. Those indexes show that between 1965 and 2005, the aging of the population has and will add less than one percent per year to the growth of personal health expenditures.⁴¹ Not until after the baby boom generation begins to reach 65, around the year 2010, will population aging have a major effect on health spending.

Other studies support this analysis. In one study, for example, researchers calculated that aging and population growth together account for only about 20 percent of the rise in hospital costs, and about 17 percent of the rise in physician costs between 1987 and 1990.⁴² The two factors accounted for about 35 percent of the rise in long-term care costs in this study, but they are still minor, compared to other factors. Inflation and rising gross national products "far outweigh all other causes as explanations of rising health expenditure" in recent decades.⁴³

There is no evidence, moreover, that an increasing proportion of resources are being devoted to dying elderly patients, despite the popular perception to the contrary.⁴⁴ Medicare data show that although expenditures increased sharply between 1976 and 1988, the proportion of dollars spent on elderly people who died remained about the same. As the authors of this study note, "apparently the same forces that have acted to increase overall Medicare expenditures, inflation, new techniques, and greater intensity of care – have affected care both for decedents and for survivors."

To assume that population aging has been the major source of rising health care costs is a mistake and detracts attention from the more serious determinants of rising costs. As one researcher has commented:

"If rising health care costs are due to aging and other external forces, then they are not "my" responsibility, nor can they be blamed on doctors, hospitals, insurance companies, governments, or indeed any of the institutions which should, in fact, be held responsible. By making it seem as if cost increases are inevitable, attention is diverted from the real and difficult choices that must be made and the institutions which make them."⁴⁵

MYTH 7

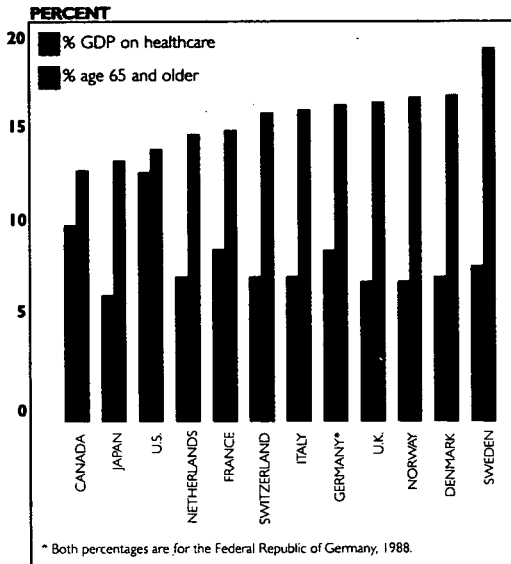
As the population ages, health care costs for the elderly will necessarily overwhelm and bankrupt the nation.

Fact: Population aging need not impose a crushing economic burden, especially if we start now to conduct the necessary research and develop policies on health care at the end of life.

One image that surfaces repeatedly in the public debate on health care costs is that of the huge wave of baby boomers who will begin turning 65 in 2011. By the year 2030, people age 65 and over will constitute 20.2 percent of our population. Often, in both the popular media and academic writings, the mention of population aging is linked with predictions of economic disaster.

Without doubt, the aging of the baby boom generation will challenge our current system, including the way we provide end of life care. But it is a mistake to consider the challenge insurmountable for two reasons. First, there is some evidence that population aging may not be as great an economic burden as many people assume.

Selected Nations Ranked by Percentage of Population aged 65 and older, compared with percentage of gross domestic product (GDP) spent on Healthcare, 1990



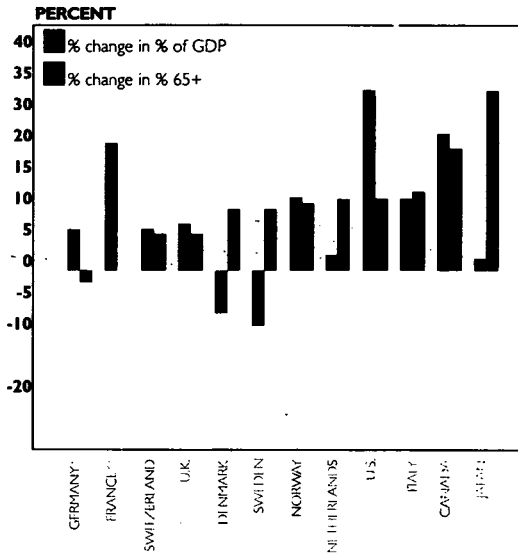
Source: Adapted from data in Schieber, Poulter and Greenwald, 1992. "U.S. Health Expenditure Performance: An International comparison and Data Update." *Health Care Financing Review* 13(4): 1-15.

Second, there is still time. As a society, we have the opportunity, now, to debate these issues and develop policies that are both economically and ethically sound.

The evidence that population aging may not be as disastrous to the economy as predicted comes from several sources, including cross-cultural studies. In other countries that have already experienced a sharp rise in the older population, health care spending has not risen proportionately.⁴⁶ For example, Japan's population aged 65 and older increased by 31.9 percent from 1980 to 1990, but its proportion of gross domestic product (GDP) spent on health care rose only 1.6 percent.

Furthermore, cross national data do not suggest that high proportions of older people are inevitably associated with high health care costs. Sweden, for instance has the highest proportion of people over age 65 among industrialized nations (18 percent), but its percentage of GDP spent on health care is comparable to that of countries with a smaller proportion of older people. In fact, overall, no pattern of relationships emerges from a comparison of population aging and health care spending in industrialized countries, even when one looks at spending for people aged 80 and over.

Selected Nations Ranked by Percentage of change in proportion of population aged 65 and older, compared with change in percentage of gross domestic product (GPD) spent on healthcare, 1980-1990



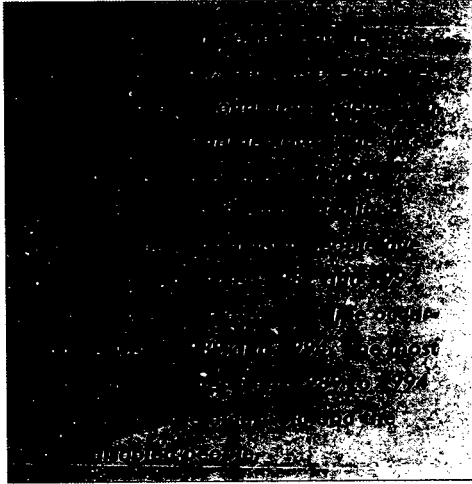
⁴⁶ Both percentages are for the Federal Republic of Germany, 1988.

⁴⁷ No change, 1980-1990, in % 65+.

Source: Calculated from data of Schieber, Poullier and Greenwald, 1992, "U.S. Health Expenditure Performance: An International Comparison and Data Update." *Health Care Financing Review* 13(4): 1-15.

One concern often cited is the changing ratio between the older users of Medicare and social security benefits and the younger working population who must support these programs. As the population ages, there will be fewer workers in relation to nonworkers. But here again, cross cultural data help put that concern in perspective. Between 1986 and 2040, the U.S. will have a low rate of increase in the ratio of inactive to active citizens compared to Japan, Sweden, France, and other industrialized countries. The U.S. rate of change is projected at 0.238 percent while The Netherlands' is .619 percent and Germany's is .778 percent.⁴⁷ As one expert has commented, "an average annual rate of less than one-fourth of one percent for a country like the United States is clearly a manageable increase, given the historical experience of that country in its economic growth and given the possibility of critical change in productivity and worklife time and allocation."⁴⁸

Another indication that health care costs for the elderly may not be headed for disaster comes from a recent study suggesting that the rates of serious illness could be falling in older people. Data from the National Long-Term Care Survey show that the prevalence of seven chronic conditions – dementia, stroke, arthritis, hardening of the arteries, high blood pressure, circulatory disease, and emphysema – declined almost 15 percent among people age 65 and older between 1982 and 1994, with the greatest rate of decline occurring between 1989 and 1994. The most significant declines from 1989 to 1994 occurred for the oldest old and the most disabled people.⁴⁹ While more data are needed to confirm this trend, this study does suggest that changes in disease patterns may be emerging.



In the health care scenario of the future, the impact of improved life expectancies is often said to play an important role. As more and more people live into their eighties and nineties, the argument goes, they are bound to place an increasingly serious burden on the health care system. However, a HCFA study shows that the impact of improved life expectancy past age 65 in 2020, considering only demographics and not inflation or developments in technology, will be quite small, amounting to only three percent of the projected increase in Medicare costs.⁵⁰

Finally, there is hope for the future. Consider the direction of much current research on aging, where the emphasis is on low-tech, preventive, and supportive interventions that improve quality of life.⁵¹ The National Institute on Aging, for instance, has major research programs on long-term care and the prevention of frailty and disability among the elderly.

While all of these are promising findings, it would be as grave a mistake to underestimate the challenge posed by population aging as it is to depict it as inevitable disaster. One of the most important tasks now is to address the crucial issues surrounding optimal health care services and health care costs at the end of life, while we still have time. It is critical that we conduct the research, gather the data, and develop policies and practices for end of life health care based on evidence and ethics rather than misconceptions.

~~SUMMARY~~

The Alliance for Aging Research, recognizing the growing negative focus on the magnitude of problems and associated societal costs incurred by the elderly, has completed this review to set the record straight. Myths and misinformation abound and with them comes the risk that the elderly population in this country are regarded as a national burden with ever increasing and insolvable problems. We want to head off that possibility along with the risk that misinformed policy-makers, blinded by negative myths and stereotypes about aging, might come to the conclusion that the only approach is to establish arbitrary limits and reductions in the health care resources on which older Americans and their families depend.

Studies in treatment and technology have made American medical prowess the envy of the world and lengthened the lives of many. However, these advances have also created unexpected consequences. Currently in the United States, it is often not death itself that is feared but rather the modern medical nightmare scenario – dying alone, in pain, without dignity, and tethered to expensive machines. In addition, demographics and economic realities have raised a host of ethical and practical issues related to end of life care for the elderly that previous generations did not have to face. These issues are real and must be faced with facts – not the myths that now surround them, fueling ageist attitudes and rhetoric.

We still have the opportunity to debunk the myths. We must address these issues head on and open the lines of communication among those facing death, their families, their health care providers and payers and policy-makers. Realizing the importance of personalized, end of life planning and communicating one's wishes to family and health care providers is only the beginning. A national dialogue involving consumers, patients, and the medical community, both academicians and clinicians, must commence in order for older Americans to be entitled to and ensured of a good death.

~~RECOMMENDATIONS~~

- More research on how and where supportive care could be provided at the end of life. What are the essential elements and outcomes of such care and what is the best way to ensure that patients have access to such care?
- More research on the costs of supportive care at the end of life. What are the costs of patients who die in nursing homes, and what can/should be done about these costs? How much of the nation's health care costs are for nursing homes and home health care at the end of life and how will these costs be affected by population aging?
- Development of more accurate methods for predicting and measuring the outcomes of treatment in elderly persons, including life expectancy.
- Mandatory training in geriatrics and end of life care, including pain management and other aspects of palliative care, in all medical schools in the United States.
- More research on the hospice program. For example, what options exist for expanding it to include more patients, and what impact would its expansion have on health costs.
- Development of methods to ensure communication between critically ill elderly patients, physicians, and families concerning patient preferences for aggressive treatment.
- Development of advance directives or other models for advance planning that can be translated readily into medical terms.
- Development of ways to measure the quality of care at the end of life so that it can become one of the criteria by which we choose health care providers and by which providers are paid.

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Senator GLENN. There was a recent study that showed that the longevity gap between men and women has shortened. Why do we have the gap?

Dr. BUTLER. Well, I am hoping—I wish Dr. Healy or the director of NIH would help us have a Men's Health Initiative so that we could catch up. [Laughter.]

Because there are decisive problems that have actually received relatively little support, for example, prostate cancer in men. So I think it might be time to try to close that gap.

I think we are very happy women are living longer, and I will say that it is noteworthy that the most recent reports show a slight gain on the part of men. But let's close that gap.

Senator GLENN. In our efforts to better our future physicians in geriatrics, what are the differences in having a full Department of Geriatrics, such as you established at Mount Sinai, as opposed to programs such as the one here at OSU which integrates geriatrics into the curriculum as such? Is it a different level of emphasis and specialization, or is there one better way to go than the other?

Dr. BUTLER. I think there are probably many different ways to go, as long as we achieve well-trained young people, developing their careers both in specialty and primary care medicine, for that matter in nursing and the other ancillary fields, I think that is just fine.

The value, of course, of a department is it does mean that the chair has direct access to funding, to the power structure within the medical school, which is not unimportant, and at least the last time I took a look, of the 126 allopathic medical schools, only 45 offered electives in geriatrics and only 4 percent of the medical students actually took the electives.

By virtue of the department, in our instance, we made it a requirement that students had to take geriatrics whether they liked it or not, just as they take pediatrics. Once we got the young people through the transom and they actually saw older people and they saw change and they saw improvement, we found out in the anonymous evaluations that the Department of Geriatrics was just as popular as other departments, which I never mention for political reasons. But we do very, very well.

So I think it is important to have departments, and we now have two others at the University of Arkansas and the University of Oklahoma.

Senator GLENN. You give full degrees in geriatric medicine; right?

Dr. BUTLER. You can have one anytime you would like. I would be happy to give you a full degree. [Laughter.]

Yes, we certify them as having gone through the experience of the required rotation through the Department of Geriatrics, which meant we teach in nursing homes, home care, and hospice. The students would see chronic illness, and, very importantly, they would see vigorous, healthy older persons in a program at the local Y, because we didn't want to create stereotypes of the older person. We wanted healthy, vigorous older persons presented to the students.

Senator GLENN. How do you handle that here at Ohio State, Dr. Healy? Do you rotate people through something like that? When

they come out of this now, would they go into geriatrics? If they want to make that a specialization, I presume they do that in residency training beyond just their medical school. Do you have any training like that here, graduate training? Are you finding that? Or how would you compare your program with the one that Dr. Butler headed at Mount Sinai?

Dr. HEALY. Well, I think the goals are all the same. I think that, you know, we recognize that any medical student graduating today has got to be well steeped in gerontology and geriatrics. There are differences in the way you prescribe drugs, different approaches, and it is essential. We may be working into the next century where one out of every five adults—one out of every five is elderly, and probably half of the patients that we care for will be so-called elderly.

We have specialty programs in the postgraduate medical side, very similar to what Dr. Butler was speaking about, and I think that that is a movement that has pretty much caught on across American medical schools. The gerontology field is a new field. There is no question about it. But it has caught up very quickly in part because the public we serve is insisting on it.

Dr. BUTLER. I might just quickly add that happily the American Board of Internal Medicine, the American Academy of Family Practice, and the American Board of Neurology and Psychiatry now do have special fellowships and examinations for competence in geriatrics, which has become highly desirable and sought after by young physicians.

Senator GLENN. Do you have training in either one of your academic environments on home care and how we encourage that, what doctors and what health professionals can do in that area? Because I think the figures that I mentioned in my opening remarks, some 80 percent of the care for the elderly is taken care of, you know, by other family members and people in the community. How do we encourage that more? Because that is a big need. Do you teach that here? What are you doing about that? That is where most of the care is being given, right there in the home. How do you relate to that?

Dr. HEALY. Well, the goal is independent living for the elderly, and it is much better to provide home care and to provide some assisted living rather than to "warehouse", which is certainly a fear of anybody as they look towards their golden years. Dr. Bonnie Kantor will go into more detail on the specific programs we have here. But they have become an essential part of training our medical students and training our future postgraduate physicians.

The key aspect, though, is very much like what has happened in space. When you first went up in 1962 in that space capsule, it was you alone in that space capsule. Now you are going to go back into space with a whole team of people with different specialized interests. The same thing has happened in medicine. Thirty years ago, it was the one doctor caring for an individual patient. Today, we have teams of physicians and health care providers, whether it be in home health, whether it be physical therapy, whether it be social work, nursing, as well as physicians who are gerontologists, general internists, cardiologists, oncologists. So we have teams caring

for the elderly, and the elderly generally need teams to deal with their mental as well as their physical well-being.

Dr. BUTLER. If I might add, it is interesting, too, when I went through my medical school training and internship and residency, the length of stay in a hospital was considerable. So the opportunity as a young physician to learn about the character of a particular disease and its natural course of events was really relatively easy. Now, with the diagnosis-related groups methodology, which has reduced hospital stays dramatically, the chance of even learning about diseases has changed. So I think we are going to be moving more and more to what might be called a multi-site medical school, which would mean the students would have, automatically need to have home care and hospice care experience and nursing home experience, assisted living experience, because to really understand pneumonia or any kind of disease process requires seeing the patient during the whole continuum of care.

Senator GLENN. Spending time in a hospital is a two-edged sword, though. Some of it is that because of increased medical capability, of course, people stay in the hospital a shorter period of time. But then we have some of the HMOs, who are so interested in the dollar end of this thing, they are kicking people out. We had to actually have some votes in the Congress so you didn't kick a new mom out who had a baby in the morning and then she is out by 2 o'clock. That wasn't much of an exaggeration either. They were sending people out, not letting even overnight stays, I think in some places, and that just seemed excessive. There was some debate about that in Congress, and I think pressure was brought, and I think most of that has been corrected now.

Dr. Butler, you look at things around the world through your International Longevity Center. Where are they doing research like we are doing in this country? What can we learn from them? Is there any place that is ahead of us and that we could use as a model in certain areas for some of our activities here?

Dr. BUTLER. Well, I think when it comes to basic biological and biomedical research, I am really happy to report that I think we are number one. The Japanese, however, very interestingly, have created a National Center of Longevity Science, their name for gerontology. Very nice, positive name. I have visited several times now their laboratories in molecular genetics, immunology, as well as social and behavioral intervention studies, and it is world class, and it will be.

So we may have a little competition, which wouldn't hurt. Certainly Sweden, Great Britain, France are still very much in the forefront with some outstanding work, and wonderful scientists in various places in the world are contributing to what is called telomere biology, which is very fascinating; the ends of our chromosomes which shorten each time our cells divide. It has become kind of a clock in nature.

But when it comes to health services themselves, I think we do have a lot to learn, a lot to learn from the Netherlands, Germany, and Japan, in particular. Japan, for example, is developing what they call the Gold Plan, which provides assistance to families in the middle of the night, 24-hour emergency service, to cover an evening in which an older family member becomes quite ill or dis-

turbed or agitated. So there are some modalities of intervention that help the family. These are pro-family policies, that I think we could learn a lot from and might wish to adopt here.

That is one of the reasons for our center, to try to learn as much as we can, to assist our country as well as be useful to other countries.

Senator GLENN. When you were at NIH, Dr. Healy, did you have contact with these other countries? Did you have an international outreach program where you kept up with what they were doing and shared information back and forth?

Dr. HEALY. The NIH has the Fogerty Center, which is its international center, and as Dr. Butler alluded to, NIH has become a mecca of biomedical research throughout the world. Through the Fogerty Center, we have a number of exchange programs as well as important work looking at not just medical basic research in other countries but also different populations. We learn a lot from studying different populations, and I think there is a two-way flow of information in international relationships. It is not just us providing the basic science, but there is really a two-way exchange. In aging, this is critically important to do. Every country seems to have a different aging history.

If you look at what is going on in Russia today, you have, if anything, a decline in longevity, and indeed a worrisome—I think 60, is that what it is? Early 60's?

Dr. BUTLER. It is really quite shocking, not only in Russia, and the devolution of the various Soviet states but in Hungary, Slovakia, etc. there have been drops in life expectancy. I think the important message for us is not to sit on our laurels and think that because we have achieved longevity we can count on it forever. We have to be mindful of infectious diseases which emerge around the world, of other possible threats against this enormous 20th century achievement.

Senator GLENN. You commented earlier about mind over matter and the example of Madame Calment. There is an interest these days in the holistic mind-body relationship and writings in that particular area, and I think you commented on those things.

Are we moving in that area? What are we doing in our med schools in those particular areas? We see all sorts of things, Deepak Chopra and some of the teachings and so on, which I find fascinating. I do think there is a relationship there that maybe we haven't explored enough yet. We have tended to think that if you gave a pill of so many milligrams, that took care of it, it was all physical, and that was it. Yet there is increasing evidence that shows that the relationship of the mind and the body and attitude and so on is perhaps a bigger part of this whole problem than just the pills we take sometimes.

