About the series

This is the first installment in Hospitals & Health Networks’ year-long series examining the many ways the nation’s 75 million baby boomers will impact the U.S. health care system as they age into retirement and senior citizenship. Caring for such a huge number of older patients is one issue; boomers also tend to be sicker than their parents’ generation, more active and used to having things done their way. And it’s not just patients — hospital leaders and staff will see a major exodus of boomers over the next decade or so. H&HN’s “The Boomer Challenge” series will include articles in the magazine and in our e-newsletter, H&HN Daily. Here’s what’s coming up in the magazine:

FEBRUARY
Meeting the challenge of chronic conditions

APRIL
The financial impact

JUNE
New care models

OCTOBER
Staffing and management

DECEMBER
Innovations in facilities and care design

BY PAUL BARR
The generation that has dominated American life for a half-century or more will have an enormous impact on health care as its members hit retirement age and beyond.

There they go again.

The roughly 75 million Americans who make up the baby boom generation are leading the country through yet another sweeping societal change. About 3 million baby boomers will hit retirement age every year for about the next 20, and will affect how caregivers and policymakers shape the health care system for decades to come.

“This is the most powerful force operating in our health system right now, this generational change,” says Jeff Goldsmith, president of Health Futures Inc., Charlottesville, Va. So far, the growth in the number of senior citizen boomers has been incremental, and its impact on health care has been overshadowed by federal reform and budget battles. “People aren’t paying much attention,” Goldsmith says.

That will change. As it has so often in the past, the boomer generation through its sheer size is likely to dominate the conversation once again. For hospitals, that conversation will take two tacks: how to address the many challenges of caring for a burgeoning cohort of elderly patients and how an aging health care workforce will impact the delivery system.

The U.S. Census Bureau categorizes baby boomers as individuals born between 1946 and 1964. The effects of having to care for such a large group will be felt in many areas already undergoing transformation. At the same time, boomers will leave the workforce in growing numbers, creating voids in clinical care and health care management.

By 2029, when the last round of boomers reaches retirement age, the number of Americans 65 or older will climb to more than 71 million, up from about 41 million in 2011, a 73 percent increase, according to Census Bureau estimates. A huge proportion will switch from commercial plans to Medicare, and that could tilt the balance either way in the success or failure of new care and reimbursement models being tested by the Medicare program, such as patient-centered medical homes and capitated, quality-linked reimbursement.

These new approaches will be applied to a generation with a reputation for indulging itself more than its parents did, which may be why boomers apparently are sicker than their parents were. Research published last March in *JAMA Internal Medicine* compared the health of both generations and found that despite a longer life expectancy, boomers had higher rates of hypertension, high cholesterol, diabetes and obesity.

The findings “support an increased likelihood for continued rising health care costs and a need for increased numbers of health professionals as baby boomers age,” the authors wrote. “Given the link between positive healthy lifestyles and subsequent health in this age group, the study demonstrates a clear need for policies that expand efforts at prevention and healthy lifestyle promotion in the baby boomer generation.”

One of the biggest stress points is sure to be the care of the chronically ill, already a struggle for the Medicare program, particularly regarding patients with multiple chronic conditions.

“The reality is most elderly people do not have one disease on their death certificates,” says Daniel Perry, president of the Alliance for Aging Research. Multiple conditions usually require care from more than one specialist in addition to a primary care physician, and the system currently is set up in a way that doesn’t encourage coordination and collaboration. “We don’t have a health care system that is well-designed to diagnose, assess, prevent, postpone and treat the multiple chronic conditions that accompany the aging process,” Perry says.

**Medicare and the pig in the python**

With waves of boomers getting older and incurring multiple chronic conditions, hospitals will take on more of the financial burden. “They drive hospital costs,” says Richard Birkel, senior vice president for the Center for Healthy Aging and director, Self-Management Alliance at the National Council on Aging, a nonprofit service and advocacy group. “People with multiple chronic conditions are much more likely to end up in the hospital, as a result of a fall, as a result of a cold, getting the flu. They are walking on a tightrope, and they are more vulnerable and, therefore, are much more expensive.”

Those issues likely will worsen without major systemic changes, especially as they relate to Medicare. Census Bureau estimates indicate the number of boomers entering retirement age each year will continue to grow at double-digit rates through 2021. That will push the proportion of Medicare-eligible Americans to 20 percent in 2029, from an estimated 13 percent in 2011. Meanwhile, the percentage of people ages 18 to 65 — and in a position to pay into Medicare — will drop to an estimated 57 percent by 2029 from 63 percent in 2011.