Can you comment on that? Are we looking into that particular area? If so, what are we doing? What do you think about it? What should we be doing?

Dr. BUTLER. Well, I think for many years psychiatry was kind of a stepchild of American medicine. With the advances of neuroscience, which have been considerable, understanding what happens in the brain, it has really opened the door to looking much more effectively at the interplay between the mind and body. Be-

reavement, for example, and the impact that it can have upon the immune system, which I know is work that is very important here at Ohio State. Immune phenomenon and their relationship to stress is just one simple example.

I think a lot is happening on the biomedical front. Moreover, NIH has developed the Center of Alternative Medicine to begin to look at some of those issues because, after all, thousands of years of history have created botanicals which have contributed to medicine. In fact, even today I think something like a fourth of all the present medicines we use derive from botanicals, including aspirin, which came from the willow bark.

So I think there is more attention and sensitivity now to both the mental health aspect and to other forms of interventions away from classical Western medicine.

Dr. HEALY. I think that the mind-body connection is something that is critically important. It is an area of research that has been difficult because we haven't had the ways to measure the brain, to look at the brain while it is functioning, for example, what happens to the signals in the brain when people are sad, when people are happy, when people laugh, and when people are depressed. We have that technology actually here at Ohio State. We have the strongest functional MRI unit that was just developed here by Dr. Pierre Robetais in the Department of Radiology, and that has really opened up enormous avenues for research when we can look at anything from learning disabilities in children, watching how their brains function as they are reading or as they are learning, to some of the learning and cognitive issues of people as they get older. Also that enables us to do interventions and see what particular intervention a pill or drug, a prayer, spirituality, a good laugh, what that does to how their brains are functioning.

So I think we are moving into an extraordinary time and being able to put the mind and the brain and the body all together, and it is not at all surprising to me that there is growing interest on things like spirituality and medicine and mind-body connections. Of course, alternative medicine that you mentioned is something that really needs a great deal of investigation. The public, all of us, like to see medication, whether as a vitamin pill or whether it is melatonin—which, I know, you are going to be taking in space, Senator, and it is important that we be able to provide the public with good information about how much to take, whether it is toxic or not. For a lot of these natural products, natural hormones, natural nutrients, we need to get that information. So here, again, research is driving it, but I think alternative medicine, complementary medicine, is going to be here to stay.

Senator GLENN. Would you both comment about the immune system? The immune system does change and yet it is at the heart of how we respond to whatever stimuli may affect us, whether it is cancer-causing or whooping cough or whatever it may be, our bodies' immune system responds. You are doing a lot of research in that area here, and you have had a lot of experience. Would you comment on that? That is so key and fundamental toward cutting back on some of the frailties of old age.

Dr. BUTLER. One of the classic theories of aging by a Nobelist, McFarland Burnet, related to the decline in the immune system.

We do have to bear in mind, though, that the causes of decline may have some biological importance, because also as we grow older, there is a greater development of what are called autoimmune diseases, where people surprisingly can become immune to their own cells, their own tissues. So we have to be very thoughtful about how we conduct these investigations.

There is also the extraordinarily increasing importance of the relationship between the brain, the endocrine system, and the immune system. So that we even talk about neuro-endocrine immunology. That speaks to the need within medical school frameworks to break down the departmental barriers from one discipline to another and to find ways to integrate them, again, in connection with that mind-body issue which you raised. So certainly the immune system is going to be increasingly important.

The infections that people can get in hospitals, for example, because of the decline in the immune system or that one might get in space because of the conditions in which a number of people are together in the same small space becomes increasingly important. Probably no system is more of a protection in the space of the world around us than the immune system.

Dr. HEALY. Well, of course, I have to brag a little bit about Ohio State. We have a pioneering program in psycho-neuro-immunology. I mentioned Dr. Jan Kiecolt Glaser and Dr. Ron Glaser, who have been real pioneers in doing some of the classic studies, for example, caregiver, how their immune system becomes depressed and how that can be because of stress, how that in turn can lead to depression and can lead to physical illnesses as well. This is something all of us in medicine have to become much more attuned to, and I think it is an incredibly important issue for happy longevity.

Senator GLENN. There are so many areas we would like to talk about more this morning. I know we have to move on very shortly. We are a little behind time already. But this alternative medicine that has been now put in as one of the study areas at NIH, did you put that in?

Dr. HEALY. It came during my time.

Senator GLENN. Good for you. I didn't realize that. It is such a big area, and it encompasses so much, some of these mind-body relationships. It gets into things like acupuncture. There have been jokes about acupuncture through the years, but I am absolutely fully convinced that acupuncture as anesthesiology is for real, and I have never understood why we didn't make better use of that.

I have been many times in China from when I was stationed back there just outside Beijing in 1946 right at the end of World War II and have been back many times since I have been in the Senate, following different areas of their development over there.

We watched operations in China where there was no anesthesia used except for acupuncture. We watched a tonsillectomy, for instance, with the person sitting up, fully conscious, had some needles sticking out, and the tonsillectomy went ahead with no pain.

Some of our group, including a doctor—I had a conflict and didn't actually see this operation,—went in and watched a woman walk into the operating room, lay down on the gurney. Her problem was she had a tumor back here that was impinging on an eye nerve, and to get this out, they actually went in and operated, took the

front part of her skull up like this, went down and cut this thing out, and she was conscious during the whole operation.

Now, I can't say that she got up and walked out. She didn't. They rolled her out on the gurney. But she knew what was going on. When Mike Mansfield and the other people who were watching up in the dome in this operating room—she waved to them like this while walking out. This is after an operation with only acupuncture.

Now, I am a little bit less encouraged by some of their treatment of disease with acupuncture, because they are in a hospital—this is back when they were still training what they called the barefoot doctors out there, the paramedics, in effect, that were going to be in every commune. Where they were training them, one of the places we went to was in Nanking. We went into a ward, and they had about 20 people lined up in a number of beds, and they were all stomach down, backs up, and needles in them, and they were giving them treatment twice a day with needles in certain areas for Bell's palsy. Bell's palsy, I think most people know, is where you—I don't know what causes it, but, anyway, half your face goes sort of numb for a while, it droops and so on, and you don't have control over that side of your face.

To the Chinese doctor there, I said, how long do you have to give this treatment? They were giving these needles twice a day to the people. He said usually about 21 days. Our doctor, the American doctor who was with us, sort of winked at me across the table. And when we got outside, I said, what was the big wink about? He said that in the United States our best treatment for Bell's palsy is don't do anything, it goes away in 21 days. [Laughter.]

Maybe we have progressed beyond that point now. But that was where we were at that time. So I am of two minds. I think with anesthesiology some of these alternative medicines really do work, and we have been perhaps laggards in this country in not taking up some of these areas where it does work. I think there are things like this we can learn a lot from around the world.

We referred several times here to the space effort I will be involved in. Let me say this: The reason we are doing this is because there are changes that occur in the astronauts up there over a short period of time, beginning about 3 to 5 days into a flight, where the immune system changes. They become less responsive to immune system responses they normally expect to have right here on Earth, orthostatic tolerance, the ability of the body to keep blood in the upper part of the body properly, sleep changes, muscle deterioration not just from lack of exercise but apparently from something that causes muscle deterioration just in that micro-gravity environment. Balance systems obviously change and so on.

There are about 10 or 12 things that occur that are very similar to what occur as a natural part of the aging process on Earth. Just by my age—or some of you in your mid-seventies here in the room, your immune system is probably less responsive than it was when you were 20, or 30, or 40, or even 50. National Institute on Aging (NIA) has looked into a number of these changes, and say they seem to come beginning in the mid-sixties. They are full blown by your mid-seventies, and get worse as you get older then, which is one of the reasons I was picked for this flight. I am at the right

age bracket that they want to look into on this as far as immune system response and all the other things.

Now, we can't do all these on one flight, and I will be involved in muscle system research using histidine and alanine. I will be given injections of that. I will be giving blood and urine samples over a period time, and we will do these tests before flight, during flight, and after flight to see how they compare and to see how I compare then with the younger people, some of whom will be doing these same things on the neurolab flight that is up there right now.

The flight now is dedicated solely to the body's nervous system and using animal studies also to learn all we can about that, and that is the flight that is up there going around right now even as we are here.

So we will be looking into all of these areas. I will be looking into the muscle deterioration and also sleep was mentioned here earlier. That is a problem, a major problem, for about one-third of our people over the age of 65, by best estimates here. So we will be looking into some of those things.

We have already had some of the rig on. I will have some 15 or 16 different leads measuring EEG brain waves, sleep pattern, rapid eye movement, muscle movements under here, as well as EKG, and doing all these measurements at the same time. Four nights out of the 9-day mission that we will be on, I will be wearing a Halter monitor, which is your heart, your EKG monitor that you keep on with a little recorder and just carry it around on your belt. I will be doing that for a 24-hour time period also to see through my own sleep cycle what the reaction will be.

So we are taking a first step at looking at some of these things where there are very definite, clear-cut parallels between what happens to the younger astronauts up there now and what they recover from when they come back to Earth, and how that compares with changes that occur as a natural part of the aging process here on Earth that we don't recover from, at least not yet, not until we learn more about them. What you are looking for, of course, or hoping for is to find out within the body and by using these cross studies of different age groups, find what turns a body on and off with regard to immunology and muscle deterioration and sleep pattern changes and orthostatic tolerance and balance and all of these things.

So that is really the purpose of my flight, and while I am obviously excited about being able to go up again on a personal basis, I am also equally or even more excited that we may be triggering off a new area of research that I think NASA will carry on in the future. People said, some of the critics said, well, I am only a data point of one. Well, absolutely, I am only a data point of one. But if I thought it was going to end there and there never would be any more data points, well, it still might be worth doing and I would still like to go, but it would be questionable.

But I think they will continue studies in these areas, and 5 or 6 years from now we will probably have data points of 10 or 12 or 13 and then it will be meaningful. We will have a database from which we can start to draw some conclusions, and you have to start somewhere. So if I am a data point of one, which they have criti-

cized, so be it. It is a data point of one. You have to start somewhere, and I am glad I am going to be the one to do it.

Another thing they have noted in space is something that happens with the elderly, too. Bodies' absorption rates of drugs are not the same. One of your problems with getting old is they give you a pill and it doesn't work. Why? Well, your body's absorption rates are different, and they have found the same thing in space, the body's absorption rates are different. How do we compensate for that?

One other part of this sleep study I mentioned is the body's core temperature. I will be swallowing a pill and it is quite a horse pill, I will tell you. You swallow it, and it is a little thermometer that transmits as it goes through your body. You wear a little recorder that will record the body's core temperature and correlate that with when sleep occurs and so, rapid eye movement and all. They can learn something about that.

So we are going to be instrumented, and I said the other day, when I had all the rig on down there at Houston it looks like something I saw in a high school biology class under a microscope. So we will be looking at some of those things now and be looking at some of those things on this flight, and I think we will be following on with other studies later on, which I certainly hope NASA decides to do, and I think they will. That is the reason we are so committed to getting good information on this flight. It will encourage them to go ahead and do further studies in this area, which I think can have such huge benefit for our people here, the aging population here in this country, and maybe an overlap around the world.

We appreciate your comments very much. We are roughly a half hour behind. Can we make it a short break? We will start back up again in a few minutes.

Thank you. [Applause.]

[Recess.]

Senator GLENN. We will call the hearing back to order, and the court reporter will be back shortly.

Our second topic is Home and Community-Based Care, and our panel consists of: Bonnie S. Kantor, Director of the Office of Geriatrics and Gerontology, the Ohio State University College of Medicine and Public Health; Connie M. Schmitt, Director, TriHealth SeniorLink; Martin Janis, a senior consultant; Matt Ottiger, Legislative Liaison, Ohio Department of Aging; and Cindy Farson, Director, Central Ohio Area Agency on Aging.

We will begin with Bonnie Kantor.

STATEMENT OF BONNIE S. KANTOR, SC.D., DIRECTOR, OFFICE OF GERIATRICS AND GERONTOLOGY, THE OHIO STATE UNIVERSITY COLLEGE OF MEDICINE AND PUBLIC HEALTH

Dr. KANTOR. Senator Glenn, thank you for convening this special hearing to examine research in aging, geriatric training, and home and community-based long-term care. It is an honor being here to discuss the vigorous leadership role that the State of Ohio and, specifically, the Ohio State University College of Medicine and Public Health have taken in training medical students in geriatrics and

gerontology so that Ohio's older citizens receive responsive and cost-effective care and caring.

Medical and health professions education face new challenges resulting from our country's changing demographics toward a growing older adult population. Currently, older adults constitute approximately 12 percent of our population and yet use more than a third of our health care resources. By the year 2030, 20 percent of our population will be over age 65 and will utilize close to half of our health care dollars. Older adults over age 85 have significant and distinct health care needs, utilize the greatest number of health services, and are also the fastest growing subgroup of the older population, having increased 200 percent since 1960. In light of these data, academic medical institutions such as the Ohio State University must take the responsibility of assuring that graduating students possess the skills, attitudes, and knowledge to provide services that respond to older adults' unique needs in settings that reflect their preferences.

Traditionally, our health care system has focused on acute care, with an emphasis on cure and specialization. The aging population, however, is causing a shift in the practical service arena toward an integrated continuum of care which emphasizes functional ability and addresses the long-term effects of chronic conditions. To prepare students for tomorrow's health care needs, medical and health professions education must shift their emphasis from acute to chronic care settings such as the home, and from practitioner-oriented to patient-centered care.

Thanks to advances in medical knowledge and technology, people are living longer than ever before, although not necessarily better. The prevalence of chronic health problems such as heart conditions, arthritis, and sensory impairments, while on the rise, is resulting in fewer deaths. Instead, these problems may result in loss of functional ability and require chronic as well as acute care services. This means that as the baby boomers age, the health care needs of the foreseeable future will shift even further away from acute care and toward the management of chronic diseases and disabilities, not just in ambulatory clinics, but in home and community-based settings as well.

Medical education programs also have to help students learn about the chronic care needs of their patients to allow patients to live in the least restrictive environment possible with the most cost-effective care possible. Students also, need to work collaboratively with all sorts of professionals in a broad range of patient-based settings. This model of medical education requires the expansion of the traditional definition of "medical faculty" to include non-academic professionals skilled in providing chronic care services throughout the community. It also requires a broader definition of teaching sites, as Senator Glenn indicated, to include non-traditional environments such as the patients' homes.

Today what I would like to do is begin with a discussion of the State of Ohio's long-standing commitment to this model of geriatric education and then focus on two outgrowths of this commitment at Ohio State that promote patient-centered care across the continuum and focus on the home as a key locus of both care and caring.

As early as 1978, the Ohio General Assembly began looking at the changing demographics in Ohio and the need for physicians to be able to respond to our aging population. The legislature even then understood that older Ohioans would have distinct and increasing needs for specialized health and supportive services, and that Ohio's physicians would have to be prepared to meet this challenge. Thus, the assembly created the seven Offices of Geriatric Medicine in the State-supported medical schools to put the State of Ohio in the forefront of geriatric education. It mandated that all students in Ohio medical schools participate in comprehensive, high-quality education in geriatrics and gerontology.

In response to this mandate, the evolving needs of Ohio's older adults, and the State of Ohio's emphasis on community-based care, the College of Medicine here at Ohio State has revised its clinical geriatrics curriculum to emphasize patient-centered care, non-traditional delivery sites such as the home, chronic care, functional ability, and interdisciplinary and transdisciplinary care. In addition, Dean Healy has developed new paradigm for clinical education for the College of Medicine's entire M.D. curriculum, which reflects the shift from acute care to continuity of care over time. The resulting major revisions in our medical curriculum, along with the State of Ohio's long-standing commitment to geriatric medicine, have resulted in two very interesting curricular initiatives that address long-term care for chronically ill older adults in their homes, and I would like to describe these two programs for you today.

The first of these initiatives is the DOC-3, the Differentiation of Care Chronic Care rotation. To the best of our knowledge, Ohio State University is the only medical school in the country with a required 4-week rotation in chronic care medicine. This rotation allows medical students to experience true patient-centered care and the importance of chronic care in helping patients function as independently as possible. As one student reflected in her journal, "Geriatrics . . . Chronic Care . . . I'm a little apprehensive about this month. I'm not sure why since all of my past interactions with geriatric patients have been quite positive. Perhaps I am uncomfortable with the concept of focusing on function and helping one live with the disease, as opposed to focusing on curing it."

By combining the perspectives of academic and community health and social service practitioners, the DOC-3 experience ensures that physicians graduating from OSU are prepared to meet the needs of the increasing numbers of individuals with chronic health problems.

Regardless of the elective the student takes, they are challenged to generalize their experiences to other chronic care populations. As one student who completed a rotation on gynecological cancers reflected, "I would like to start this journal to state how fortunate I was to learn better the issues of chronic care medicine. They certainly are individualized and depend on a person's social support, personal coping mechanisms and financial health, life goals, and relationship with a physician and other caregivers. This rotation was very educational for me, not by memorizing the various gynecological cancers, but by learning social, emotional, and financial issues from my patients."

As each of these journal entries attest, the experience at OSU provides a case study for chronic care in general as students focus on maintenance of function and maximization of quality of life; learn about community and ancillary services that are available to improve patients' quality of life; experience a true interdisciplinary approach; and participate in the management of patients in the home.

As a student who completed a rotation in geriatrics indicated, "In summary, this rotation was an excellent experience. I came into it thinking I would learn about managing hypertension, diabetes, arthritis, and other chronic problems. What I took away from the rotation was an understanding of a functional approach to patients. I learned that the focus of medicine is more appropriately focused on maintenance of independence and prevention of disability rather than on treatment of disease itself. By treating the treatable and minimizing the impact of the untreatable, geriatric medicine is a very rewarding field."

Both the chronic care training program at Ohio State and the geriatrics initiatives focus on caring for patients "where they find themselves" rather than on where physicians traditionally round. As a result, care for patients in the home has become a focus of our educational endeavors. This is especially timely since there is inadequate involvement of physicians in the provision of home care. This lack of physician involvement takes on added significance when one considers the enormous growth in the home health industry over the past 15 to 20 years and the concomitant national, State, and local concerns over fraud and abuse of the system.

At Ohio State, we believe that increased physician involvement in the delivery of home care will enhance the work of the home care team, provide additional and important services to the patient, and furnish an additional oversight function. One important method, of course, to ensure more complete and appropriate physician involvement in home care is to require education and training in that area.

There are several very important reasons why academic medical institutions must assume responsibility for providing home care experiences for medical students. First, home care is the fastest growing component of our health care system. Second, home care is going to become increasingly important for physicians' duties since home care services are increasing not only in quantity but in complexity as a result of the aging of the population, the increasing burden of chronic illness, patient preference, and, of course, economic factors. Third, with the rapid expansion of technology, physicians are going to be able to complete procedures in the home that could not have been attempted in the past. However, physicians receive very little or, as Dr. Butler said, in many cases no training in medical management in the home, the availability of services, or even the benefit of these services to patients.

Physicians have many different roles to play in the provision of home health care, ranging from referring patients to actually providing house calls or home services themselves. Yet, as late as 1994, it was reported that almost half of all medical schools provided no training in home care over the 4-year curriculum, and

only 3 of 123 medical schools required their students to make 5 or more home visits.

To facilitate the expansion of home care into academic medicine in medical schools, the John A. Hartford Foundation developed an initiative, The Expansion of Home Care into Academic Medicine to encourage all medical schools to view the home as a very appropriate and essential site for clinical teaching. Ohio State is one of ten medical schools across the country that is participating in this initiative. Our initiative here is funded locally by the Columbus Medical Association Foundation. Through this initiative, all fourth-year medical students are required to participate in home care visits and in a home care curriculum.

Through this home care rotation, students at Ohio State will learn a number of things. First, they will appreciate the importance of home care, and they will understand the needs of homebound patients. In our community we have many patients that just can't get out to visit their physician. They will also acquire skills required to assess an older patient in the home and the skills required to understand more about a patient's functional capability.