“With that many new people enrolling in Medicare, there are definitely challenges out there,” says the NCOA’s Howard Bedlin, who is vice president, public policy and advocacy. However, he adds, “I don’t think there’s any great emergency in the short term.”

Further down the line, the surge of boomer enrollees...
poses potential problems in funding Medicare. “With the demographic pig in the python, there are definitely long-term fiscal challenges,” Bedlin says.

Ominously for providers, many members of Congress view Medicare as a place to cut spending. "Basically, Medicare is the federal deficit problem," says Ian Morrison, an author, consultant and futurist. "If you look at different projections, big chunks of the deficit going forward are [caused by] health care and the vast majority of that is Medicare.”

Policymakers have bandied about different structural changes to the way Medicare is funded and paid for that would reduce costs, such as raising the eligibility age and requiring enrollees to contribute more.

Raising the retirement age would have given a short-term financial boost to the program, but in the long term may have less of an effect because of improvements in life expectancy.

The fastest growing part of the population is the group that is older than 85, Morrison says. "We are adding a lot of elderly each year, and they age one year at a time. But because of longevity increases, we’re also increasing more rapidly the proportion of people older than 85," he says.

Putting more of the responsibility for Medicare into the hands of the boomers also may not be helpful. Experts note that boomers as a group have less money than believed, meaning they’ll not be in a position to pay much toward Medicare as enrollees. Except for the wealthiest 10 percent of the generation, boomers’ financial resources shrank following the downturn in the economy. "It’s middle- and lower-income baby boomers who got absolutely decimated in the last decade,” Morrison says. “They lost their jobs, have been unemployed and spent down savings.”

The Pew Charitable Trusts estimates that those boomers born between 1946 and 1955 lost 28 percent of median net worth during the Great Recession as of 2010, while boomers born after that lost 25 percent of median net worth. That put the two groups’ median net worth at $173,000 and $111,000, respectively. At the same time, Fidelity Investments recently
A dearth of clinicians
Then there’s the question of health care staffing. Experts say the medical workforce is already too small to handle the aging baby boom population and the shortage will worsen with time. Not only will there be too few physicians to meet demand, the doctors now coming on board want more balance between work and personal time. The current generation of workaholic physicians is being replaced by Gen Xers and millennials who demand a 35-hour work week, Goldsmith says.

Providers with the skills to care for aging patients already are scarce. “There are not a lot of geriatric physicians — that’s something we’re trying to change,” says Lil Banchero, R.N., clinical director of patient access and director of the acute care for the elderly unit at Anne Arundel Medical Center in Annapolis, Md. Anne Arundel also is filling the gap with other clinicians, requiring its nurses and technicians to undergo basic geriatric training.

The Institute of Medicine forecasts a need for all types of caregivers, not just physicians and nurses, the NCOA’s Bedlin says. “A big shortfall is expected in direct care workers, particularly among home health aides and personal care aides,” he says. “We’re going to need about 1.6 million new positions by 2020 and we’re not on a path to meet that need by any stretch of the imagination.”

The effects of baby boomers’ retiring on management ranks has yet to be seen, says Deborah Bowen, president and CEO of the American College of Healthcare Executives. Bowen says the ACHE is trying to ensure that succession planning is taking place at an appropriate pace.

“I don’t think that all of a sudden somebody will flip a switch and there will be a mass exodus,” Bowen says.

These things should help
Despite much of the gloominess surrounding the aging of the boomer generation, there are reasons to be optimistic. The development of new care models combined with advances in technology could save the system billions even as baby boomers pour into Medicare and live longer. The Affordable Care Act is a major driver of innovation in improving care for older patients. The Medicare program is promoting and testing models that reward the value rather than volume of care delivered; if effective, they should make caring for the boomers more efficient and relieve stress on the system.

Projects backed by the Centers for Medicare & Medicaid Services through the ACA include efforts to test bundled payment for acute care and post-acute care stays, the use of community-based organizations to assist patients in the transition out of the hospital, the creation of accountable care organizations and the use of patient-centered medical homes.

An increasing number of providers also are implementing care models geared toward the health of the elderly. By the time boomers’ hitting retirement age reaches its crescendo, they may estimated that the total out-of-pocket, medical costs for a couple retiring in 2013 will be $220,000.

Teaming up on eldercare
Peace Health system’s Senior Health & Wellness Center—Barger Clinic in Eugene, Ore., uses an innovative, multidisciplinary approach to caring for seniors that could be adopted by others seeking to offset some of the challenges presented by the large number of baby boomers who will need geriatric care.

With elderly patients often seeing multiple specialists, aligning care can be difficult. The Barger Clinic’s approach brings together different caregivers, boosting the ability to coordinate care and improve outcomes.

“It was clear that geriatric care needs to be multidisciplinary,” says Margaret Njonjo, M.D., interim director of the clinic. Included in the model are caregivers qualified as geriatricians, nurse practitioners, social workers, pharmacists, dieticians and audiologists.

The approach, begun in 2001, has resulted in the use of fewer medications, lower inpatient charges and lower overall costs. According to a report on the effort published by Health & Human Services’ Agency for Healthcare Research and Quality.

More recently, Peace Health added an acute care for elders unit at Sacred Heart Medical Center, University District in Eugene, further supplementing the clinic’s work.

But with grant money gone, the clinic is hoping the movement to create medical homes in primary care environments will boost its similar effort with geriatric patients, Njonjo says.
have figured out a way to fund them.

A clinic in Oregon is finding success by providing team-based care — a model that could be effective with the relatively sicker baby boom generation — but it’s struggling to finance the model under a fee-for-service model [see sidebar, Page 25]. The clinic created the approach several years ago through a grant that since has run out. Now it has a more effective care model but no way to efficiently pay for overhead, such as for on-call nurses or pharmacists, says Margaret Njonjo, M.D., interim director of the Senior Health & Wellness Center–Barger Clinic, part of Peace Health Sacred Heart Medical Center. “It’s still all dependent on how many visits you can get the patients in for,” she says.

But Njonjo says adoption of patient-centered medical homes could drive interest in using the team-based approach. “I’m encouraged that if everybody adopts [the medical home] model, we’ll be able to show the value of the way we practice,” she says.

Innovation in facility design and mobile health also holds promise for improving the quality and effectiveness of care.

And in what could be the most hopeful news of all, health care may be on the cusp of major advancements in how it treats older patients based on a theory that it is aging itself that causes chronic ailments. Researchers are studying the relationship between aging and the development of chronic illnesses and trying to figure out how to delay the aging process, says Jim Kirkland, M.D., a geriatrician and director of the Robert and Arlene Kogod Center on Aging at Mayo Clinic.

Researchers also are achieving early successes in trying to increase the time that people can live relatively healthy, known as health spans, rather than simply prolonging life.

More immediately, specialized acute care for the elderly units in hospitals, such as the one unveiled last year at Anne Arundel, and resident facilities that offer a spectrum of medical assistance are becoming more common.

And the boomers themselves have shown an inclination to adopt new technology, and may be asked to do so for in-home care. “A lot of people strongly believe that baby boomers in particular are going to receive a lot of their care in the future over the Internet, over the phone,” Birkel says. “Health care is going to have a significant e-health component. It does already, but nothing like we’re going to see in the next five to 10 years, and I think baby boomers are going to be leaders in that area.”

Mobile health offers a way to replace or enhance office-based care, such as by monitoring medical status or telling patients to take a medication. Patients are getting more adept at such things as monitoring and checking their blood sugar levels.

In an ideal world, the new, more-efficient care models and the improvements in technology and care itself will increase health care’s supply capacity enough to offset the extra demand created by the boomers.

The alternative is not attractive. “Unless we make quantum improvements in clinical productivity, we’re not going to have anyone to take care of us,” Goldsmith says. “We’re going to have a tremendous crisis of access.”

The U.S. Census Bureau estimates that by 2029, when the last round of boomers reaches retirement age, the number of Americans 65 or older will climb to more than 71 million, up from about 41 million in 2011.
A Chronic Problem

Caring for chronically ill elderly patients represents one of the biggest challenges in health care, a challenge that’s likely to intensify as the baby boom generation grows older and, inevitably, sicker.

Though boomers may benefit in many ways from maintaining a more active lifestyle than their parents did, they’re also likely to enter their senior years a little more banged up. Moreover, boomers tend to indulge themselves when it comes to food and alcohol consumption, which can lead to long-term ailments.