We want them to appreciate the interdisciplinary nature of home care and the fact that the team is the most important provider of services. Through their experiences in the home, they learn first hand about multiple agencies that are out there working together.

They also develop the skills necessary to assess the physical environment for safety. They learn more about what caregivers can and can't do and what individual caregivers need to care for their loved ones at home as long as possible.

Finally, students in our program focus on trying to understand patient preferences for end-of-life issues. We teach them to manage the terminally ill in the home, paying specific special attention to pain control.

The faculty at Ohio State believe that students trained in home care will be more likely to integrate the delivery of home-based services into their practices and will view the care of patients in their homes as a core component of high-quality geriatric care. We think we will be more able to do this especially now that reimbursement rates for home care have been modified.

In summary, caring for the growing number of older patients with chronic illnesses and caring for patients in their homes are becoming increasingly important components of both the delivery of effective health care and the training of our young physicians. Academic medical centers such as our own have a vital role to play in training physicians to meet the needs of tomorrow's health care consumers in settings that are preferred by these consumers. The shift in medical education at the Ohio State University College of Medicine and Public Health from acute care to chronic care settings and from practitioner-oriented to patient-centered care is a very important step in the right direction. [Applause.]

[The prepared statement of Dr. Kantor follows:]

Testimony of Bonnie S. Kantor, Sc.D.

Director, Office of Geriatrics and Gerontology

The Ohio State University College of Medicine and Public Health

before the United States Senate Special Committee on Aging

April 27, 1998

*Ok. He'd
upfront me
after a break.*

INTRODUCTION

Senator Glenn, thank you for convening this special hearing to examine research in aging, geriatric training, and home and community-based long-term care. It is an honor being here to discuss the vigorous leadership role that the state of Ohio and, specifically, The Ohio State University College of Medicine and Public Health have taken in training medical students in geriatrics and gerontology so that Ohio's older citizens receive responsive and cost-effective care and caring.

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Traditionally, our health care system has focused on acute care, with an emphasis on cure and specialization. The aging population, however, is causing a shift in the practical service arena toward an integrated continuum of care which emphasizes functional ability and addresses the long-term affects of chronic conditions. To prepare students for tomorrow's health care needs, medical and health professions' education must shift their emphasis from acute to chronic care settings such as the home, and from practitioner-oriented to patient-centered care.

Thanks to advances in medical knowledge and technology, people are living longer than ever before, although not necessarily better. The prevalence of chronic health problems such as heart conditions, arthritis, and sensory impairments, while on the rise, is resulting in fewer deaths. Instead, these problems may result in loss of functional ability and require chronic as well as acute care services. This means that as the baby-boomers age, the health care needs of the foreseeable future will shift even further away from acute care and toward the management of chronic diseases and disabilities, not just in ambulatory clinics, but in home and community-based settings as well.

With disease states and acute illnesses of major concern in acute care settings, the need for patients to be able to manage their activities of daily living (ADL) often goes unmet and, when addressed, poses a challenge to physicians. Knowing how to help patients live in the least restrictive environment with the most cost-effective care will be an increasingly important skill for health professionals, especially since the number of older Americans with activity limitations is projected to double in the next 30 years. Fortunately, educators and providers alike are beginning to realize that having the right technical skills is not the only factor in providing good care. Knowing how to secure a whole continuum of services, especially beyond the hospital or clinic walls, is also important in providing responsive, appropriate care to patients with chronic problems. The Ohio State University has taken a pro-active approach to these issues in medical education by developing a physician training model that can meet the functional as well as acute care needs of tomorrow's consumers. The key educational precept underlying this model is *functional status*, the ability of persons to function independently on a daily basis.

The aim of chronic or long-term care is to restore a person to the highest level of functioning, given his or her illness or disability. Meeting this goal typically involves services from professionals in different healthcare fields as well as a process of communication which conveys the individual's needs and potential for recovery. Services must be organized and delivered in such a way that they improve the patient's quality of life. Historically, the healthcare and social/support systems have not developed effective and strong avenues of communication between themselves. Providers in one arena often have difficulty moving their clients into and out of other arenas. Consequently, a gap has developed between the two systems of care, frequently at the expense of optimal care for patients. These problems are beginning to be addressed as acute and primary care facilities attempt to integrate their services with community-based and home health care. The process, however, needs to accelerate and to reach into each arena's respective educational programs. The need for physicians practicing in chronic care and home settings currently outstrips the supply.

To summarize these issues, medical education programs--especially in large academic settings such as The Ohio State University-- need to help students learn more about the chronic care needs of patients. Students need to work collaboratively with professionals in a broad range of client-based settings and have access to training experience with patients who are receiving chronic care and their families. This model of medical education requires expanding the traditional definition of "medical faculty" to include nonacademic professionals skilled in providing chronic care services throughout the community, and of key teaching sites to include nontraditional environments such as the patients' homes.

Today I will discuss the State of Ohio's long-standing and pro-active commitment to educating physicians to care for older adults in the most responsive and cost-effective manner possible. I then will focus on two outgrowths of this commitment, programs at The Ohio State University College of Medicine and Public Health that promote patient-centered care across the continuum and focus on home care as a key locus of care and caring. The Ohio State University College of Medicine and Public Health is the only medical school in the country that requires all fourth year students to complete a month-long rotation in chronic care medicine. Through this clerkship, medical students experience the breadth, scope, and importance of chronic care medicine in helping patients function as independently as possible. Additionally, all medical students at The Ohio State University now

participate in a home care curriculum whose goals are to: (1) help change students' attitudes and practice approaches to the provision of home care; (2) increase students' awareness of the needs of homebound older patients; and (3) teach students appropriate medical management in the home. This program is supported in part by The Hartford Foundation initiative whose purpose is to encourage medical schools to view the home as an appropriate and essential site for clinical teaching.

BACKGROUND: GERIATRICS EDUCATION IN OHIO

In 1978, the Ohio General Assembly began looking at changing demographics in Ohio and the role physicians could play in ensuring cost-effective, responsive health care for a growing older adult population. The Legislature understood that older Ohioans would have distinct and increasing needs for specialized health and supportive services, and that Ohio's physicians would have to be prepared to meet this challenge. Thus, the Assembly created the seven Offices of Geriatric Medicine and Gerontology in the state-supported medical schools (The state mandate is set forth in Ohio Revised Code Section 3333.111). The mandate states that each Office will: "*Incorporate subject matter relating to geriatric medicine into existing (medical school) courses, . . . and establish courses in geriatric medicine wherever appropriate . . . (and) provide clinical and research experience in geriatrics.*" This legislative act put the state of Ohio in the forefront of geriatric education by establishing geriatric programs in all seven state-supported medical schools. The seven state-supported Offices of Geriatric Medicine and Gerontology have created a strong collaborative network through the Consortium of Ohio Geriatric Academic Programs (COGAP), and have maximized valuable resources and developed innovative programs that keep Ohio in the forefront of geriatric education and research.

Building on this strong, supportive foundation and its many unique accomplishments over the past 20 years, The Ohio State University's Office of Geriatrics and Gerontology is poised to meet the challenges of an aging population, of healthcare reform, and of scarce economic resources. The Office fosters the cost-effective delivery of high-quality health services to improve the health of Ohio's older citizens--through teaching, research, service, and consultation. Continued funding from the Ohio Legislature and the oversight of the Ohio Board of Regents has enabled the Office of Geriatrics and Gerontology at The Ohio State University to develop and strengthen a comprehensive geriatric and gerontologic medical education effort. As a result, faculty at The Ohio State University developed and applied a solid foundation in geriatric education, training, service, and research within the College of Medicine and Public Health, with all medical students receiving preclinical and clinical exposure to the health and medical needs of older adults. The Office of Geriatrics and Gerontology also works closely with all other departments, schools, and colleges at the University in education, service and research programs and provides education and training opportunities throughout central Ohio for providers, families, and clients.

Many individuals and groups benefit from the programs and activities of The Ohio State University Office of Geriatrics and Gerontology. In the most direct fashion, medical students and residents receive the Office's services through dedicated course work and broad-based clinical experience in geriatrics. Through Continuing Medical Education programs, practicing physicians enhance their

skills in this area. And, through community-based educational offerings, community providers and family members learn more about the needs of our aging population.

The ultimate beneficiaries of the Office's services, however, are older adults throughout the state of Ohio who receive the support they need to remain independent longer without unnecessary utilization and further treatment.

MEDICAL STUDENT EDUCATION IN GERIATRICS AND GERONTOLOGY

A key goal of the Ohio Board of Regents is to *"assure that the students in Ohio medical schools participate in comprehensive, high quality educational experiences designed to develop attitudes, knowledge and skills critical to supporting the health needs of older adults."* In 1994, in response to this goal, the Office of Geriatrics and Gerontology at The Ohio State University developed a strategic plan for the College of Medicine to revise the clinical geriatric curriculum by emphasizing: (1) patient-centered care; (2) nontraditional delivery sites, including the home; (3) functional need/ability which moved medical training beyond the disease state; (4) chronic care; and (5) interdisciplinary and transdisciplinary care. These revisions to medical education reflected the evolving needs of Ohio's older adults, the intent of the Pew Health Professions Commissions, *Healthy People 2000*, and the state of Ohio's emphasis on community-based care. In 1996, Dr. Bernadine Healy, Dean of the College of Medicine and Public Health, charged a committee to develop a new paradigm in clinical education for the College of Medicine's entire M.D. program. Specifically, the committee was asked to *"redefine the clinical education experiences of Med I through Med IV with a goal of preparing physicians who will be practicing in the year 2006 and beyond."*

The shift in emphasis from acute care to continuity of care of patients over time was one of the key factors considered as this new curriculum was developed. The resulting major revisions in the medical curriculum, along with the longstanding commitment of the state of Ohio to geriatric medicine, have resulted in two major curricular initiatives that address long-term care for chronically ill older adults in their homes. The first of these initiatives is the DOC-3 (Differentiation of Care) chronic care rotation.

DOC-3 ROTATION: The Patient With Chronic Care Needs

The Ohio State University College of Medicine and Public Health is the only medical school in the country with a required rotation in chronic care medicine, the DOC-3 Chronic Care Rotation. This experience provides all fourth-year medical students with either a four-week or an extended individual study rotation working with chronically ill patients. Developed in response to identified medical student training needs, the curriculum provides: (1) more varied ambulatory care experiences in the community; (2) experience with community-based medical interventions for older adults and chronically ill patients; and (3) increased opportunities to understand the significance of delivering health care services within patients' communities and homes. The DOC-3 initiative reflects movement away from acute care, with its emphasis on cure and specialization, toward a

continuum of care that emphasizes functional ability and long-term social and individual affects of chronic conditions most often seen in older adults. This rotation allows medical students to experience patient-centered care and the breadth, scope, and importance of chronic care medicine in helping patients function as independently as possible. As one student reflected in her journal:

Geriatrics . . . Chronic Care . . . I'm a little apprehensive about this month. I'm not sure why since all of my past interactions with geriatric patients have been quite positive. Perhaps I am uncomfortable with the concept of focusing on function and helping one live with the disease, as opposed to focusing on curing it.

By combining the skills, knowledge, and perspective of both academic and community health and social service practitioners, the DOC-3 experience ensures that physicians graduating from The Ohio State University are prepared to meet the needs of the increasing number of older patients with chronic health problems. Twenty-nine distinct "selectives"—including patients of all ages and care options across the continuum—allow medical students to develop a deeper understanding of the chronic care needs of the patients and both the informal and formal services and resources available to meet them. According to another student:

I am not sure I am any closer to addressing my questions about the human reaction to chronic disease. It certainly is individualized and depends on a person's social supports, personal coping mechanisms, financial help, life's goals, and relationship with a physician and other care givers. I have seen how various medical personnel can make a difference in the life of the patient with chronic care needs.

Regardless of the specific selective, i.e., rotation, disease state, or population served, all medical students are challenged to generalize their experiences to other chronic care populations. As a student who completed a rotation focusing on the care of patients with gynecological concerns reflected:

I would like to start this journal to state how fortunate I was to get to learn better the issues of the chronic care patient. The first DOC-3 lesson, taught to me by my patients, is that I will wake up each day and thank God for what I have been blessed with and try to think not of what isn't going great with me, but rather what I can do to improve someone else's day or life. . . . This rotation will be very educational for me, not by memorizing the staging of the various gynecological cancers, but by learning social, emotional, and financial issues from my patients.

As each of these journal entries attest, the DOC-3 experience at The Ohio State University thus becomes a case study of chronic care in general as students:

- ▶ participate in the care of chronic care patients, focusing on maintenance of function and the maximization of quality of life over time.
- ▶ learn more about community and ancillary resources which are available to improve the quality of life with patients with chronic care needs.
- ▶ gain exposure to the interrelationships between the patient with chronic disability and

- his/her family and socioeconomic environment.
- ▶ experience an interdisciplinary approach to caring for the patient with chronic disability, one that includes physicians and other health care providers.
- ▶ participate in medical management of patients in the home; learn about resources available for interdisciplinary management of patients in the home through medical, environmental, and caregiver assessments and interventions.

One student who cared for stroke patients during his chronic care rotation in Physical Medicine and Rehabilitation summed up well how the DOC-3 experience changed his perspective on the practice of medicine:

I started this rotation thinking about going into PM&R but worried about dealing with chronic patients where the rewards are often delayed and often subtle. I now think it would be very rewarding to help people through their dramatic, life-altering experiences and help return them to function as best they can as independently as they can. I really now enjoy the team approach. I didn't think I would. But the PT, OT, Social Workers, Psychologists, etc. all have good knowledge and experience and all can contribute and often can contribute in a more meaningful way to the patient than the physician. I am very frustrated by all the obstacles and hoops you must jump through in order to provide adequate care. (In terms of insurance/welfare and various services) But at the same time, I'm impressed with all that is available if you know how to plug into the system. I would be lost without a social worker. I know that it seems obvious, but something that I have really gained from this rotation is to appreciate that these chronic conditions are life long. Things just don't get better someday and certainly the patient does not suddenly get better upon discharge. This is why we must give them as much independence as possible. More than any specific medical knowledge, this rotation has enlightened me to considering all of the issues that confront a patient. . . i.e. to deal with the total patient.

Within one short month students gain substantial insight into the importance of functionality and the need to focus on helping their patients maintain as much independence as possible. A student completing her chronic care rotation in geriatrics provides a concise and astute summation of the chronic care rotation at The Ohio State University:

In summary, the geriatric rotation was an excellent experience. I came into it thinking I would learn about managing hypertension, diabetes, arthritis, and other common chronic problems. What I took away from the rotation was an understanding of a functional approach to patients. I learned that the focus of medicine is often more appropriately focused on maintenance of independence and prevention of additional disability rather than on treatment of disease itself. Geriatric medicine, prior to my experience, seemed to me largely an exercise of futility. Now I know that this is not the case. By treating the treatable and minimizing the impact of the untreatable through medical and social intervention, geriatric medicine is a very rewarding field.

Home Care Education and Training

Both the chronic care training program (DOC-3) and the geriatrics initiatives at Ohio State focus on caring for patients "where they find themselves" rather than where physicians traditionally round. As a result, care for patients in the home has become a focus of our educational endeavors. This is an especially timely effort since there is currently inadequate involvement of physicians in the provision of home health care. This lack of physician involvement assumes added significance when one considers the enormous growth in the home health industry over the past 15 to 20 years and the concomitant national, state, and local concerns over fraud and abuse of this system. At The Ohio State University, the belief is that increased physician involvement in the delivery of home care will enhance the work of the home care team, provide additional important services to the patient, and furnish an additional and necessary oversight function. One important method to ensure more complete and appropriate physician involvement in home care is to require education and training in that area.

There are several reasons why medical schools should assume responsibility for providing home care experiences for medical students. First, home care is the fastest growing component of the health care system today, yet the number of physician visits to home care patients has steadily declined. Second, home care will become a central part of physicians' duties since home care services are increasing both in quantity and complexity as a result of the aging of the population, the increasing burden of chronic disease, patient preference, and economic factors. The range of home health services requiring physician supervision include both acute and subacute care, rehabilitation programs, long-term care and hospice. Third, the rapid expansion of technology has contributed to the ability of physicians to provide medical care and complete procedures in the home. However, physicians who order these services are poorly prepared in these areas and received little if any formal education or training in either medical management in the home, the availability of services, or the benefit of these services to patients.

Physicians have a variety of roles to play in the delivery of home health service, ranging from referring patients to agencies and prescribing services to providing home care, or making "house calls" themselves. Yet, as late as 1994, it was reported that almost half of all medical schools did not devote even a single hour to home care over the four-year curriculum; only three of 123 schools required their students to make five or more home visits.

To facilitate the expansion of home care curricula in medical schools, the John A. Hartford Foundation developed an initiative to encourage all medical schools to view the home as an appropriate and essential site for clinical teaching. The Ohio State University College of Medicine and Public Health is one of ten medical schools nationwide chosen to participate in the Hartford Foundation Program, *Expansion of Home Care Into Academic Medicine*. Knight Steel, M.D., UMDNJ Endowed Professor of Geriatrics at the New Jersey Medical School and Director of the Hackensack University Medical Center directs the initiative. Through this program, which is funded in Columbus by the Columbus Medical Association Foundation, home care has become a required component of the curriculum for all fourth-year medical students at The Ohio State University. The program's goal is to change students' attitudes and practice approaches to the provision of home care. As one student writes:

The most memorable part of this week was the home visit I attended with the home health nurse. Mrs. Y is a morbidly obese woman who approximately two weeks ago had gastric bypass surgery. I was impressed by the great value of the service provided by the home health care nurse. The money and time spent if she would have been admitted to the hospital not to mention the hassle for the patient far outweighed the time and money spent on the home health nurse and the patient was able to avoid the hassle of hospital admission as she stayed in the comfort of her own home. Although on my various rotations I discharged patients with home health care services, this week I saw firsthand a home health visit and came to appreciate the good service this program provides both patients and physicians.

The program also increases students' awareness of the needs of home-bound patients (especially older adults). One student completing a home care rotation in hospice reflected:

Today was my day to experience Hospice.... On the way to the home visit, I rode with the R.N. and we had a great discussion on what exactly Hospice and home care were. We spoke about the care of the whole patient and the family support that is given. We also had an interesting conversation about when exactly a person enters a Hospice program. It was this particular topic that made me think a lot about myself. I am the type who sees myself as a fighter, someone who would be willing to try anything if it promised the hope of improving my health. However, I have never experienced anything like these patients were experiencing, and through our conversation, I began to understand the desire of these patients to "go in peace." The patient was an extremely kind man. He didn't want me to see him as a sick and dying man, but as the man who once was. (There) was a hospital type bed in the middle of the room. As I waited for the R.N. to finish, I thought about the other setting and the impact that this man's illness was having on his significant other and her son. As I was riding home, I thought about what I had just seen. The affects of cancer on this patient reached far beyond on the actual damage it had done to his lungs. It had medical, social, and financial ramifications on impacting people in various ways. It was truly an eye-opening experience.

The overriding goal is to provide a curriculum that includes sufficient training and skill development so graduates will be fully able to integrate home care into their practice. Specifically, as outlined by the Hartford Foundation, the home care curriculum at The Ohio State University has the following objectives for all fourth-year medical students:

- ▶ Appreciation of the importance of care in the home with special attention to both the needs of those receiving care in the "peri-hospital" period and those requiring home care on a more chronic basis.
- ▶ Acquisition of those skills, especially history taking and physical diagnosis, required to assess in the home an older person who may be acutely or subacutely ill and to develop a care plan based on that assessment.
- ▶ Acquisition of those skills (and underlying knowledge base) required to determine

functional capability, the "bottom line" of all care. Nowhere is the importance of functional capability better appreciated than in a person's home.