One study found that baby boomers are more likely to have hypertension, high cholesterol, diabetes and obesity than their parents’ generation did, according to JAMA Internal Medicine.

Boomers already are driving increases in certain chronic

As baby boomers age, a huge spike in chronic illness poses a thorny problem to an evolving health care system

BY PAUL BARR

Illustration by Nikolai Punin

About the series

This is the second installment in Hospitals & Health Networks’ yearlong series examining the many ways the nation’s roughly 75 million baby boomers will affect the U.S. health care system as they grow into old age. One of the areas that will be affected is chronic care, a segment of health care already under stress by the challenges of treating multiple chronic conditions. Team-based coordinated care models are being tested by some providers, and may offer a good solution nationwide if an affordable reimbursement approach can be established. The series will include articles in the magazine and in our e-newsletter, H&HN Daily. Here’s the complete lineup:

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Knee replacement procedures rose 218 percent from 1999 to 2008 among those ages 45 to 64, and the reasons go beyond population growth, according to a 2012 study published in the Journal of Bone and Joint Surgery. Obesity and conditions tied to a more active lifestyle, such as sports injuries, were among the big reasons for the increase, according to the study, whose lead author was Elena Losina, co-director of Orthopaedic and Arthritis Center for Outcomes Research at Brigham and Women’s Hospital, Boston.

“We baby boomers are not going to age gracefully,” says Margherita Labson, R.N., executive director of the home care program at the Joint Commission. Boomers want to remain active in their senior years and Americans in general are living longer, she adds.

**When I’m 75**
This means demand for chronic care likely will expand sharply as the 76 million baby boomers continue to reach retirement age. And, if nothing changes by the time this generation hits 75 and older, that’s when the health care system will become particularly stressed.

“It’s certainly a substantial issue going forward,” says Mike Kern, M.D., senior vice president and medical director of John Muir Health’s Physician Network based in Walnut Creek, Calif. “Consider the fact that [because] Medicare is growing so quickly, we’re going to have twice as many Medicare recipients in 2030 as we do now.”

Kern notes that roughly 90 percent of serious, complex cases are among patients in the Medicare age group, and primarily in patients older than 75. The number of people in that key category is expected to double by 2033 to about 38 million from its current 19 million, according to the U.S. Census Bureau.

The members of the gray-haired set also are more likely to have one or more chronic conditions; as a result, they account for a bigger chunk of Medicare spending, particularly as they near death.

“The nature of chronic disease is that it disproportionately affects patients who are advancing in age,” says Kori Krueger, M.D., medical director of the Marshfield (Wis.) Clinic’s Institute of Quality, Innovation and Patient Safety.

**Multiplicity**
Roughly 90 percent of deaths among Medicare participants are associated with nine chronic illnesses: congestive heart failure, chronic lung disease, cancer, coronary artery disease, renal failure, peripheral vascular disease, diabetes, chronic liver disease and dementia, according to the Dartmouth Atlas of Health Care. And Dartmouth researchers found that people with chronic illness and in the last two years of life account for about 32 percent of total Medicare spending.

The percentage of Medicare patients with specific chronic conditions can be startlingly high. Fifty-eight percent have high blood pressure, 31 percent have ischemic heart disease and 28 percent have diabetes, according to the Centers for Medicare & Medicaid Services chartbook "Chronic Conditions among Medicare Beneficiaries," 2012 edition.

“If you have a doubling of the size of the older population, then even things that have the same prevalence, the number of people with [the disease] doubles,” says Marcel Salive,
Seven out of 10 Americans die of chronic disease, according to researchers for the Dartmouth Institute for Health Policy and Clinical Practice

MEDICARE POPULATION DEATHS CAUSED BY CHRONIC ILLNESS

Source: Dartmouth-Atlas of Healthcare: Care of Chronic Illness in Last Two Years of Life, 2013

M.D., a researcher in the Division of Geriatrics and Clinical Gerontology at National Institute on Aging, which is part of the National Institutes of Health. “The burden on the system is going to go up, no doubt.”

That burden grows greater for patients with multiple chronic conditions, and the majority of Medicare beneficiaries are in that position. Medicare calculated that 32 percent of these patients have two or three chronic conditions, 23 percent have four or five and 14 percent have six or more chronic conditions.

The National Institute on Aging began an effort to boost clinical research specifically for patients with multiple chronic conditions, in part because there has been a lack of studies of patients with more than two conditions. The NIA awarded four grants last August looking at such areas as multimorbidity in heart failure and the effects of common medications among the elderly with multiple conditions.

“A lot of heart failure patients, of course, have heart disease,” Salive says. “A lot of them also have diabetes, kidney disease, things like that. The patients tend to be on a lot of different drugs.”

Clinical trials usually focus on patients with a single chronic disease or involve early-stage participants who have not acquired the multiple conditions that are likely to show up later. “In the initial part of their diagnosis, they may not have any complications or they may not have any other diseases. But as they age, they may develop those other diseases,” Salive says.

The NIA also will try to expand multiple chronic-condition research infrastructure by potentially funding a grant that pays for one. If the concept gets approved and funded, a grant announcement would be made in the summer, he says.

Patients with multiple chronic conditions cost more money for care. “In the Medicare program, about 80 percent of the growth in spending is due to the increase in the share of Medicare patients who have chronic illness,” says Kenneth Thorpe, professor and chairman in the Department of Health Policy and Management at Emory University’s Rollins School of Public Health.

Moreover, “roughly 80 percent of the spending is associated with patients who have five or more chronic health care conditions,” says Thorpe, who also is the executive director of Emory’s Institute of Advanced Policy Solutions and director of the Institute’s Center for Entitlement Reform.

Medicare beneficiaries who have two to three chronic conditions cost an average of $5,698 in 2010 — which is below the average cost of $9,738 that year. However, beneficiaries with four to five conditions cost $12,174 and those with six or more cost $32,658. “That’s where all the money is, and the challenge we face is that a little more than 70 percent of the Medicare population is in a fee-for-service program that doesn’t really do effective, comprehensive care coordination,” Thorpe says.

Widening support
Thorpe notes that Medicare is moving slowly toward a care coordination model, primarily through selected Medicare Advantage plans. But things may speed up with the appointment expected this month of Sen. Ron Wyden (D-Ore.) to the position of chairman of the Senate Finance Committee, which has oversight of much of Medicare’s funding. Wyden, who has made improving chronic care one of his main causes, last month announced he would co-sponsor a bill that, among other things, would create specially designated Medicare plans that would have incentives to respond to the needs of the chronically ill.

The bill aims to encourage care that revolves around teams of providers, uses telemedicine and makes it easier for such clinicians as nurse practitioners and physician assistants to operate at the top of their license.

A number of efforts are under way across the country to boost chronic care, including the type of care coordination that Wyden desires.

John Muir Health has focused on improving care transitions as part of its broader chronic care improvement efforts, which began more than six years ago, Kern says. “At the time, there was, from today’s perspective, the strange notion that readmissions weren’t really a problem,” he says. But studies found otherwise. When a patient is readmitted, the secondary admission generally is worse.

“Readmissions are deadly, readmissions are really ugly,” Kern says.

John Muir implemented a program called Care Transitions that sends health coaches to the homes of high-risk patients to educate them on their care and medications. Readmissions have dropped 20 to 30 percent among these high-risk and often chronically ill patients, he says.
Evolving innovation
Researchers at Group Health in Seattle were the primary developers of a well-known approach called the Chronic Care Model in the mid-1990s. Now, the organization is adding a medical home-based structure to the mix, says Eric Larson, M.D., vice president for research for Group Health and executive director and senior investigator for Group Health Research Institute.

The Chronic Care Model aims to be more efficient and effective by reorganizing how providers care for and monitor patients and by trying to get patients and their families more involved in care. The model is based on a more proactive approach to working with the patient that is explicit and evidence-based, according to Rand Corp., which has evaluated it in several papers. A patient registry is used to create for clinical staff to reach out to patients. In some cases, the portal provides health monitoring data such as blood pressure or glucose levels.

The portal has proved popular with all ages of patients. “We thought the secure portal would be a place where just young techies are more likely to go to, and older people, people who are really ‘sick,’ are not going to go there,” Larson says. “But in fact, what we found is that the use paralleled the use of services. The people who need more services actually use the secure portal more than anybody, even though they may be in the age demographic you wouldn’t expect.”

User-friendly
That may bode well for the boomer generation, which eagerly embraces technology and wants to be a more active participant in its health care processes. An Accenture survey of Internet users found that members of the pre-boomer generation are surprisingly active fans of information technology. Boomers ages 55 to 64 have “even higher digital use rates” and are “poised to drive adoption as they age in” to the Medicare program, according to the survey report, “Silver Surfers Are Catching the eHealth Wave.”