- ▶ Appreciation of interdisciplinary professional care. The home setting, perhaps more than any other, highlights the importance of physicians collaborating with nurses, other professionals and paraprofessionals so that clinical outcomes can be maximized.
- ▶ Understanding and appreciation of the multiple professional agencies who work together to provide care. In contra-distinction to hospital-based care where all personnel (save the physician) caring for a person are employees of the same organization, the very process of home care entails multiple, often quite distinct, agencies working together in the interest of the patient. For example, visiting nurse services, social agencies providing meals, and case managers arranging for transportation to a radiology appointment must coordinate their services both with respect to care planning and in a very pragmatic manner with respect to the timing of each service.
- ▶ Specific knowledge about the growing array of services available to persons living at home, for example, the use of home oxygen.
- ▶ Acquisition of the skills (and underlying knowledge base) to assess the individual's physical environment. Physicians must have an appreciation of the need to carry out an assessment of the home itself, as well as of how technology (such as advances in the fields of physical and occupational therapy and computer-assisted technologies) can be adapted to home use.
- ▶ Appreciation of the importance of assessing the needs of the caregivers and an ability to do so. At this time when many family caregivers (usually women) are employed outside the home, have few siblings living close by to call upon for assistance, and often have other dependent relatives (usually children), the physician must appreciate what can and cannot be accomplished in the home setting.
- ▶ Appreciation of the need to discuss with the individual under care his or her wishes with respect to hospitalization, resuscitation, etc.
- ▶ Acquisition of the skills and appropriate knowledge to manage the terminally ill at home, especially with respect to pain control.

Because the home care experience at The Ohio State University is an integral part of a required chronic care rotation, students have the opportunity to participate in the entire range of home care--for different age groups and for individuals and families with a wide range of chronic and acute concerns.

In addition to standard evaluation instruments, an evaluation component is being developed that uses patients to provide feedback to both the medical students and the program. Professional older actors will be trained to serve as standardized "patients" and scenarios will be developed for them in association with the Central Ohio Area Agency on Aging. The evaluation will take place in an adapted two-room apartment located within the Medical Center. Through the feedback we receive from this evaluation, the home care experience will be modified to ensure that students are learning the key aspects of delivering care in the home.

Faculty at Ohio State believe that students trained in home care will be more likely to integrate the delivery of home-based services into their practices especially now that reimbursement rates for physician home services have been modified. Training programs, such as the ones participating in the Hartford Foundation initiative, will encourage physicians to view care in the home as a core component of high quality and responsive patient-centered care. A student completing home visits in rheumatology certainly confirms this notion when she writes:

On a home visit this week we visited an elderly female with longtime rheumatoid arthritis, who now lives in a high-rise apartment building. . . . From this patient, I learned what a high level of function can be maintained in the face of devastating disease. From looking at the chart and seeing the patient, I would have predicted a much lower level of function. However, through the support network described above, she is able to maintain a level of function which satisfies her needs and motivates her to keep living her life to the fullest possible extent.

SUMMARY

Care for the growing number of Americans living with chronic diseases and home care are becoming increasingly important components in the delivery of effective health care. Academic medical centers have a vital role to play in training physicians to meet the needs of tomorrows' health care consumers in settings preferred by these patients. The shift in emphasis in medical education at The Ohio State University College of Medicine and Public Health from acute to chronic care settings and from practitioner-oriented to patient-centered care is an important step in the right direction.

Senator GLENN. Just a couple of questions, because our time is short. I might add also that we have asked all of our participants if they could summarize their statements, and their more lengthy full statements will be included in our hearing record when it is printed back in Washington. We also will have additional questions that we just don't have time to get to today that will be submitted to them, and I would ask all of you to respond to those questions so we could have them included in the hearing record also.

Just a couple of questions, though. How many geriatricians do we have in Ohio now? Do you know? And how many did we graduate this year or how many do we train?

Dr. KANTOR. I don't know the answer to the question of how many geriatricians, but our perspective at OSU is a touch different, and it goes back to what Dr. Butler was saying. Our goal at Ohio State is to ensure that all physicians, no matter what specialty they choose prepared to care for older adults. Therefore, we integrate our geriatrics program throughout the 4 years to ensure that all medical students benefit from it. In sum, our focus at Ohio State is not to train specialists in geriatrics. We want to ensure that all graduates provide responsive, cost effective care to older patients. However, there are other fine institutions in Ohio that focus specifically on training geriatricians.

Senator GLENN. You require them to actually go out there, in other words, making house calls. Right?

Dr. KANTOR. We absolutely are, and we didn't know how the students would react, but they love it. They don't just like the medical aspects. They appreciate the fact that we are teaching them what it takes to live independently. One of the things that they write about or talk to us about most is doing the home assessment to keep the home safe. They like the preventive aspects such as making sure the throw rug is moved so that no one is going to break a hip. They are very interested in the nutritional aspects as well. They really enjoy looking at the needs of the caregiver and negotiating with both the caregiver and the patient to understand what it is the patient really will be able to do and making sure that that is what they prescribe.

Senator GLENN. What do you see as a core team for geriatric patients? In other words, you have a physician, they go out; then you have a nurse practitioner maybe, then you maybe have a social worker. Is this a team approach, and do they get together, or is there some sort of disjointedly one person calling, another calling the next day and so on? How does this work?

Dr. KANTOR. As far as our home visits are concerned, it is a very integrated approach. Our students will see patients in the clinic setting or perhaps they've seen them in the hospital, and we want them to follow that patient into the home or whatever setting the patient is in. So they will go out with a variety of providers because we also want them to learn what it is that the social worker does in the home, what the nurse does in the home, etc. We are less concerned about who the individual provider is for a particular visit; instead we make sure they see all the providers. Yes, we want them to see the complete plan for that patient to understand that what is being put together is not something that came out of a cookbook or a textbook. We are responding to what that individual

need is, and everyone has to work together with the patient at the center of it and develop a very unique plan.

Senator GLENN. Good. Thank you very much.

[The prepared statement of Dr. Steel follows:]

Expansion of Home Care into Academic Medicine

**The Evolution of Home Care
The Population Served by Home Care
Home Care Policy and Physician Involvement
Medical Schools and the Teaching of Home Care
The Expansion of Home Care into Academic Medicine Initiative**

*was not
present*

R. Knight Steel, MD

**UMDNJ Endowed Professor of Geriatrics at the New Jersey Medical School
Director, The Homecare Institute, Hackensack University Medical Center**

I. The Evolution of Home care

Less than a century ago almost all medical care was provided in the home by family members, neighbors and clergymen as well as physicians and other health care professionals. The explosive growth of the medical sciences after the Second World War changed the way in which health care was delivered. The importance of home care waned as people sought treatment of acute disease in hospitals and physicians' offices. Thus, in the 1960s and 1970s home care for acute illness had all but disappeared and subacute home care services were viewed as being supplemental to hospitalization; that is, they were provided almost exclusively as an "add on" to hospital care.

Over the past decade, there has been a marked increase in the number and importance of such "peri-hospital" services as attempts are made to control the costs of health care in general. Hospital stays have progressively shortened resulting in an expansion of the home care services both in number and in the level of acuity. Furthermore, both pre-hospital home care, for example to ensure adequate hydration before chemotherapy, and post-hospital home care require that services be coordinated with those provided in the hospital. Therefore, home care is being increasingly used by large numbers of individuals whose relatively intensive care on an inpatient service or in the clinic must be bracketed by less intensive monitoring over a period of days or weeks.

Furthermore, over the past few decades, chronic illness accumulated over a lifetime has come to replace acute illness as the focus of healthcare concern and therefore care over extended periods of time has also been required for ever larger numbers of Americans. That segment of the population comprised of the elderly and those with chronic illness has grown substantially

over the immediate past and will continue to expand for the foreseeable future. Increases in the numbers of elders and infirm persons of all ages assures that there will be great pressure on the health care system to provide coordinated medical and social services on a long term basis. With respect to home care services directed to those with chronic disease, formal providers have supplemented the care offered by family members.

Yet informal caregivers, largely women, are finding it increasingly difficult to serve individuals requiring long-term care, given the need to balance the time requirements for raising children, having careers outside the home and caring for older relatives. As the birth rate has fallen, this middle-aged generation is frequently unable to distribute the burden of family care among siblings. Nonetheless, the very considerable support these informal caregivers provide to relatives allows large numbers of elders to remain at home and therefore there is a requirement for ever increasing quantities of formal home care services as well. Furthermore, long term institutional resources are expressly or implicitly capped in many states ensuring that the need for home services for the chronically ill will continue to expand rapidly.

It is no wonder then that the home care industry has grown faster than any other component of the health care sector, now accounting for some thirty billion dollars annually. Although home care services provided under an evolving capitated system may be fewer in number than those provided in the fee for service sector as has been suggested by Shaunessey, Schlenker and Hittle (1) their importance to both clinical outcome and cost containment will unquestionably increase. There is also a trend toward more technologically sophisticated home care services including, for example, the use of respirators, oxygen equipment and implantable pumps. Recently, two articles in the *New England Journal of Medicine* described the use of low

molecular weight heparin in the home for the treatment of venous thrombosis--a condition long requiring a lengthy hospital stay (2,3).

Thus, the number of home health care agencies has increased dramatically over the last decade and the types and quantities of the services provided at home are in a period of rapid change. Yet home care continues to be viewed in isolation from the remainder of the health care sector. Perhaps for this reason a home care experience rarely is included in the curricula of medical schools.

II. The Population Served by Home Care

Current statistics demonstrate that one in seven Americans requires home care services annually and approximately seventy-five percent of these services are directed to the needs of the elderly. Of special concern to the home care sector are those individuals over the age of eighty, the old-old, who represent the fastest growing segment of the population. Their need for chronic home care services is substantial.

A quarter of a century ago, the inpatient hospital population was considerably younger than it is today and persons were usually admitted to a hospital with a single diagnosis--a "chief complaint." In contrast, large numbers of those in hospital today are Medicare eligible and have accumulated disease over a lifetime. The immediate cause for hospital admission is characteristically a flare-up of a chronic illness or an acute disease superimposed on a host of chronic illnesses that have already diminished the physical and functional reserve of those needing the care. Addressing the needs of those in the hospital therefore often requires not only a comprehensive evaluation, but an appreciation of the need to aggressively maintain the

function and quality of life of the individual, two issues rarely central to the thinking of those providing care in the acute setting in contradistinction to the home setting. Thus a home care exposure for physicians will likely improve hospital care as well, as home care is more appropriately viewed perhaps as more central to the health care system with hospital care as an "add-on" service.

With a shortening of hospital stays, the need to develop a seamless healthcare system with home care intimately coordinated with both hospital care, outpatient medicine and long-term institutional care is essential. Although it is not a replacement for all hospital care, home care, with increasing frequency, is used to deliver care to ever more acutely ill population as well as preventative, diagnostic, therapeutic, rehabilitative and long-term maintenance services in an environment that is almost always the site of first choice for care of the individual needing medical attention.

III. Home Care Policy and Physician Involvement

At this time, home care is almost exclusively provided by nurses and aides and few home care agencies have persons other than nurses as CEOs. Yet for some time physicians have described home care visits in glowing terms in the literature (4-7). Nonetheless surveys have shown that the number of home visits by physicians continues to decline and what few visits are still being carried out are made disproportionately by older doctors (8). Reimbursement issues have been a considerable force in determining the numbers of home visits performed by physicians (9). The very recent increase in reimbursement rate for physicians who make home visits is an important incentive. In fact, almost all home care matters are driven extensively by federal and state

regulations and reimbursement policies with little involvement of physicians in the writing of the regulations and very limited interest in these policies once mandated. Post-hospital home care is all too often considered at best an annoyance by physicians and many doctors begrudge the time spent to oversee care in the home when required to do so in order to satisfy Medicare and Medicaid regulations. In fact, many physicians, upon questioning, admit to signing orders on a continuing basis for the home setting without a full appreciation of what is or is not required by their patients. Nonetheless for more than a decade some of the largest medical organizations, including the American College of Physicians, have urged more physician involvement (10).

Although physicians must authorize home care services paid for under the Health Care Financing Administration (HCFA) it was only approximately three years ago that reimbursement for physician oversight of care at home was made available (11). At that time Bruce Vladeck, Immediate Past Director, HCFA spoke to the urgent need for meaningful physician involvement in the provision of home care (12). It is interesting to speculate that the issue of physician reimbursement for an individual home visit may fade from consideration under a capitated system of care. Under any circumstance, physician involvement will surely have to increase, as ever more care, including technologically sophisticated interventions, moves to the home setting.

Further, it will be necessary to utilize an assessment tool for all settings which will "cross-walk," allowing for person-specific rather than site-specific assessment and care management and comparisons between similar populations in different settings (13). Inter *RAI*, a not-for-profit multinational research organization has designed such an instrument for use in home care, as well as for acute care, transitional care, chronic and acute psychiatric care, and hospice care.

IV. Medical Schools and the Teaching of Home Care

Over approximately the past fifty years, academic medical centers have restricted their attention to a very significant degree to the care provided in the acute care setting. Even ambulatory experiences closely tied to hospitals were judged to be of secondary importance. Notwithstanding the changes in the way health care will be delivered in the future, both undergraduate and postgraduate training continue to focus upon patient care in the traditional hospital setting and to a lesser extent in the "office practice" setting. Home care is almost universally disregarded by medical school curricular committees. In 1994, it was reported that almost half of all medical schools do not devote even a single hour to home care over four years, and only three of one hundred twenty-three schools require five or more home visits of their students (14). Of interest in this regard, a conference on home care provided to attendees at the Annual Meeting of the Association of American Medical Colleges in the fall of 1994 attracted fewer than five individuals other than the speakers themselves.

V. The Expansion of Home Care into Academic Medicine Initiative

Because American medical schools have failed to address the issues discussed above, The John A. Hartford Foundation awarded the University of Medicine and Dentistry of New Jersey-The New Jersey Medical School a grant entitled Expansion of Home Care into Academic Medicine, an initiative which aims to encourage all medical schools to view the home as an appropriate and essential site for clinical teaching. Fifty-seven medical schools applied to receive these funds. The John A. Hartford Foundation therefore increased funding from six to eight medical schools to support models for the teaching of home care, for both acute and chronic conditions. In

conjunction with The John A. Hartford Foundation, the Columbus Medical Association Foundation and the Jewish Health Care Foundation have provided funds to an additional two medical schools to implement a home care learning experience for medical students. More than that this program is designed to plant the seeds for the growth of home care "within" academic institutions by encouraging faculty development in this venue--individuals who will see patients and teach in the home setting and pursue scholarly activities relevant to the further development of home care.

This program of The John A. Hartford Foundation has demonstrated both the extraordinary need for the training of medical students in home care and the very substantial pent-up demand. Virtually all medical students in all schools will likely benefit from similar experiences and more importantly, one can only guess at the large number of patients who will be the beneficiaries of these programs.

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Recommendations:

In order to ensure that Americans can live longer healthy lives at home:

1. Home care should not be viewed in isolation from care in other sites as care is required and increasingly provided across a continuum of sites. This will require:
 - Meaningful physician involvement in home care service delivery and expansion in the training of physicians about home care (presently Medicare supports post-graduate training programs almost all of which takes place in hospitals and their associated clinics).
2. A comprehensive assessment which is person-specific not site-specific with targeted interventions so as to be most cost-effective is required. To this end, InterRAI, a not-for-profit (501 c3) corporation dedicated to research, is reformatting the Minimum Data Set (mandated in all nursing homes in the United States) for use in the home, acute hospital, board and care setting, and step-down unit. Because it will "cross-talk" and "cross-walk" an individual's needs can be determined, interventions directed expressly to them and outcomes assessed. Differing assessment protocols in differing settings of care as presently exists will not allow older persons to remain at home as long.
3. A continuing emphasis on breadth of service research so as to continually update our understanding of the optimal type and number of services required to maximize each individual's function and quality of life for the longest period of time.
4. An expansion of those services which permit caregivers to function for the longest period of time with the least stress. Day care and respite care services will likely be especially advantageous in allowing many caregivers (most often women) to remain employed, care for their children and still participate in the care of their frail elders. Also, many caregivers today are themselves in their late fifties or sixties and have chronic illnesses themselves.
5. Risk factors for many chronic disabling diseases must be emphasized by the public and the health care professions from a young age. For example, emphasis should be on the diminution in the risk of osteoporosis (leading to hip and spine fractures) by supplying adequate calcium and vitamin D intake, coronary heart disease by eliminating smoking, cerebrovascular disease and strokes by eliminating hypertension, and generally maintaining a healthy life style by controlling obesity and increasing exercise.

Senator GLENN. Our next panelist, Ms. Connie Schmitt, is manager of adult day health care for TriHealth, a community partnership of Bethesda and Good Samaritan Hospitals in Cincinnati. She is responsible for the development and operation of TriHealth SeniorLink, a PACE program, which she will tell us about today.

In addition, Ms. Schmitt maintains the administrative responsibilities for the Bethesda Day Break, an adult day-care program that she developed for Bethesda Hospital beginning in 1987. She is currently president of the Ohio Association of Adult Day Services. Ms. Schmitt, welcome.

STATEMENT OF CONNIE M. SCHMITT, DIRECTOR, TRIHEALTH SENIORLINK

Ms. SCHMITT. Thank you, Senator, for this opportunity to comment on the unique health and social service needs of Ohio's frail older adults. I am speaking on behalf of TriHealth SeniorLink, which is the Program of All-Inclusive Care for the Elderly replication project in Cincinnati, Ohio. It is the first program in the State of Ohio, which is kind of significant, for our services.

The Program of All-Inclusive Care for the Elderly, which is referred to as PACE, is the national demonstration to determine whether the risk-based model of long-term care developed by On Lok Senior Health Services in California could be replicated in other areas of the country. Currently, there are 70 organizations in 30 States across the country in some stage of development of the PACE model. We are very proud to bring this model to the continuum of long-term care in Ohio.

The PACE model, which was developed in 1983, is a total system of care directly providing a comprehensive package of acute and long-term care services on a fully integrated basis. It is designed specifically to address the complex medical and social service needs of frail older adults allowing them to continue to live successfully in the community. Although viewed by many as a managed care plan, PACE programs differ from other managed care entities and long-term care providers in the following ways:

First, PACE programs enroll only the very frail, the older persons who meet the State's eligibility criteria for nursing home care. This approach is fundamental and unique among managed care programs. There is no mixture of good risks with poor risks. The primary objective of PACE is to maximize the function and independence of enrollees in order to delay or prevent nursing home placement.

Second, PACE provides a comprehensive range of primary, acute, and long-term care services. We provide the majority of services, including medical care, adult day care, home care, rehabilitative therapies, personal care, transportation, prescription drugs, and meals to enrollees both in the community and in nursing homes without any limits on dollars or durations of service.

Third, PACE programs fully integrate the delivery of acute and long-term care through interdisciplinary teams consisting of physicians, nurses, social workers, physical, occupational, and recreational therapists, dietitians, and home care workers. The integration of services is achieved through daily, face-to-face inter-

action between program enrollees and the professionals and para-professionals who provide their care.

Fourth, PACE programs receive capitated payments from Medicare, Medicaid, and in some States, private-pay sources. These payments are pooled at the program level, allowing health care providers enormous flexibility in developing treatment plans that respond to enrollees' needs rather than reimbursement regulations.

Last, PACE programs assume total financial risk and responsibility for all medical and long-term care without limitation.

The typical PACE enrollee, as we spoke earlier, is an 83-year-old widowed woman who suffers from six to eight chronic and acute medical conditions, things like arthritis, diabetes, congestive heart failure, and dementia. She requires assistance in two to three activities of daily living such as bathing, dressing, and using the bathroom, as well as needing help with other aspects of her care, like housekeeping and managing her medications. In the traditional home and community-based service system, these services are coordinated through a case manager but provided through multiple providers, which can lead to fragmentation and duplication of care. In PACE, participants receive all their services through a single agency that assumes total responsibility for providing and integrating all care.

The traditional home and community-based service system is successful in meeting the long-term care needs of older adults, but are usually left out of the loop where primary care is concerned. In PACE, the management of health care needs of the frail elderly serves to reduce the frequent and sometimes inappropriate use of physician and hospital services.

Service integration is a fundamental element of the PACE program. That is, the same people who deliver care meet together on a regular basis to discuss and develop an overall assessment and treatment plan for each enrollee. This approach allows for health professionals to respond immediately to changes in enrollees' conditions which are frequent, sudden, and often serious in the case of the frail elderly.