Many experts also anticipate that the boomers’ success at getting what they demand may be a boon to efforts to better engage patients in their care. “I think that baby boomers are going to be more informed and more engaged in their health care than generations before,” Marshfield’s Krueger says. Marshfield tries to boost patient access and interaction, using such things as telehealth.

Smaller physician groups are finding ways to create chronic care teams as well. MedNet-One Health Solutions, which assists physician groups with wellness activities and chronic care models using the approach developed by Group Health, has found success working closely with various partners in southeast Michigan, says CEO Ewa Matuszewski. A large payer, Blue Cross Blue Shield of Michigan, in particular, has been very helpful, she says, but MedNetOne also works with partners as varied as hospitalist groups and community organizations to revamp and improve chronic care.

She believes that big changes are needed in primary care, and that they will come. “Once you reach a point where a patient has a chronic condition, you need to do everything you can to make sure they’re healthy,” Matuszewski says.

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reminders and for scheduling, as well as data collection and performance reporting. “Instead of reacting to the next crisis, you try to care for people, and have people care for themselves in a way that’s more mindful,” Larson says.

The use of a medical home approach has been a part of Group Health’s research since 2006. Teams have been set up to enhance collection and performance reporting. “Instead of reacting to the next crisis, you try to care for people, and have people care for themselves in a way that’s more mindful,” Larson says.

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It’s a Numbers Game

Absorbing the baby boom generation into Medicare sounds daunting, but health reform offers reasons for hope

BY PAUL BARR

About the series

This is the third installment in Hospitals & Health Networks’ yearlong series examining the many ways the nation’s roughly 75 million baby boomers will affect the U.S. health care system as they move into old age. The Medicare program, which is at the heart of many of the changes taking place in the industry, will swell in coming years as the boomers hit retirement age. While that will stress Medicare’s financial viability, the transition to more efficient models of care may come fast enough to avoid disaster. The series will include articles in the magazine and in our e-newsletter, H&HN Daily. Here’s the complete lineup:

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H&HN / APRIL 2014 / www.hhnmag.com
The members of the baby boom generation — 76 million strong and aging into retirement quickly — carry the potential to financially rescue or destroy the Medicare program.

The $574 billion government payer already is under pressure in multiple ways, and adding the baby boomers to the mix only magnifies the challenge of keeping the program solvent for future generations.

The trust fund backing the hospital portion of Medicare Part A is forecast by federal actuaries to run out of money in 2026. At the same time, Medicare’s physician reimbursement, which flows through Part B, is in flux due to the seemingly endless debate over the sustainable growth rate index. The convoluted physician payment formula has been modified on an annual basis 16 times over the past 11 years, forestalling massive payments. At press time, various congressional committees were eyeballing a long-term solution to the SGR mess.

One of the biggest stumbling blocks: how to pay for it. The Congressional Budget Office estimates that repealing the SGR would cost $116 billion over 10 years. Officials from hospitals and other segments of the health care field worry that their payments could be at risk to cover the cost.

More broadly, attention to deficit reduction continues to put Medicare payments in the crosshairs. The deficit is estimated to tally $514 billion in 2014. Meanwhile, Medicare spent $139.7 billion on hospital inpatient care in 2012, according to the Medicare trustees’ report.

Despite the fact that the Affordable Care Act trims hospital payments by $155 billion over 10 years — largely from Medicare, although other programs are included — federal budget-cutters have sought to extract even more savings from Medicare, and that trend shows no sign of abating.

Beyond outright cuts to Medicare payments, the ACA and other policy initiatives seek to inject different ideas of paying for care into the system. Bundled payments, accountable care constructs and other programs are being tested to see if they can improve Medicare’s value proposition.

The jury is still out on how effective these programs will be, however. RAND Corp. last month issued a report that had assessed 10 years’ worth of demonstrations under various value-based initiatives.

“Although the past decade has witnessed a fair amount of experimentation with performance-based payment models ... we still know very little about how best to design and implement VBP programs to achieve stated goals and what constitutes a successful program,” the researchers concluded.

Nonetheless, with an estimated 3 million boomers a year reaching age 65 through 2026, policymakers have to continue to reassess how Medicare is run and financed.