PACE enrollees attend the day health center on an average of 2 to 3 days per week to receive primary medical care, nursing and social services, rehabilitation and recreation services, and personal care. On average, each PACE enrollee will see their physician twice a month or more frequently if necessary. If necessary, these services can be provided in the individual's home. An enrollee who requires hospital or nursing home care remains in PACE, and care continues to be coordinated and monitored by PACE staff, thus assuring continuity of care between services provided in the center, at home, and in institutions.

Hospitalization utilization rates for PACE enrollees are at or below levels for the general older population, and nursing home rates are way below levels for a comparably frail group. Analyses of costs for individuals enrolled in PACE show that Medicare and Medicaid save between 5 and 15 percent relative to expenditures for a comparably frail population in the traditional Medicare and Medicaid systems.

TriHealth SeniorLink in Cincinnati began providing services in November 1996. Our census growth has been slower than originally

expected. We currently have 21 enrollees in the program, which is half of what was projected. Census growth is a challenge for all PACE sites, and this is primarily due to the fact that in enrolling in the program, individuals have to give up their primary care physician and come under the direction of a physician on staff. That is difficult for older adults, as many of us know.

Although we have experienced that resistance to enrollment in our program, a larger obstacle to enrollment has been problems with financial eligibility for individuals in the program, which is an issue that has been addressed with the passage of the Balanced Budget Act last summer, which incorporated Medicare provider status for PACE sites across the country, and which provides a more equitable financial limitation for older adults to accept program services.

Another issue affecting the continued success of the PACE model are the ever increasing shortage of home health aides to provide the supportive services necessary to keep older adults in their homes. This issue is not unique to PACE. The home and community-based service system is also facing this dilemma. With the continual shift of care back to the community, we must assure that qualified individuals are available to meet the needs of the elderly.

Last, there continues to be a shortage of affordable housing for older adults. With the services available through the PACE program, we are successful in managing the health and supportive service needs of frail elderly, but, unfortunately, many times housing options are not available for them, and nursing home placement is inevitable.

I appreciate the interest that the committee has expressed in the PACE program and our success in the State of Ohio. It is definitely an added component to our continuum of long-term care. [Applause.]

[The prepared statement of Ms. Schmitt follows:]

Statement of Connie M. Schmitt, MSW
Director, TriHealth SeniorLink

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to comment on the unique health and social service needs of Ohio's frail, older adults. I am speaking on behalf of TriHealth SeniorLink, a replication of the Program of All-Inclusive of Care for the Elderly (PACE) in Cincinnati, Ohio. PACE is the national demonstration to determine whether the risk based model of long term care developed by On Lok, Inc. in San Francisco can be replicated in other areas of the country.

The PACE model, developed in 1983, is a total system of care directly providing a comprehensive package of acute and long-term care services on a fully integrated basis. It is designed specifically to address the complex medical and social service needs of frail older adults allowing them to continue to live successfully in the community. Before I explain the PACE model further, I want to express my appreciation for the strong bipartisan support in Congress for PACE over the last 15 years which has culminated in establishing provider status for the model as part of the Balanced Budget Act of 1997. This legislation allows for the continued expansion of PACE services to many more qualified frail, elderly individuals throughout the United States.

PACE programs differ from other managed care entities and long term care providers in the following ways:

- **PACE programs enroll only the very frail** -- older persons who meet the states' eligibility criteria for nursing home care. This approach is fundamental and unique among managed care programs -- there is no mixture of "good risks" with "poor risks". The primary objective of PACE is to maximize the function and independence of enrollees in order to delay or prevent nursing home placement.
- **PACE provides a comprehensive range of primary, acute and long-term care services.** We provides the majority of services, including

medical care, adult day care, home care, rehabilitative therapies, personal care, transportation, prescription drugs and meals to enrollees both in the community and in nursing homes without any limits on dollars or durations of service.

- **PACE programs fully integrate the delivery of acute and long-term care** through interdisciplinary teams consisting of physicians; nurses; social workers; physical, occupational and recreation therapists; dietitians and home care workers. The integration of services is achieved through daily, face to face interaction between program enrollees and the professionals and paraprofessionals who provide their care.
- **PACE programs receive capitated payments from Medicare, Medicaid and in some states, private pay sources.** These payments are pooled at the program level, allowing health care providers enormous flexibility in developing treatment plans that respond to enrollees' needs rather than reimbursement regulations.
- **PACE programs assume total financial risk and responsibility for all medical and long-term care without limitation.**

The typical PACE enrollee is an 83 year old, widowed woman who suffers from several chronic and acute medical conditions, and some degree of cognitive impairment. She requires assistance with various activities of daily living such as bathing, dressing and using the bathroom as well as help with other aspects of her personal care, housekeeping and managing her medications. In the traditional home and community based service system, these services would be coordinated through a case manager but provided through multiple providers which can lead to fragmentation and duplication of care. In PACE, participants receive all their services through a single agency that assumes total responsibility for providing and integrating all care.

Service integration is a fundamental element of the PACE program. That is, the same people who deliver care meet together on a regular basis to discuss and develop an overall assessment and treatment plan for each enrollee. This approach allows for health professionals to respond immediately to

changes in enrollees' conditions which are frequent, sudden and often serious in the case of the frail elderly.

Enrollees attend the PACE Center, on average, two to three times a week. There they receive primary medical care, nursing and social work services, rehabilitative and restorative therapies, personal care, meals and an opportunity to participate in various activities. Participants see their physician an average of twice a month and more frequently if necessary. When enrollees do not come to the Center, services are provided in their homes. An enrollee who requires hospital or nursing home care remains in PACE and care continues to be coordinated and monitored by PACE staff, thus assuring continuity of care between services provided in the Center, at home and in institutions.

Hospitalization utilization rates for PACE enrollees are at or below levels for the general older population, and nursing home rates are way below levels for a comparably frail group. Analyses of costs for individuals enrolled in PACE show that Medicare and Medicaid save between 5% and 15% relative to expenditures for a comparably frail population in the traditional Medicare and Medicaid systems.

The quality of care provided by PACE programs to date has been high and is never sacrificed in pursuit of lower costs. Federal and state review processes, an independent review by the Community Health Accreditation Program in 1993, ongoing consumer satisfaction surveys, and the findings of HCFA's evaluation verify the high quality of PACE care. To assure continued quality services, the National PACE Association is developing standards of care for the PACE program.

Since opening for services in November, 1996, census growth for TriHealth SeniorLink has been slower than what was originally expected. We have 21 individuals enrolled in the program which is half of what was expected at this time. Census growth for all PACE sites is a challenge usually due to the requirement that individuals seeking services must give up their primary care physician to enroll in the program.

Although we have experienced this resistance, a larger obstacle to enrollment has been the limited amount of income an individual can have to

meet the requirements established in the Medicaid Agreement with the Ohio Department of Human Services (ODHS). This criteria is significantly lower than those individuals currently being served by the Home and Community Based Services Waiver which prohibits ease of movement to TriHealth SeniorLink when an older person's needs require more extensive services. However, this issue has been addressed through the establishment of provider status for the PACE program which will establish the same financial guidelines for both TriHealth SeniorLink and the Home and Community Based Services program.

The TriHealth SeniorLink program appears to have turned the corner on success. Because of the comprehensiveness of the service package and the uniqueness of the model, ongoing education has been directed to community referral sources to help identify appropriate individuals for the program. Our successes in improving the health and functional status of our enrollees has alleviated the apprehension associated with referring to a new service. Through the efforts of our multidisciplinary team, we have enabled individuals to leave nursing home care and return to live with family members in the community. Individuals who have not been out of their homes in years now receive appropriate medical and supportive care within the day health center.

With the passage of the "provider status" legislation and efforts to move through the process, PACE sites are finding that in order to provide services under dual waivers they must adhere to the guidelines established for health maintenance organizations. PACE programs, on average, enroll a maximum of 350 individuals when at mature status (3 sites with a census of 130 each). With such small numbers, it will be both financially and operationally burdensome to adhere to guidelines that are established for such large volume organizations. Adjunct to this issue, it would make more sense and be more beneficial if the managed care providers would be encouraged to look at the PACE model on a contractual basis to provide the services that their enrollees will eventually need as they move along the aging continuum.

Additional issues affecting the continued success of the PACE model are the ever increasing shortage of home health aides to provide the supportive services necessary to keep older adults in their homes and the lack of

affordable housing for older adults. Assisted living has expanded the housing options for the private pay population and comparable effort must be targeted at addressing these same needs for the lower income populations. Although significant to the PACE model, these issues are critical for all long term care providers faced with keeping older adults living within their communities.

I appreciate the interest that the committee has expressed in the PACE program and its success in Ohio. PACE, creates an opportunity to work together to improve the delivery of services to a subset of the most needy Medicare and Medicaid beneficiaries.

Senator GLENN. Thank you very much.

How do seniors find out about this program? Is it just word of mouth or is there an outreach program that lets people know about it?

Ms. SCHMITT. There is a considerable outreach program to let people know about it. A campaign that we have just undertaken is several radio newscasts and advertisements on public radio stations to inform people of the availability of the service. We are also attempting billboards and bus shelter advertisements at this point in time.

A lot of it is more contact with case managers within the home and community-based service system because they have already identified frail older adults, and it is establishing the working relationships with referral services.

Senator GLENN. Do you enroll private-pay patients?

Ms. SCHMITT. We do not enroll private-pay at this point. PACE sites across the country have enrolled private-pay. There is a program in Rochester, NY, that has been successful with the private-pay population at this point in time. But due to restrictions with our contract with the Ohio Department of Human Services, we are not able to do that.

Senator GLENN. You are president of the Ohio Association of Adult Day Care. Is this expanding now across Ohio? Is this sort of an experimental program?

Ms. SCHMITT. Our State association has been organized since 1980. We have seen considerable growth in membership across the State since that time. However, in the past 2 or 3 years, our membership has pretty much leveled off. We have seen new programs develop, join our membership organization, but we have also seen programs that have been established for quite some time close.

Senator GLENN. Some of these people really need a lot of help, as you pointed out. Do you provide transportation, or how do they get there? How do you take care of that?

Ms. SCHMITT. We provide the transportation to and from the program.

Senator GLENN. Good. Are the programs open on weekends also?

Ms. SCHMITT. Our program is not at this point in time because our service doesn't demand it. But that is a philosophy of PACE. It is a 7-day-a-week, 24-hour program.

Dr. HEALY. One thing that keeps coming up again and again, it seems that Americans are not willing to give up the choice of their physicians, and you mentioned that. Is there a way to kind of meld that, give them their choice and let them be in this wonderful program?

Ms. SCHMITT. I think that the PACE program, the National PACE Association, is looking at that. As the model evolved back in the early 1980's, they saw that as the best way to learn how to manage the care of older adults. On Lok has had a lot of success at that, and the more established sites are moving in that direction. They are beginning to look at utilizing more different primary care providers within a program, as well as contracting with people outside of the system.

Dr. BUTLER. Let me introduce a little sense of impatience on behalf of the country. I am thinking back to the 1970's, sitting in the

office of the Secretary of the Senate when Mike Mansfield was the majority leader, when the On Lok people first came to Washington to try to get support, waivers, in order to study this very important effort to try to integrate care through the variety of services that were necessary. Here we are almost 20-plus years later, and we are still in a demonstration mode with regard to PACE. With the baby boomers about to land in Golden Pond just about 12 years from now, we ought to get moving. You would agree with that statement?

Senator GLENN. I am sure you would agree with that statement.

Ms. SCHMITT. Yes, I would agree with that statement, and the legislation passed last summer will help that.

Senator GLENN. Good.

We'll move along to Mr. Martin Janis. I'm sure Martin Janis needs very little introduction to anybody here today. He has had a long and distinguished career in business and public service. He is founder of what is now the Ohio Department of Aging. He has participated in the last three White House Conferences on Aging. Many of the programs for older Ohioans that you are hearing about today are in place due to the inspiration and the hard work of Martin Janis.

Martin remains very active in aging and other community affairs. He has been a friend and adviser to me during my years in the Senate. We welcome him this morning. Martin, we look forward to your statement.

STATEMENT OF MARTIN JANIS, SENIOR CONSULTANT

Mr. JANIS. Thank you very much, John, for your kind remarks. It is indeed a pleasure to participate in this discussion of health care for older persons.

As I sat there waiting for my turn, I was reminded of an incident that occurred to me many years ago when I was serving as the director of the Department of Mental Hygiene and Corrections of the State of Ohio. An important element was to visit the 27 institutions that were part of the Department.

But I did get around, and the one thing that I would insist on was that the superintendent had to go with me as we walked around the place. I was at one of our facilities, which was spread out over quite a campus, and as the superintendent, the doctor was taking me about, his beeper came on, and he said to me, Director, I have to answer this and I will just go over to the nearest telephone and so if you will wait a few minutes. Fine. So he went on, and I, of course, waited. But then I saw a man who was washing his car and so, of course, in kinship with the staff members, I too had to go up and talk to him. So I did. Of course, after exchanging pleasantries, he was interested in what it was that I am doing, and I said well, I am here on an inspection to look at the facility. Oh? he said Are you a psychiatrist? I said no. Are you a physician? No. Are you a psychologist? Are you a social worker? I said no. Are you a therapist of some kind? No, I am not. Who are you then? Well, I said, to be honest with you, I am the director of the department that overlooks this facility. With this response, a change occurred on his face. The look of puzzlement changed to one of compassion,

and he said to me, Now, don't you worry a bit, they will take good care of you here. Everything will turn out fine. [Laughter.]

So I never worried, that no matter what it was that I found myself doing, everything would turn out very well.

Now, as was indicated, the statement apropos my comments is going to be in the report. So I shall indulge myself in some remarks.

First of all, I want to compliment Bonnie on what it is and how it is that she presented what it is that Ohio State is doing in geriatric medicine and gerontology to a great extent because Bob Butler was responsible for my seeking the necessary legislation that mandated—and incidentally, Bob, we are still the only State in the Nation that mandated that our seven medical schools had to have offices in geriatric medicine.

I served on the advisory council that Bob headed for—I think it was about 1977, and in 1978, in the course of his remarks to the members of the committee, he did mention the lack of geriatric training in our medical schools. Because of that, I decided when I came back that I was going to see to it that we had such training in our medical schools.

I want to say, Dr. Healy, I am particularly happy to see you here. It took until Dr. Tzagournis became the dean before we got a real program going. Then one of the great things that he did was to appoint Dr. Bonnie Kantor as the director. In that period of time, that she has headed that program, we have taken great strides because of the support that she got from Dr. Tzagournis. I am sure that with Dr. Healy's impressive background in meeting the needs of people as a whole, she will see to it that we get the kind of impetus that will bring Ohio State on a par, forgive me, with Case Western and with the University of Cincinnati, because those two schools have been leaders in this area for many years, let alone my own school in Toledo, the Medical College of Ohio.

So, you see, I have had a very personal interest in this, and as Senator Glenn indicated, I have been a part of aging program development in Ohio for some years.

With your indulgence and forgiveness from the Lord for my showing this vanity and, thus, maybe minimizing my chances of getting into heaven—because you know if you get too many plaudits from the people, then the Lord asks what is it that I can offer you after you have had all of your rewards given to you. This is an anniversary year for me. It was 35 years ago that I first started Ohio's official programming in the area of geriatrics and gerontology. This also represents my 30th anniversary of having started the Governor's conferences on aging. The 30th consecutive one will be held here next month, but it was in 1968 that I began the first conference.

I thought surely, Senator Glenn, that with you leading this, that everybody would come here not to attend what it is that was going to be said here, but just to see you, because, in common with others, I wrote to Senator Glenn congratulating him, and I want to share with you—I didn't congratulate him so much for the research that he was going to be undergoing that would be of benefit to us in the area of those things that you heard earlier, both from Dr. Healy as well as from the Senator, what we will learn about the

body in relationship to space. No. The thing that I was so proud of was that here was a man who is living up to what Justice Oliver Wendell Holmes used to say: It is so much better to be 80 years young than it is to be 40 years old.

So, Senator, what you have done, you are helping contribute to that image to let people know that, look, after 65, you have got a great life ahead of you, take care of yourself so that you can enjoy it, because every moment of your life is precious. If you have been given the opportunity of enjoying an extended life beyond what it is that we were promised in the Bible of three score ten, take advantage, enjoy it, you still have much that you can do. So you have proven that that is the case, and I thank you for it because it is very, very helpful to correct that image that so many have of the fact that as you get older and pass 75, you are through. Figures don't support that.

Now, let me get at least a touch on some of the things that I have in the written testimony. I became interested in health care for older persons in 1961 as a first-year member of the Ohio Legislature. I was surprised when I, after being sworn in, was called by the director of health asking me if he could meet with me as well as with some of his colleagues. So, of course, I said yes.

So we met, and he proceeded to tell me about the abominable, the appalling conditions that existed with most of the nursing homes. So I reviewed many situations that he brought to my attention, and also went out and visited quite a few. We, on hold—because most of you are too young to look back to the 1960's, early 1960's, but they were terrible. They were appalling.

But since then, there has been a great improvement, and Bob can attest to that. Incidentally, may I suggest to each one of you if you haven't read his book, turn to page 263 in his book, wherein Bob defines a nursing home of that day. So when I say that they were appalling, that it was disgraceful, you will find that attestation in the definition that he gives of nursing homes of that time. They have changed considerably. That is how it is that I became interested in programs for older persons. So that in 1962, Governor Rhodes, I heard, had decided that he was not going—forgive me, Bob—he was not going to have a psychiatrist to head the Department of Mental Hygiene and Corrections. Later, lo and behold, he called and asked me or offered me the position. I said to Governor Rhodes, gladly, I will take it, because I have some thoughts in mind. However, I want to ask you: Will I have freedom of doing the things that I want to do to correct the situation as it exists? To his credit, the Governor said yes, except, Martin, never do anything that might embarrass me or cause a reflection on my record.

With that, I assumed that role and did so because—of course, I don't know how many of you are familiar with State hospitals of that day. Incidentally, I was responsible for changing to local autonomy and local facilities, but at that time, it was terrible. Most of the people who were in our State hospitals didn't belong there. But, you know, in those days, there were no homeless people, the reason being that if you showed any kind of a deviation from what might be called accepted behavior, they would go to the probate court and you would end up in a State hospital. So that many of the persons who were in not only the State hospitals in Ohio, but

throughout the Nation, didn't belong there. This was particularly an indictment because so many of them were older persons.

So the first action that I took was to say to the Governor, I want to separate the older population from the general population. The Governor agreed. The only thing he said to me—and this is a good subject by reason of some of the discussion that took place earlier—don't ask me for any more money. I said, no, you don't have to worry about that. We will figure it out somehow.

Anyway, on that basis, I went to Washington, met the head of the Public Housing Administration, told him what it was that we wanted to do in Ohio, and he consented and said that he would advise the local metropolitan housing authorities to cooperate with us. So in that year of 1963 was the beginning of the first assisted living unit operation in the State, let alone the Nation.

It was quite a feat, because first I had to work with the Federal Government—and they are not the easiest to work with—the State government, the local metropolitan housing authorities, and the residents. But after a period of time, we were successful.

In 1967, we opened the first assisted living unit in Toledo; 1968, here in Columbus. The one in Toledo took care of 150 residents. The one here took care of almost 300.

Eight years later, 1975, this committee, the Special Committee on Aging recommended to all State agencies throughout the Nation that they should follow the example that was established here. So I take, of course, a great deal of pride in the fact that we were indirectly involved in the operation of the first assisted living unit. To corroborate that, here is a booklet that was published in 1975 wherein that reference is made, wherein the Special Committee on Aging in print publicly lauded Ohio for the steps that it had taken.

Take in my own time, in Ohio, in 1963, there were about 50,000 persons who were 85 years of age and older. The demographers from the U.S. Bureau of Census project that in 1990—in the year 2000, 2 years from now, there will be 185,000 persons who will be 85 years of age or older. Think of the change that that represents.

There are almost as many persons in Ohio who are 75 years of age and older today as the entire population of those who were 65 years of age or older was back there when we started. It is growing and as you heard—I think it was Dr. Healy who mentioned demographics—by the year 2030, 2050, that population group will be almost as large as the number we had 65 years age or older.

Assisted living, then, as you know, is an important element in the care and treatment of older persons. Assisted living simply, as you know, without my enunciating it, is the providing of housing as well as personal care services. We, back in 1968, 1969, provided the housing through metropolitan housing, the clinic services through the existing facilities that we had, and everybody paid for it.

I want to read to you just very briefly this statement, issued by the U.S. Senate Special Committee on Aging. If there had been assisted living housing for senior citizens throughout the last decade, how many thousands of older persons would be residents in there today rather than being patients in nursing homes? Tomorrow, will the low-income older person be sent to institutions, nursing homes, or become burdens on sons and daughters or on society? Will there

be assisted living housing such as that represented by Ohio's programs where they can live semi-independently for many, many years? These are questions that must be answered.

That was the statement that they made. Now, there has been a great—you have heard from Ms. Schmitt, and you will hear from the two that will follow me who more directly work with providing home health services. I ask you—and I have heard much about planning, but my Bible has always been the Older Americans Act. The Older Americans Act, in its preamble—now, mind you, this was passed in 1965. In its preamble, it states that it is the responsibility of Congress to recognize the dignity of its older people and it is their responsibility as well as the responsibility of the sovereign States and its subdivisions to recognize that and to provide for the meeting of certain objectives. Then it recites those objectives. One of them is—I am not going to read the whole thing to you, but one of them says that you should provide the best possible physical and mental health to all older persons regardless of economic status.

Now, this is not a fulmination of mine. This is actually part of the preamble to the Older Americans Act. Then it goes further to state: An array of comprehensive basic home health services should be provided to every older person.

Now, think of that. This was written in 1965. Here we are—in Ohio, we didn't start the home health program services through the Department of Aging until the early 1990's. We have not reached totally the needs of so many older persons. We don't need any more planning. What we need is to live up to the charge that we had in the Older Americans Act. I only hope that I leave you with the fact that some day you might be in that position and certainly would want to be given an opportunity to be able to live out your life to the fullest degree of your intellectual ability.

Thank you. [Applause.]

[The prepared statement of Mr. Janis follows:]

Statement of Mr. Martin Janis

at a field hearing of

The U. S. Senate Special Committee on Aging

ELDER CARE TODAY AND TOMORROW

Senator John Glenn, Chair

The Ohio State University

Columbus, Ohio

Monday, April 27, 1998

STATEMENT OF MARTIN JANIS, SENIOR CONSULTANT

Thank you very much, John for your kind remarks. In making my presentation as a part of this panel of individuals involved in one aspect or another in health care for older persons, I ask your indulgence of these personal remarks before presenting my written testimony.

1998 marks the 35th anniversary of the beginning by the state of Ohio of programs for its older citizens. They began as a part of the Department of Mental Hygiene and Corrections of which I was the Director. Prior to 1963 as a member of the Ohio Legislature I visited many of the state mental health institutions and was concerned by the number who really didn't belong in that setting, particularly older persons.

As a consequence, when Governor Rhodes appointed me as the director of the department, I immediately took action to correct this situation. Briefly, a program called "Golden Age Villages" providing housing and personal care services (meals, activities and health care) for its residents.

There was considerable apprehension by the Governor and key members of the Legislature about it, but it did become reality through the coordination of effort by the State, Federal Government, Metropolitan Housing Authorities and the State Legislature. Two factors were important but I won't take the time to discuss them, unless there is time after the hearing.

In my own instance I never had any doubts by reason of an incident that occurred while I was visiting one of the mental health institutions that was part of the department.

While moving from one building to another, the superintendent's beeper came on and he said to me "Director, excuse me while I answer this call. I'll be right back." So he went on and I waited. As I glanced about I saw a man washing a car, so I went up to him. After exchanging a few pleasantries, he was interested in what I was doing there. I answered that I was on an inspection tour. He remained silent and then after a few minutes, asked "Are you a psychialist?" I answered "no". "Are you a physician?" "No". "Are you a phychologist?" "No". "Are you a social worker?" "No". "Are you some kind of specialist?" Again, "No." By now, seeing the look of puzzlement on his face, I said to him, "I am the director of the dept. of which this facility is a part." With that response, the look of puzzlement changed to one of compassion and he turned to me and very kindly said "don't you worry one bit. They'll take good care of you here. Everything will turn out fine."

By now, the superintendent returned and we were on our way. However, those last words have become a part of my personal philosophy for they symbolize that everything will turn out all right through the interrelationship between the mind and spirit. Use your mind to its fullest but never overlook the spirit. The power of the mind and of the spirit.

Forgive these personal comments, but I have been privileged to be a part of aging programs as well as the aging population for approximately 35 years. I have seen the changes that have occurred in each over those years. In addition, I have visited as many of the variety of senior facilities as anyone, and spoken to more older persons than most.

It was also my privilege to serve as a member of the Board of Trustees to the National Institute on Aging at the time that Dr. Butler was its first Director. At each meeting of the Board, Dr. Butler stressed the need for geriatrics and gerontology to be a part of medical school education.

It is because of his emphasis on this need, with the efforts of a few persons, legislation was enacted by the Ohio legislature that Ohio's seven state supported medical schools established offices of Geriatrics and Gerontology.

Bob, you can understand my personal pleasure in listening to the presentation by Dr. Bonnie Kantor of that office at Ohio State University. She was appointed by Dr. M. Tzagournis Dean of the Medical School at Ohio State at the time, and now vice president of health affairs. Incidentally, very similar programs are to be found at the six other medical schools.

Now that Dr. Healy, with her impressive background, is the head of the medical school at Ohio State, we envision great progress in meeting the challenge of the burgeoning older population.

God stated in Genesis " My spirit shall not remain in man forever for he is flesh and his days are numbered and they shall be 120 years." It's the responsibility of not only the medical schools but of every service that touches the lives of older persons that those years be quality years.

In concluding the personal comments of my testimony, Senator Glenn, I repeat what I have written you at the time of the announcement of your selection as one of the team members of the October Shuttle flight.

Undoubtedly, research that will be forth coming from your trip at age 77 will be beneficial and of value to all persons, young and old.

But equally important is the effect on the young and old of today. We live at a time when imagery has become a part of our culture. You will help to create a positive image of growing older. 77 years young and into space. Wow!

Now to my written testimony as it relates to Elder Care today and Tomorrow and specifically to Assisted Living.

As one who has been a part of programs for older persons for approximately 35 years, I have seen the great change in health care for older persons.

I can well remember the early years of nursing homes. In 1961 as a member of the Ohio Legislature and at the invitation of the director of the Ohio Department of Health, I reviewed a number of situations concerning nursing homes.

For that reason I am aware of the great improvement that has been achieved since those early years. Another member of our panel, Dr. Robert Butler, can corroborate that statement by reason of having defined a nursing home of that earlier period in his book "Why Survive? Being Old in America" published in 1975.

Undoubtedly much of the improvement can be attributed to the Older Americans Act which came into being in 1965. The Older Americans Act is important, particularly for older persons. In the preamble, it states "Congress hereby declares and finds in keeping with the traditional American concept of the inherent dignity of the individual in our democratic society, the older people of our nation are entitled to, and it is the joint and several duty and responsibility of the governments of the United States and of the several states and their political subdivisions to assist our older persons to secure equal opportunities to the full and free enjoyment of the following objectives."

It then lists the various objectives, among these, "the best possible physical and mental health which science can make available and without regard to economic status and full restorative services for those who require institutional care and a comprehensive array of community based long term care services adequate to appropriately sustain older people in their communities and in their homes."

Although clearly stated it has only been in the last few years that we have seen the availability of home health care services as set forth in the Older Americans Act.

As our older persons population increases the number of older persons with some degree of health impairment does also. The following illustrates the growth in numbers of those 65 plus in Ohio:

<u>Ages</u>	<u>1963</u>	<u>1990</u>	<u>2000</u>
65-74	583,050	830,107	815,179
75-84	260,130	436,158	549,117
85+	53,820	140,696	189,433
	<hr/>		
	897,000	1,406,961	1,553,729

Note that in the year 2000 we will have almost as many persons 75 years and older as we had in 1963 of persons 65 years and older.

By the same token there will be an increase in the number requiring health care services, but not necessarily nursing homes. With an older population that is in better general health than those before it, the needs of older persons with health impairments can be met in great measure through an expansion of home health care services.

However, not all persons want to remain in their own homes. Fear as to worrisome possibilities make many persons prisoners in their own homes. Being alone is also the plight of many older persons. These two situations are deterrents to good health. Neighborhoods change. Thus there has been, within recent years, a great interest in Assisted Living apartment complexes.

What is an Assisted Living unit? The late Dr. Wilma T. Donahue, who was director of the International Center for Social Gerontology, stated it as being "a residential environment which includes services such as meals, house cleaning, health, personal hygiene, activities, and transportation which are required to assist impaired, but not ill, older tenants to maintain a semi-independent life-style and avoid institutionalization as they grow older."

In other words, assisted living is the providing of those services, except skilled nursing care, that help a person with health impairments maintain independence. It is not a nursing home.

Dr. Donahue's definition as well as a fuller description was included in the report by the U.S. Senate Special Committee on Aging with respect to Ohio's Golden Age Villages (assisted living for the elderly).

This report covered the first eight years of operation, (1968-1975). It examined the benefits that accrued to the residents during that period physical, psychological and social health.

Was the Golden Age Village program (Assisted Living) a success can best be judged by this paragraph which is a part of the U.S. Senate Special Committee on Aging report:

"If there had been assisted living housing for senior citizens throughout the last decade, how many thousands of elderly would be residents there rather than patients in nursing homes? And tomorrow? Will the low-income elderly be sent to institutions, nursing homes, or become burdens on sons and daughters or on Society? Will there be Assisted Living Housing such as Ohio's Golden Villages, where they can live semi-independent lives for many, many years? These are questions that must be pondered and answered."

Despite this endorsement, the development of Assisted Living units for the low and moderate income older person has been relatively slow. However, in the last few years there has been an increased interest in assisted living complexes for older persons with high moderate to high incomes.

A few states are beginning to develop programs that combine various federal programs with a state supplement for the development of assisted living units for low income older persons.

In 1994 the Robert Wood Johnson Foundation in conjunction with a national lender that focuses exclusively on nonprofit organizations providing services on moderate and low income persons joined together to focus on nonprofit groups that work exclusively in developing assisted living units for older persons of low and moderate incomes. Although they have projects in several states, Ohio is not one.

Victor Regnier, author of "Assisted Living for the Elderly" states that the vast majority of European projects are open to low and moderate income persons. However, due to lack of funding in the U.S the majority of the assisted living projects in this country are targeted toward middle and upper income older persons.

I conclude my testimony by repeating the paragraph from the Senate Special Committee on Aging report, " If there had been assisted living housing for senior citizens throughout the last decade, how many thousands of elderly would be residents there rather than patients in nursing homes? And tomorrow? Will the low-income elderly be sent to institutions, nursing homes, or become burdens on sons and daughters or on Society? Will there be Assisted Living Housing such as Ohio's Golden Villages, where they can live semi-independent lives for many, many years? These are questions that must be pondered and answered."

Martin A. Janis

Founder- Ohio's programs for older persons
(the Department of Aging)

Senator GLENN. Thank you very much. Your dedication to the elderly through the years is one that is very exemplary for all the rest of us here. You have done an outstanding job through the years.

Because of time, I think we are going to have to move along to our other people. Our next witness, Mr. Matt Ottiger, is the legislative liaison to the Ohio Department of Aging. In this position, he represents the department and Ohio's nearly 2 million senior citizens on initiatives and legislation before the State's General Assembly. Mr. Ottiger also interacts with the Governor's office on the implementation of priority legislative initiatives related to aging issues and serves as liaison to the State of Ohio's Washington, DC., office regarding Federal legislation.

Matt, we welcome you this morning and look forward to your statement.

STATEMENT OF MATT OTTIGER, LEGISLATIVE LIAISON, OHIO DEPARTMENT OF AGING

Mr. OTTIGER. Thank you very much.

Mr. Janis, you are a tough act to follow.

On behalf of the Department of Aging and its director, Judith Y. Brachman, I would like to thank Senator Glenn for bringing this hearing to Columbus today. It is a pleasure and honor for me, as the department's legislative liaison, and a graduate of Ohio State, to participate in this afternoon's hearing with such a distinguished list of leaders—leaders who have made a difference, leaders who have made elder care what it is today, and who are working to improve it for tomorrow.

The Ohio Department of Aging serves and represents nearly 2 million older Ohioans and acts as their chief advocate within State government. We strive to improve the quality of life for older Ohioans, helping them live independently, active, and healthy in their communities, and we work to promote positive images and attitudes toward older people.

A major emphasis of the Voinovich administration and the Ohio Department of Aging has been placed on keeping frail elderly living as independently as possible in their own home.

We have been extremely successful in this endeavor, thanks to the support of Congress, Ohio's General Assembly, and in partnership with the aging network.

Our success has come mainly through the implementation of the Community Care Choices initiative. The initiative, which is the foundation of a whole new era for long-term care in Ohio, contains three programs: the PASSPORT program, Residential State Supplement program, and Care Choice Ohio.

According to Governor Voinovich, "Home is where the heart is, and home is at the heart of the PASSPORT program." Ohio's PASSPORT program provides long-term care services where the overwhelming majority of Ohioans want them—in their own homes.

PASSPORT offers in-home services to Medicaid-eligible older Ohioans whose impairments are severe enough to otherwise require nursing home care.

When Governor Voinovich took over the PASSPORT program—or took office 7 years ago, 2,700 older Ohioans received PASSPORT services. This year, we hope to serve over 22,000, nearly 9 times the number served at the beginning of this decade. By 2003, with the Federal approval of our waiver renewal application, we will serve nearly 25,000 annually on the program.

We are proud of the enormous growth in our PASSPORT program, and we are equally proud of the measures we have put in place to assure that: one, our programs are serving a valued purpose; two, our programs are serving those they are designed to serve; three, our clients are satisfied with those services; four, Ohio's taxpayers are getting the most efficient, most effective services the State can offer its older population; and, five, our programs are continually fine-tuned for improvement so that we may better serve all Ohioans.

PASSPORT offers a fine example of how we have been able to better serve Ohio's taxpayers while at the same time better serving older Ohioans.

Streamlined management and improved administration have saved over 15 million over the past few years, money that we have reinvested to serve more people on the program.

We have also saved 2.1 million in the PASSPORT program thanks to a quality improvement suggested by the quality team. We are improving management through performance-based budgeting. A portion of the administrative funds allocated to the agencies that operate the program in the field, PASSPORT administrative agencies, is now tied to how well they perform. The new system acts as an incentive to control administrative costs and provides regional agencies with more flexibility to make decisions.

We have also undertaken other steps to assure that PASSPORT is responsive to the needs of its clients.

We utilize annual client satisfaction surveys to ensure that our customers are satisfied with their services. We are proud of the 88 percent satisfaction rate our survey generated in 1996, but we did not rest on our laurels. We were able to boost the satisfaction rate to 92 percent last year.

Our goal is to keep learning, however, from our clients and to continue to refine our services until our satisfaction rate is 100 percent.

According to last year's survey, PASSPORT clients received services for an average of 18 months at an annual cost of \$558 per month per client. At this rate, we are serving PASSPORT clients at about 40 percent of the cost of nursing home care, significantly less than the 60 percent cost of nursing home care.

In addition, our study and monitoring of PASSPORT effectiveness has been enhanced by Scripps Center at Miami University, which last summer released some interesting research that noted a few trends in long-term care.

That research indicated that our efforts to expand home and community-based care have made a difference for Ohio's seniors and played a considerable role in diverting older Ohioans from institutional care.

The study found that, at a time of increasing aging population, the occupancy rate of nursing home beds in Ohio shrank from 92 percent in 1992 to 88 percent in 1995.

In addition to PASSPORT's impact on changing the culture of long-term care, other components of the Community Care Choice initiative have made a difference for the State's seniors.

Thanks to the Care Choice Ohio program, we have taken tremendous strides in getting older Ohioans to begin thinking earlier about the potential long-term care needs for themselves and their families.

Care Choice Ohio's message is relatively simple. The message is that long-term care for older Ohioans is a subject that will touch us all to some degree.

For older consumers, the program is a short cut to long-term care information and planning. And for the children of seniors, Care Choice Ohio can help open doors to solutions for families who are faced with having the difficulty of long-term decisions.

The Ohio Department of Aging is proud of the enormous growth in our programs and services. However, we cherish events in which the achievements of senior citizens can be illustrated for the world to see.

The department works hard to highlight the many outstanding accomplishments of our State's older population. During May, the State's spotlight will again focus on seniors as we celebrate Older Americans Month and Senior Citizens Day here in Ohio.

In conjunction with this celebration, the department each year recognizes a few seniors for their extraordinary efforts by inducting them into the Ohio Senior Citizens Hall of Fame. This year is no exception. Ohio will be inducting 17 new members into the Ohio Senior Citizens Hall of Fame. I am pleased that Ohio's elder statesman, Senator John Glenn, will be among them. [Applause.]

Over the past 7 years, working with the Area Agencies on Aging, the PASSPORT administrative agencies, service providers, and others in the aging network, the Ohio Department of Aging has changed the shape of long-term care in Ohio.

Together, we have improved the quality of elder care today and made great strides in meeting the challenges of tomorrow.

Thank you. [Applause.]

[The prepared statement of Mr. Ottiger follows:]

Field Hearing of the
United States Senate Special Committee on Aging

Elder Care Today and Tomorrow

Monday, April 27, 1998
The Ohio State University Fawcett Center
9:30 AM - 12:00 Noon

**REMARKS FROM THE OHIO DEPARTMENT OF AGING'S
LEGISLATIVE LIAISON, MATT OTTIGER**

On behalf of the Ohio Department of Aging and its Director, Judith Y. Brachman, I would like to thank Senator John Glenn for holding this field hearing of the U. S. Senate Special Committee on Aging here in the Buckeye State.

It is a pleasure and honor for me, as the Department's Legislative Liaison and an Ohio State graduate, to participate in this morning's hearing with such a distinguished list of leaders - leaders who have made elder care what it is today and who are working to improve it for tomorrow.

The Ohio Department of Aging serves and represents nearly 2 million Ohioans age 60 and older and acts as their chief advocate within state government. We strive to improve the quality of life for older Ohioans, helping seniors live active, healthy and independent lives, and promote positive attitudes toward aging and older people.

As most of you are aware, a major emphasis of the Voinovich Administration and the Ohio Department of Aging has been placed on keeping frail, low-income older Ohioans living as independently as possible - for as long as possible - in the domain of overwhelming popular choice - their own homes.

We have been extremely successful in this endeavor - thanks to the support of Congress, Ohio's General Assembly, and in partnership with the aging network.

Our success has come mainly through the implementation of Governor Voinovich's Community Care Choices initiative. The initiative, which is the foundation of a whole new era for long-term care, contains three programs: PASSPORT, Residential State Supplement and Care Choice Ohio.

According to Governor Voinovich, "Home is where the heart is, and home is at the heart of Ohio's PASSPORT program." Ohio's popular PASSPORT program provides long-term care services where the overwhelming majority of older Ohioans want them, in their own homes.

PASSPORT offers in-home services to Medicaid-eligible older Ohioans whose impairments are severe enough to otherwise require care in a nursing home.

If an older person is found eligible for PASSPORT, a case manager designs a personal care plan to meet the person's needs at home, by arranging the most appropriate mix of in-home services to supplement care provided by family members and friends.

These services can include adult day care, transportation to medical appointments, case management, medical equipment, home modifications, home-delivered meals, homemaker services, physical therapy, and in-home personal care.

When Governor Voinovich took office seven years ago, 2,700 older Ohioans received PASSPORT services. This year, we hope to serve over 22,000 - nearly nine times the number served at the beginning of this decade. And by 2003, with federal approval of our waiver renewal application, we will serve nearly 25,000 individuals on the program.

We are proud of the enormous growth in PASSPORT and our other home and community-based programs and services for seniors. And we are equally proud of the measures we have put in place to assure that:

- 1.) Our programs are serving a valued purpose;
- 2.) Our programs are serving those they are designed and targeted to service;
- 3.) Our clients - our customers - are satisfied with those services;
- 4.) Ohio's taxpayers, also our customers, are getting the most efficient, most effective services the State can offer its older population;
- 5.) Our programs are continually fine-tuned for improvement that we may better serve all Ohioans.

PASSPORT offers a fine example of how we have been able to better serve Ohio's taxpayers while, at the same time, better serving older Ohioans.

Streamlined management and improved administration have saved over \$15 million over the past few years - money we have been able to put back, or reinvest, into the program to serve even more clients each year.

We also saved \$2.1 million (in just six months) in the PASSPORT program thanks to a suggestion made by a quality improvement team composed of state and regional PASSPORT staff. The team suggested ways to streamline the process for assessing older Ohioans' needs as they consider long-term care services.

And we are improving management processes through performance-based budgeting. A portion of the administrative funds allocated to Ohio's 13 PASSPORT administrative agencies (PAAs) is now tied to how well they perform and meet certain standards. The new system acts as an incentive to control administrative expenses, and the regional agencies have more flexibility to make decisions.

Complimenting improved program management, we have undertaken other valuable steps to assure that PASSPORT is responsive to the needs of its clients. First and foremost, the Department utilized an annual client satisfaction survey to ensure that our customers are satisfied with PASSPORT services.

Our 1996 and 1997 PASSPORT client satisfaction surveys have produced very heartening results. We were very proud of the 88 percent satisfaction rate in 1996, but we did not rest on our laurels. We were able to boost the client satisfaction rate to 92 percent in 1997.

Our goal is to keep learning from our clients and to continue refining our services until the satisfaction rate is 100 percent.

But, what has the Department learned from the two client satisfaction surveys? In short, a lot.

Based on the results from the surveys, the Department found that the average PASSPORT client is 78.6 years old and three out of four clients are female. Interestingly, nearly 40 percent of the clients felt they would be in nursing homes if not for the program.

The survey results also identified personal care (received by 87% of respondents), homemaker services (85%), home-delivered meals (47%), day care (13%), and respite (10%) as the most popular services received by PASSPORT clients.

While ODA's PASSPORT surveys are mainly interested in client satisfaction, our evaluation of the program also provided us with valuable information on how we are doing fiscally with the program.

According to our 1997 survey, clients received PASSPORT services for an average of 18 months (per client) at an annual cost of \$668 per month/per client.

At this rate, we are serving PASSPORT clients at about 40 percent of the cost of nursing home care, which is significantly less than the program requirement that care be provided at no more than 60 percent of the cost of nursing home care.

In addition, our study and monitoring of PASSPORT effectiveness has been enhanced by Scripps Gerontology Center at Miami University (OH), which last summer released some interesting research that noted a few trends in long-term care in Ohio.

That research, "A Study of Home Care and Nursing Home Patterns in Ohio," indicated that our efforts to expand home and community-based care options have made a difference for Ohio's seniors and played a considerable role in diverting older Ohioans from nursing homes.

The study found that, at a time of rapidly aging population, the occupancy rate of nursing home beds in Ohio shrank from 91.9 percent in 1992 to 88.1 percent in 1995.

In addition to PASSPORT's impact on changing the culture of long-term care, two other components of the Community Care Choice initiative have made a difference for the State's senior citizens.

Through the Residential State Supplement (RSS) program, the Ohio Department of Aging has been able to triple the number of older and disabled persons able to live fairly independently in home-like, group settings. RSS was serving fewer than 1,000 persons when we took over the program nearly four years ago. Today, we are serving well over 3,000 annually.

Additionally, thanks to the Care Choice Ohio program, initiated by Governor Voinovich in 1996, we have taken tremendous strides in getting Ohioans to begin thinking earlier about the potential long-term needs for themselves and their families.

Care Choice Ohio offers free in-home consultations to Ohioans by personnel who are well-trained to present the wide variety of long-term care service options available.

Care Choice Ohio's message is relatively simple. The message is that long-term care for older Ohioans is a subject that will touch nearly everyone in this State to some degree.

For older consumers, the program is a short cut to long-term care information and planning. And for the children of seniors, Care Choice Ohio can help open doors to solutions for families who are faced with having to make difficult long-term care decisions.

The Ohio Department of Aging is proud of the enormous growth in our programs and services. However, the Department cherishes events, like this, in which the achievements of senior citizens can be illustrated for the world to see.

From the Director's monthly television program, "Finer with Age," to the Department's quarterly magazine, *Ohio's Heritage*, the Department works hard to highlight the many outstanding accomplishments of our state's older population.

During May, the State's spotlight on seniors will come into greater focus as we celebrate Older Americans Month and Senior Citizens Day in Ohio.

In conjunction with this celebration, the Department each year recognizes a few seniors for their extraordinary efforts by inducting them into the Ohio Seniors Citizens Hall of Fame.

Over the past seven years, working with the Area Agencies on Aging, the PASSPORT administrative agencies, service providers, and others in the aging network, the Ohio Department of Aging has changed the shape of long-term care in Ohio.

Together, we have improved the quality of elder care today and made great strides in meeting the challenges of tomorrow.

In closing, I would like to express the Department's appreciation to the Ohio State University for hosting this event and to Senator Glenn and all of this morning's panelists for their commitment and dedication to Ohio's senior citizens. Thank you.

Senator GLENN. I have a list of questions here. We will submit those to you and ask that you respond, if you could. We have about a dozen questions here, as I do for Martin also, if he would respond to these also. We will move right along here.

Our next witness this morning is Cindy Farson, executive director of Central Ohio Area Agency on Aging here in Columbus. The agency administers 20 million of senior services annually. The programs include PASSPORT and Care Choice Ohio, as Mr. Ottiger has just described, the Older Americans Act, Social Services Block Grant funds, Franklin County Senior Options, the Volunteer Guardianship Program, the Congregate Housing Services Program, and the Robert Wood Johnson Client Choice demonstration. You are not without enough things to do, Cindy. That is for sure.

Cindy has been a great help to me and my staff over the years. It is a special pleasure to have you with us today.

Cindy had a bad accident just before Christmas while she was on a trip abroad and is still recovering from it, still walking with a walker. Cindy, I will leave it up to you, if you want to struggle up to the podium, fine; if not, speak from right there where you are.

STATEMENT OF CINDY FARSON, DIRECTOR, CENTRAL OHIO AREA AGENCY ON AGING

Ms. FARSON. Thank you. I think I will just sit. I have a new appreciation for community-based services now. [Laughter.]

Senator Glenn, our organization is pleased to have the opportunity to discuss the important issue of home and community-based services. Your initiative to hold a field hearing of the Senate Special Committee on Aging in Columbus is very much appreciated.

A recent study by AARP notes that the major funding sources for home services include Medicare home health benefits; Medicaid waivers; the Older Americans Act; the Social Services Block Grant and State general revenue funded programs. It describes the enormous variations in the amount of State general revenue funds allocated to home and community-based services for older Americans and the resulting differences in services available in each State. What is clear in this report is the widespread recognition of the growing need for these services and the willingness of States and local communities to go beyond existing Federal programs that provide home care services.

At the local level, we try to coordinate Federal, State, and local resources to develop programs that work for individuals and families in central Ohio. One program I would like to comment on is the Federal Congregate Housing Services Program. This HUD-funded program provides services in senior congregate housing facilities in a limited number of communities. In 1993, we were fortunate to receive grants to provide services in four Columbus facilities. With a 50-50 match requirement, participation is difficult. However, Franklin County had recently passed a senior services levy to provide additional community services to seniors, and funds were available for match purposes. We are fortunate that the Franklin County commissioners have continued to support the program.

The CHSP currently operates in one metropolitan housing facility and in three facilities funded by HUD 202 or 232 programs. The program now serves 110 residents in those facilities. It provides funding for service coordination and services. The nice thing about the program is the ability to have on-site service coordination, and that means the same social worker is available in the building on a regular basis. Many people who need assistance and are reluctant to seek help find it easier to ask a familiar face. We use a clustered service model in all of the facilities. Instead of having different agencies serve clients at scheduled times, we have one agency assign staff members to a building and they are available all day. The client then receives help when they need it instead of in one-hour blocks of time. For example, a client with a chronic illness who doesn't feel well enough to get a scheduled bath at 9:00 a.m. can delay the bath until a later time. Others can be reminded to take medications throughout the day or receive help with unexpected chores. It also provides a consistent staff of caregivers to clients which is always a factor in home care satisfaction.

The concept of clustered services has been so successful that we are now using it with our Medicaid-funded PASSPORT clients who live in these buildings. The CHSP has also helped to establish a congregate meal program in two of the facilities, and that is a benefit to everyone that lives in the building.

I wanted to focus on one of our housing programs because the need to allow people to stay in housing facilities where they have often lived for years is so important. This is true from a human standpoint and a public policy perspective. The lack of a safe living environment or a caregiver prevents people from using community-based services and results in premature nursing home placement. Both can be provided to those living in senior housing facilities given programs like CHSP. Funds should also be available for facilities to update structures to accommodate frail residents. In many States, including Ohio, assisted living is not a Medicaid-funded option. Developing comprehensive programs in senior housing facilities can be the next best thing. HUD needs to step up coordination with the Administration on Aging so that long-term residents of HUD facilities can age in place using community-based programs.

Like all aging advocates, we are concerned about the severe proposed cuts to senior housing programs in the Federal budget. We believe a closer look should be given to the importance of providing services in Federal housing projects. Programs like CHSP are difficult to administer because of the extreme match requirements and the rules on client co-pay that don't always blend easily with local and State co-pay services. With some changes, the program could be very effective and allow impaired residents of HUD facilities to stay there.

Another issue that has recently been of great concern to our case managers is the impact they are beginning to see from Medicare managed care products. Often we come across clients that have signed up for a managed care product without understanding the implications. Case managers have been stunned by the limited home care visits allowed by some plans. It has been necessary to help some clients get back on Medicare fee-for-service to get the

care that they need. We hope that the limits placed on home services by managed care plans do not shift the burden to State and local resources that have been developed to expand available home care. We believe consumers should be able to compare insurance plans by having access to average utilization data for services like home care.

It is understandable that Congress would like to see more people enrolled in efficient Medicare managed care plans that can save seniors money; but the new Medicare choice products will be confusing to many, and people need to understand the implications of not being able to return to the fee-for-service system. We think HCFA must offer good consumer education programs and opportunities to get advice that is not tied to product marketing. Also an independent appeal process would go a long way in giving folks confidence to try the managed care products.

Finally, I would like to encourage the long delayed reauthorization of the Older Americans Act. This legislation, which acts as a base for the aging network in Ohio, also needs more than the flat funding recommended in the 1999 budget. National aging groups are recommending an 8 percent increase to keep up with the need for community-based services, and we strongly support that recommendation.

Again, our thanks for the opportunity to bring these issues forward and for your ongoing support of older Americans through the work of the Senate Special Committee on Aging.

Thank you. [Applause.]

[The prepared statement of Ms. Farson follows:]

"ELDERCARE TODAY AND TOMORROW"

THE SENATE SPECIAL COMMITTEE ON AGING

FIELD HEARING CHAIRED BY SENATOR JOHN GLENN

THE OHIO STATE UNIVERSITY - COLUMBUS OHIO

CINDY FARSON, EXECUTIVE DIRECTOR

CENTRAL OHIO AREA AGENCY ON AGING

Senator Glenn and Members of the Committee:

My name is Cindy Farson and I am the Director of the Central Ohio Area Agency on Aging and the immediate past president of the National Association of Area Agencies on Aging. Our organization is so pleased to have the opportunity to discuss the important issue of home and community based services. Your initiative to hold a field hearing of the Senate Special Committee on Aging in Columbus is appreciated.

A recent study by AARP notes that the major funding sources for home care services include Medicare home health benefits; Medicaid home and community based waivers, personal care services; the Older Americans Act; the Social Services Block Grant and state general revenue funded programs. It describes the enormous variations in the amount of state general revenue funds allocated to home and community based services for Older Americans and the resulting differences in services available in each state. What is clear in this report is the widespread recognition of the growing need for these services and the willingness of states and local communities to go beyond existing federal programs that provide home care services.

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senior services levy to provide additional community services to seniors and funds were available for match purposes. We are fortunate that the Franklin County Commissioners have continued support of the program.

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Like all aging advocates, we are concerned about the proposed cuts to senior housing programs in the federal budget. We believe a closer look should be given to the importance of providing services in federal housing projects. Programs like CHSP are difficult to administer because of the extreme match requirement and inflexible rules on client co-pay that do not blend easily with local and state co-pay services. With some changes, the program could be very effective and allow impaired residents of HUD facilities to age in place.

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the limits placed on home services by managed care plans do not shift the burden to state and local resources that have been developed to expand available home care. We believe consumers should be able to compare insurance plans by having access to average utilization data for services like home care.

It is understandable that Congress would like to see more people enrolled in efficient Medicare managed care plans. But the new Medicare choice products will be confusing to many and people need to understand the implications of not being able to return to the fee for service system. We think HCFA must offer good consumer education programs and opportunities to get advice that is not tied to product marketing. Also an independent appeal process would go a long way in giving folks confidence to try the managed care products.

Finally, I would like to encourage the long delayed reauthorization of the Older Americans Act. This legislation, which acts as a base for the aging network in Ohio, also needs more than the flat funding recommended in the 1999 budget. National aging groups are recommending an 8% increase to keep up with the need for community based services and we strongly support that recommendation.

Again, our thanks for the opportunity to bring these issues forward and for your ongoing support of older Americans through the work of the Senate Special Committee on Aging.

Senator GLENN. Thank you very much, and we will be submitting additional questions, as I indicated, and we hope you would all respond promptly so that we can have that as part of our committee record.

One major oversight I had this morning, and I will try to correct that right now. I should have introduced Annie. [Laughter.]

You can't leave yet.

I forgot to introduce her. I have been accused of marrying above myself, and I am the first to admit it. Annie. [Applause.]

Kathy Smith is doing the stenographic record here this morning, and I didn't get her name before, and I wanted to make sure we noted her presence here this morning. She is making the record that we will use back in Washington, the record that will be printed.

I think it has been interesting and informative this morning. I wish we did have much more time to discuss these issues. But just bringing them to everyone's attention repeatedly, repeatedly, repeatedly, whether on the Aging Committee or a field hearing or whatever, it is part of our job in moving these things along and hoping the work gets done. It is not just a matter of throwing money at problems. It is a matter of interest in it and making people aware of what the problems are, whether it is in aging research or geriatric training or home and community-based care, all of which we have covered various parts of here this morning.

I want to thank Bob Butler particularly for coming all the way from New York to participate in today's hearing. Bob, we really appreciate it.

Dr. BUTLER. My pleasure.

Senator GLENN. A very special thanks to Dr. Bernadine Healy and Greg Moody of her staff, Dr. Bonnie Kantor and all the people here at Ohio State, who have been so helpful to us in making possible this field hearing of the Senate Special Committee on Aging.

I also wanted to especially recognize Diane Lifsey, whom you have seen me consulting with back here behind me. Diane has been with me for years in Washington. [Laughter.]

For 23, 24 years, whatever it is, and she has been on the Aging Committee staff. We worked together back and forth with Dr. Butler, and she was instrumental in setting up our previous hearings in Ohio. And so we particularly appreciate her efforts and her expertise through all these years.

In particular, we would ask that the comment sheets that you were given earlier, those will be collected in the back of the auditorium as you leave. We welcome those. We will go through them. We want to make sure that any ideas you have are included in our committee record of this hearing.

Senator GLENN. So thank you all for coming, and we look forward to getting your comments. We will get the hearing record printed so that it will be available for all of you who might want a copy for future reference. Thank you all for being here today. Thank you very much. [Applause.]

The hearing is adjourned.

[Whereupon, at 12:30 p.m., the committee was adjourned.]

APPENDIX

RESPONSES TO QUESTIONS

OHIO DEPARTMENT OF AGING RESPONSES TO QUESTIONS

Question. Is PASSPORT in place statewide now?

Answer. Yes, PASSPORT has been in place statewide since 1990. There are thirteen PASSPORT Administrative Agencies that administer the PASSPORT program throughout the state.

Question. When individuals sign on the PASSPORT program, what is the transition period like for them? How long is the enrollment period? What kind of assistance are they provided in securing the appropriate mix of services they need?

Answer. Once it is determined that all eligibility criteria is met, then the individual can be enrolled immediately after an assessment has been completed. However, services may not begin until a few days later when a provider can staff the client. The average waiting period, based on a weekly PASSPORT activity report has been 13 days since the middle of February 1998.

An assessment is conducted which consists of a face-to-face evaluation to collect in-depth information about the individual's current situation and ability to function. The assessment identifies the services currently provided by informal and formal supports and the need for additional services.

A care plan is done in collaboration with the individual that addresses the individual's long-term care needs in consideration of available community resources and existing formal and informal support systems.

Question. Are the participants in the PASSPORT program able to keep their own doctors? As Ms. Schmitt pointed out in her testimony, the inability of seniors to retain their own physicians can seriously affect their willingness to participate in coordinated care programs.

Answer. Yes, participants must have the approval of their attending physician for the Service Plan.

Question. What types of respite programs for caregivers are included in the PASSPORT program?

Answer. Personal Care Services may be provided for extended hours in order to provide the client's informal caregiver with respite. There is also Adult Day Care Service which provides informal caregivers with respite.

Question. How do you monitor the quality of care provided to PASSPORT participants?

Answer. The Ohio Department of Aging has an annual monitoring process that evaluates all areas of the program. The PASSPORT Administrative Agency is monitored through regular reporting. The PASSPORT Administrative Agencies also have a Quality Assurance process to evaluate the service providers and the programs.

Question. Are most PASSPORT recipients dually eligible for both Medicare and Medicaid? Does the State of Ohio have particular efforts in place to ensure that Medicare, rather than Medicaid, pays for home health services whenever possible for beneficiaries eligible for both programs?

Answer. Since the program serves people over the age of 60, most clients are on both Medicare and Medicaid. Program rules require, that Medicaid is the payor of last resort. The Ohio Department of Aging verifies this during the annual monitoring visit.

Question. How is it decided that the PASSPORT program is no longer adequate for an elder's needs, and how are they moved into a higher level of care?

Answer. The purpose of the PASSPORT program is to provide eligible individuals in need of nursing facility placement with an in-home alternative. When those needs can no longer be safely met with in-home alternatives and/or the cost of the services exceed a cost capitation, then other long term care options must be considered.

Question. Do you have any collaboration or information exchange with other states that are implementing Medicaid home and community-based care waiver programs?

Answer. Yes. The Ohio Department of Aging is a member of the National Association of State Units on Aging (NASUA). As a NASUA member, the Department benefits greatly from the information exchange among other member state units on aging. In addition, the Department gains valuable information on waiver programs as a member of both the American Society on Aging and the Gerontological Society of America. Informally, the Department also networks with other state waiver agencies and participate in an annual home and community-based care waiver conference.

Question. Is the State of Ohio looking at other ways to reduce spending for long-term care?

Answer. Yes, the Department is looking at other ways to reduce spending for long-term care by expanding other less costly in-home services to delay or prevent nursing facility placement. The Department also collects and analyzes data on long-term expenditures.

Additionally, as mentioned in my testimony, the Department has initiated the Care Choice Ohio program to educate Ohio consumers about their future long-term care needs. Care Choice Ohio offers Ohioans with an opportunity to be better informed about long-term care services before they are needed and to be better prepared to assume personal responsibility for the costs.

By fostering an explanation of future long-term care needs, Care Choice Ohio helps to preserve Ohioans' consumer choice. More importantly though, by promoting the better use and planning of personal resources, Care Choice Ohio can help to conserve State and Federal Medicaid dollars for those most in need.

Question. Is Ohio requiring or encouraging elderly Medicaid recipients to enroll in managed care plans?

Answer. No, Ohio does not require that Medicaid recipients enroll in managed care plans.

BONNIE S. KANTOR, SC.D—RESPONSE TO QUESTIONS

Question. To what extent do you work with other medical schools to share the positive work you have done with geriatrics and home care initiatives?

Answer. We work collaboratively with other medical schools to disseminate our current initiatives in geriatrics education and home-based medicine in a number of ways. First, the Offices of Geriatric Medicine and Gerontology in the seven medical schools in Ohio work closely together through the Consortium of Ohio Geriatric Academic Programs (COGAP) for this exact purpose. The Directors of the Offices meet quarterly to develop joint initiatives, share curriculum, and help each other implement new initiatives to further enrich our students' experiences. In this way, the monies allocated to geriatric education by the Ohio Legislature are used in the most cost-effective manner. We work closely to avoid duplication of effort and in general, the synergistic affect is impressive. In addition, we work closely with the other nine medical schools nationwide who are participating in the Hartford Foundation initiative, The Expansion of Home Care Into Academic Medicine. The principal investigators from each school have been most generous in sharing programmatic materials, ideas, and protocols. Currently, the group is working to develop a unified evaluation instrument to assess each of our programs. Wherever possible, we are also attempting to develop a core curriculum. Finally, through The Ohio State University's web site, we receive many inquiries concerning our community-based programming and especially our home care initiatives. It is with pleasure that we disseminate the information in this manner.

Question. What are the major barriers to an interdisciplinary approach to care? Are they the time commitment of providers? Financial? Regulatory? Start-up costs?

Answer. There are many barriers to providing an interdisciplinary approach to care. As a result, all of our efforts here at The Ohio State University focus instead on the transdisciplinary approach to caring for older adults. Our experience indicates that physicians and other health care providers tend not to practice in ways that they have not been taught. Therefore, we hope to influence the practice environment of the future through our educational efforts.

Interdisciplinary is what professionals mean when they talk about working collaboratively as a team which has a common purpose, separate skills, and a system of communications. Multi disciplinary, on the other hand means that more than one profession is involved in the work, but the definition says nothing about the process and whether or not it is interactive.

Transdisciplinary implies more than a sharing of ideas and plans across disciplinary boundaries. In a transdisciplinary team, each member still has a specialized body of information but members also share a common "supra-specialty" or areas of knowledge. In the care of older adults, this common "supra-specialty" is clinical gerontology. The transdisciplinary approach cuts across disciplines and then provides for the syntheses and integration of methods and findings. This is an ideal methodology for the care of older adults because of the complexity of issues involved and the varieties of needs expressed. This holistic and collaborative process provides for optimal understanding of the clinical needs of older clients, and can result in a new or modified approach to care. It works because clinical team members share a common understanding of the special needs of frail older adults.

Gerontology and aging are uniquely appropriate for transdisciplinary research, education, and practice. As research in clinical practice in gerontology become more complex and holistic, the transdisciplinary model leads to a team approach to treatment and care. In addition to working together, a transdisciplinary group provides opportunities for cross-fertilization of ideas and the development of new approaches to problem solving.

Question. I read that your office is offering a "Specialization in Aging" for all OSU students, no matter what their field. What is the major purpose of this program? What has been the response to it?

Answer. The Graduate Interdisciplinary Specialization (GIS) In Aging provides graduate students throughout The Ohio State University with the opportunity to expand their knowledge, skills, and attitudes to meet the needs of our nation's growing older adult population. This Specialization emphasizes a comprehensive basic knowledge in geriatrics and gerontology, team training, and service delivery in community-based and home settings. The program is housed in the Office of Geriatrics and Gerontology and is coordinated by a broad-based committee on graduate faculty representing most colleagues throughout campus.

The GIS in Aging includes both required and elective course work. The required core curriculum, an integrated series of four courses, focuses on basic components of clinical gerontology shared by many disciplines including essential theories of aging; issues related to diversity; public policy; the opportunity to apply these skills and concepts throughout the continuum; and health promotion and disease prevention. This core curriculum in integrated with over seventy required and elective courses in aging offered throughout campus. Designed in this way, the core curriculum enhances the discipline specific instruction and training that each unit provides for graduate level students. Through the Specialization in Aging, students are learning new ways to approach the burden to chronic illness; health care delivery in community-based and team settings; and the practical applicability of research, education, and training in geriatrics and gerontology.

Students who enroll in the program need to complete at least twenty-one hours of graduate course work in aging including nine credit hours from the core curriculum. The successful completion of the Specialization is noted on the student's transcript. The response to the Specialization has been overwhelming. We are currently working with close to seventy graduate students' from a wide variety of colleges and disciplines. In addition, the Specialization has served to attract incoming graduate students. Finally, in response to this demand, faculty are developing new courses that will further enrich our students experiences. For example, a new course in elder law will be offered during the 1998-1999 academic year as will an additional course on death and dying. Currently, we are developing plans to expand this curricular option to all professional students throughout campus as well.

TriHEALTH,
May 13, 1998.

Senator GLENN,
Senator GRASSLEY,
Senator BREAUX,
Hart Building, Washington, DC.

Dear SENATORS: Thank you so much for the opportunity to share the challenges and successes of TriHealth SeniorLink, (PACE) at the Senate Special Committee on Aging's field hearing "Elder Care Today and Tomorrow" in Columbus, OH.

Enclosed you will find my responses to your additional questions pertaining to TriHealth SeniorLink and the PACE model of care. I will be happy to respond to any further questions from you or your committee members.

I enjoyed participating in the field hearing and offer my assistance in any future endeavors.

Sincerely,

CONNIE M. SCHMITT, MSW,
Director.

Question. Do you have any insight into how the provider community views the PACE program? Is there resistance among physicians to refer to TriHealth SeniorLink?

Answer. The long term care provider community has been very receptive to the PACE model of care. It is viewed as a true alternative to nursing home placement that enables many of their clients to continue to live at home when care needs exceed the abilities or limitations of the provider. PACE is a concept that has taken providers awhile to grasp because of the magnitude of services provided through this model. Providers express frustration with the financial eligibility criteria for TriHealth SeniorLink during the pre-PACE phase, operating under Medicaid capitation only. The acquisition of Medicare and Medicaid waiver status would provide easier movement from many community-based service programs into TriHealth SeniorLink.

The medical community is more skeptical about the PACE model of care. Initial physician response within the TriHealth System was mixed, with many physicians opposing the creation of another "managed care" program for their patients. Some physicians thought it was ludicrous to try to manage the frail elderly population and do it successfully. Although, initially, physicians were concerned about losing their patients to TriHealth SeniorLink, they have realized that the eligible patients are the ones who consume the larger portions of physician time with the multiple problems they experience. From the beginning, the geriatricians in the community embraced the PACE model as an excellent opportunity to manage the ever changing needs of the aging population in a holistic manner. Rather than resistance from the physicians in referring, there is more resistance on the part of the older adult to give up their physician with whom they have established a long term relationship.

Question. I am aware that high staff turnover is a tremendous problem for facilities and programs which serve seniors. Has this been the experience for the Cincinnati PACE site? How do you recruit and train employees? Do you have particular programs in place to try to retain employees.

Answer. In the first twelve months that TriHealth SeniorLink was serving participants, there was turnover in three professional staff positions. The other six positions have been stable throughout. The PACE model of care is very non-traditional in its delivery which is a difficult adjustment for many established professionals. PACE requires an "out of the box" approach to service delivery that is uncomfortable for many professionals.

Employees are initially recruited through the TriHealth system, and if no qualified candidates are found, open positions are advertised throughout the community via newspaper, professional journals, etc. Employees participate in an extensive training program that includes corporate orientation, TriHealth SeniorLink orientation, and job specific orientation/training over a 3-5 day period. Additionally, professional staff participate in a 3 day intensive training on the PACE model at On Lock, Inc., in San Francisco.

TriHealth SeniorLink views employees as our most valuable resource and strives to create an environment conducive to long term employment. A combination of close supervision, continuing educational opportunities, service recognition and team development promotes professional growth and facilitates ownership of each discipline's contribution to the program. This concept has worked well in TriHealth's existing adult day care programs which have experienced very little turnover over the past ten years for reasons other than moving out of the Cincinnati area.

COMMENTS FOR HEARING RECORD—ELDERCARE TODAY AND TOMORROW

Thank you for drawing attention to the coming crisis in the increase of elderly longevity. As a staff member of a major home health care agency in central Ohio, I would hope for greater collaboration with OSU in providing opportunities for medical students to interact in service delivery with large numbers of frail, low-income, over 75, and many minority clients. Our meal programs which serves 3500 people daily would provide good clinical settings. In the area of nutrition education, much more needs to be done in the expansions of research, dietetic consultation, medical nutrition therapy and creative development of community support systems for elderly individuals outliving their personal support systems of family and friends. There

is always difficulty in getting funding for the under 60 population who have need of home care services.

Patricia A. Durbin, *Columbus, OH.*

What are other health care programs, schools, etc. doing to education our children and future providers about aging?

All areas of health care—hospitals, clinics—need more sensitization to aging with programs that teach them about the needs of our aging populations, how to help them and address their needs. Our schools for the future need to teach about aging successfully and to respect and help their seniors, learn from them. Academic health care programs besides medicine need more practical emphasis on helping with the age.

Shirley Fields McCoy, *Orient, OH.*

Alternative medicine was mentioned by Senator Glenn and Dr. Healy but not much talk about vitamin and mineral supplements and herbs. Will more study be made to recommend these to seniors?

Robert Donaldson, *Columbus, OH.*

In attending the Special Committee on Aging it's apparent that the need for funding and improvements are necessary in the area of aging/elderly care. As a dietetic intern, I am also aware from experience, the importance of medical nutrition therapy. It's a huge need in this area as well as other areas of preventive medicine. We aren't getting any younger and are only living longer. Nutrition is an integral part of this. This awareness will drastically cut costs by decreasing hospital stays and educating the public.

Julie Greenwald, *Columbus, OH.*

The speakers at this hearing pointed out the need for increased services to the elderly to improve overall health and quality of life. As a dietetic intern, I have worked with the elderly in the acute setting, long-term care and home care. While nutrition is not a cure for disease, it can promote recovery at a faster rate as well as serve as a preventative factor. Improving the nutritional status of older adults can improve overall health, speed recovery and improve quality of life. For this reason medical nutrition therapy is a necessary service to promote improved nutrition. Reimbursement for MNT will allow older adults to receive these beneficial nutrition services. In addition, MNT can reduce costs in the long-run because of the focus on prevention and increased recovery.

Barbara Shaw, *Dublin, OH.*

This hearing was an informative and interesting review and preview of elder care today and tomorrow. Thanks for all participants/panelists.

More media publicity is essential to inform and educate the general public about these important issues/matters that affect all of us—as professionals, family members, caregivers, taxpayers, socially responsible citizens, consumers, etc. Thanks for today!

Drusanne Shaulis, MA, MPH, *Columbus, OH.*

Very informative. From the perspective of a younger person, I found the wide range of topics enlightening, particularly Dr. Kantor's and Dean Healy's information on the programs at OSU. But I especially enjoyed Dr. Butler's international perspective on aging. As Americans, sometimes we can be too geocentric, but the information given by Dr. Butler helped bring to light the issues of aging and geriatric medicine in countries all across the world. Thank you for holding this Senate hearing here in Ohio.

Trudi Powell, *Columbus, OH.*

How are we supposed to provide quality home care to the elderly when Medicare is dictating what is "quality" for a general population instead of an individual case?

Betsy Stuart, *Columbus, OH.*

A great panel of speakers with much expertise and visions to report to the Special Committee.

Jackie Emch, *Columbus, OH.*

Please press for the renewal of the Older Americans Act of 1965, which expired in 1995.

I am personally interested in research in decision making for/by older adult—Affect of M.D. decision, children's decision as compared to decision by older adult; how who makes lifestyle changes affects the older adult; where the religious community

fits into the decision making process. I am not thinking only of advance directives, but of nursing home placement, etc. My point of view is that the older adult benefits from making the decision, consulting with others, and adjusts better when the decision is his/her own.

Cathering Loveland, *Powell, OH.*

Thank you for the opportunity of being in attendance at this important hearing. I fully support the actions and look forward to doing what I can.

Brenda Hammond, *Columbus, OH.*

I enjoyed the hearing. It was highly informative. As one who has watched my own mother and the parents of my friends prematurely go into nursing homes and even die prematurely, I strongly support assisted living and home health care for older adults. I support increased funding for NIH and for all agencies involved in older adult care. (In addition to seeing the unfortunate aspect of aging for our parents, I am concerned for the future of my colleagues at Ohio State in elder years. There isn't a great surplus of money in their pensions!)

Sara Strong, *Columbus, OH.*

I agree with Cindy Farson's idea of having a service coordinator in the CHSP. I hope to see this program grow where the coordinator can help with reminding individuals of taking medicine, assisting with transportation, housekeeping and other needs. Transportation needs to be addressed for other than medical appointments.

G. Kern, *Lancaster, OH.*

Excellent. Glad it was factual. Senator Glenn did a good job asking probing questions. Liked Dr. Healy and Dr. Butler. Martin Janis is a wonderful man, a wonderful friend—active in veterans affairs as well as the aged.

Betty Thompson, *Columbus, OH.*

My concern regards funding for home-based health care, particularly within the managed care framework. It is difficult to provide adequate care with a six visit limit! Home-based care is a vital and growing need for the elderly in our country, but without some help financially, it is out-of-reach for most seniors.

Beverly Mellum, *Hilliard, OH.*

Please pass the reauthorization of the Older Americans Act this year. And, do so with a provision to allow cost sharing by clients.

Robert Horrocks, *Delaware, OH.*

We badly need more subsidized housing for elderly and disabled. In addition, we need to make eligibility for subsidy a little more generous. Subsidized housing for elderly and disabled should have on site social work to assure that the most needy residents do not miss becoming linked with needed services.

Professionals in the aging field, elderly and family members are very frustrated that nursing homes can receive Medicaid payment but not assisted living, facilities. Many people who can afford it live in assisted living facilities but poor elderly with the same health problems must live in nursing homes. It's a class difference. Assisted living facilities right now tend to have some "fancy" cosmetic elements. These are not needed—just good quality care.

Hollie Goldberg, *Columbus, OH.*

Connie Schmitt spoke about the problems facing the PACE program, particularly the shortage of home health aides. As the director of a home care company in Columbus for the past 9 years, I have seen a dramatic change in the availability of home health aides. Along with an increasing shortage of HHA's there has been an increase in the aged population who benefit from home care. I believe there needs to be a greater emphasis placed on the promotion of HHA's as a career. Along with this there needs to be easy access to training programs in career centers, 2 year colleges and possibly even high schools. Home Health Aides will continue to be in demand as long as the older population grows. We must promote this profession as a career, and not just as "job" until something better comes along.

After listening to Mr. Ottiger I was surprised by the fact that the current costs associated with the PASSPORT program are 40 percent of the cost of nursing home placement which is well below the required 60 percent. I wonder whether this is an appropriate area to be frugal. With more resources allowed to seniors or longer hours of service by home health aides or homemakers, we may better service this population and keep clients at home even longer than they currently are.

The average PASSPORT client receives 3 to 5 hours per week by an aide and 2 to 4 hours of work of a homemaker. Due to the short hours of care allowed for cli-

ents, HHA's very often choose not to take these cases because of the shorter hours. With the use of the entire 60 percent of allowed costs and possibly increase the number of hours given to PASSPORT clients might help with the problem of HHA shortage as well as keeping PASSPORT clients home longer.

Debra Cronin, *Worthington, OH.*

The panel lacked a very important representative, a home care administrator. This person could have spoken to the concerns of current and future issues for home care and the elderly. How can great strides be made for the elderly in their homes if home care professionals are excluded from programs/hearings of this type? Thank you for bringing this very important special field hearing to OH. Hopefully, this hearing will raise person's awareness of aging issues.

Kathleen Anderson, *Columbus, OH.*

No mention was made of the legal responsibility (or intrusion) into the care of the elderly in limiting or extending certain treatments in managed care programs and hospitals—and especially with respect to "heroic treatment" of incurable patients. Doctors are forced to make decisions based upon liability rather than practical treatment. This needs to be addressed and a definite policy established.

Roy Zimmerman, *Columbus, OH.*

As physicians are trained to care for the aging population, there is a need for them to spend time to focus especially on home care. Many times physicians order meds, therapies, etc. that people cannot manage at home. As an RN at a nonprofit social services agency I often see poor understanding, on the physicians part, of conditions in a patient's home—i.e. lack of support (mental, physical), patient's inability to read (and people often don't communicate this openly!), poor education or physical conditions and other key issues. Therapy/meds etc. can't work if it can't be done in the home. Doctors need to see an elderly person's whole picture!

Paula Sparkman, R.N., *Delaware, OH.*

Increased commitment must prevail to allow our elderly to remain in their homes—where cherished memories and love comforts them. All aspects of care needs requires support; physical, mental, psychosocial, etc. in addition for the caregivers of the elderly. Access is still a barrier to available services. Both from a professional and personal experience background, continued outreach and awareness building is desperately needed to bridge elderly in need of programs of service. Please continue to support and grow resources for the elderly population!

Melaina Grubich, RN, *Reynoldsburg, OH.*

What surprises me is that while the patient-centered, functional and holistic approach is new for MD's, nurses have long led the way in this very concept. I caution the medical community to remember as they come aboard, what in history has belonged to nursing and social work, that it will be as a team member on this interdisciplinary team approach. Let us, as nurses and social workers, help you, as MD's, to help others how to live and die with the diseases you diagnose (how to live between office visits).

Theresa E. Lennon, *Powell, OH.*

I would like to reiterate Dr. Butler's comments regarding a focus on team, quality and inclusion of patient and family in care of the elderly. Hospice is a prime example of providing supportive services in a holistic manner to these individuals in the end stages of their lives. We as a community of people need to continue efforts to support open, comfortable discussion about death and dying as a natural process that each individual will experience. End of life issues can be positively enhanced by a willingness to address, acknowledge and permit as opposed to a denial of death attitude. We must learn to "live with dying," rather than "die with living."

Jean O'Leary-Ryles, *Columbus, OH.*

Would like to emphasize Dr. Butler's comments which emphasized geriatric care throughout the continuum of life. This care should include specific rotations through hospice and palliative care. More research is needed in determining "those who will survive and those who will not." It is currently difficult to determine the appropriate level of care since current diagnostic indicators are imprecise.

I am concerned that the hospice was not present on the panel.

Michael S. Barrett, RN, BSN, *Columbus, OH.*

More emphasis is needed on the role of family caregivers and their importance. If caregivers are not involved in planning care, the plans will not be carried out. They are the "third leg of the stool" of community based care.

We need to help families modifying homes and to encourage builders to build homes using universal design. This approach allows older adults to age in place.

Margaret H. Teaford, Ph.D., *Columbus, OH.*

Education and training are essential to preparing health care providers to meet the diverse needs of the aging population. As mentioned by Dr. Health, a team approach is needed to address the health, social and psychological needs of the elderly. Toward this end, the need to provide funding to train all health care providers (nurses, dentists, pharmacists, optometrists, etc.) appears to be the key to the development of a team of health care providers to meet the health and social needs of the elderly.

Michael Strayers, DDS, MS, *Columbus, OH.*

I am a student intern completing an Associate Degree in Gerontology with 12 years experience in nursing home, hospital, and adult day care settings. I am glad to hear the emphasis on "required" gerontology education in medical schools. While I feel good about all that is being done to educate older adults in prevention and maintenance, I am very troubled about focus turned away from needed changes in long-term care to improve quality of life for the 5 percent in nursing homes.

Cindy Hubbard, *Columbus, OH.*

In support of Bonnie Kantor, Sc.D, and her talk on home and community-based care for the elderly, I'm the professional student representative for the OSU GIS (Graduate Interdisciplinary Specialization) in Aging degree. Also, I'm a junior in the College of Optometry. The GIS in Aging degree directed by Bonnie Kantor provides medical students in addition to other health professionals with the training to best deal with geriatric issues in medicine and social support. As a future doctor of optometry, a primary eye care giver readily available to the elderly in every community, I am prepared to work on a community-based interdisciplinary team to comprehensively care for the aged.

John E. Kaminski, *Columbus, OH.*



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