“We have to improve what we have and we also have to come up with more efficient models,” says Phillip Polakoff, M.D., senior managing director and chief medical executive at FTI Consulting. “The cost of care, the frequency of care and the quality of care are all being challenged. This is a major issue.”

**Boomer boom**

Baby boomers are expected to max out as a percentage of the retirement age population by 2029. At that point, the number of Americans 65 and older is expected to be 71 million — 58 percent higher than in 2013 — and 61 million of them will be boomers.

As the percentage of older Americans climbs, it follows that the relative size of the population 65 and younger will shrink, with proportionally fewer income-earners paying into Medicare compared with beneficiaries.

“The next generation that’s supporting the older people can’t afford it,” Polakoff says.

Neither can the boomers. The trend in health care, in general, is to shift more costs onto the patients, but many baby boomers’ retirement portfolios were decimated by the downturn in stock prices during the Great Recession, and haven’t recovered.

On top of that, many boomers have no idea how much they should have saved to support their intended lifestyle after retirement, and medical expenses aren’t often talked about, says Liz Davidson, CEO of education firm Financial Finesse. “I think there’s this fear to find out the truth,” Davidson says.

That also means that many boomers who eventually need long-term nursing home care may not have the money when the time comes, creating a financial threat to Medicaid programs, which fund a significant chunk of such care [see story on Page 38].

“There’s no question that the influx of the baby boomers remains a significant challenge,” says health policy consultant William Scanlan. In a financial cost analysis of Medicare, “you’ve got the issue of the per capita costs, and then you’ve got the demographics driving those per capitas,” Scanlan says. “The net result is the total spending. What we’re worried about is the share of spending as a percentage of our economy.”

The trustees that oversee most parts of the program expect Medicare spending as a share of the gross domestic product to rise to 6.1 percent by 2040 from its current 3.6 percent, not including the Medicare Advantage program.

**THE SMALLER THE SLICE:**

Congress is trying to reduce Medicare spending as a share of GDP
It’s complicated

Getting a grip on how big a challenge the boomers might pose is not easy or, perhaps, even possible. “It’s a complicated story in a lot of ways,” says Jack Hoadley, speaking in his role as a research professor in Georgetown University’s Health Policy Institute. [He is a member of the Medicare Payment Advisory Commission].

Broadly, the biggest uncertainty concerns the effort to change the way health care is delivered and paid for. “We are making some fundamental changes to the system for the better, and we have the potential to make more of those changes,” Hoadley says.

All the variables make it difficult to figure out what will happen with the program. “When you look at the dynamics, it is a little complicated to think about how it plays out,” Hoadley says.

For example, the initial effect of the boomers may be to shift the program’s population toward the younger side of the spectrum. “They should actually bring the average per-person cost down a bit,” Hoadley says. But later, they will drag the average per-person cost back up, he adds.

Sound footing

Despite the uncertainty surrounding the Medicare program’s ability to absorb the baby boom generation, some experts are optimistic things could turn out well.

“Before you can really judge the financial viability of Medicare, you have to think about how successful a lot of today’s experiments with [accountable] care organizations will be over time,” Hoadley says, encouraging patience. “There are a lot of good ideas out there, a lot of good ideas in play.”

A long-term — and bleaker — problem

The members of the baby boom generation were among the first to be given control of their employer-sponsored defined contribution plans, and helped to pioneer online investing.

Though seen as a triumph of individuals over institutions and something anyone can do — remember the E*trade monkey? — boomers have not done a good job of managing their retirement funds. That spells trouble for any plans to shift more of Medicare program costs onto beneficiaries, as well as for Medicaid programs, which funded more than $86 billion worth of care for seniors in 2010.

“There’s a presumption that baby boomers are prepared to retire. That’s not, in fact, the case for most of them,” says Howard Bedlin, vice president of public policy and advocacy for the National Council on Aging. “They haven’t really saved. There have been big changes in terms of their pensions. They’re probably going to struggle.”

Meanwhile, funding of nursing home care poses one of the biggest financial threats to state Medicaid programs and to boomers in retirement; yet, it appears that this fact has not hit home. A long-term care insurance program with fairly generous terms has been a failure for the most part.

The Partnership for Long-term Care insurance program, offered optionally through states, is designed to ease the stress on Medicaid. In states that have adopted the program, residents who purchase private long-term care insurance would qualify for Medicaid long-term care insurance benefits before draining their assets to the usual low levels. The cushion generally would be equal to the benefits they’ve received.

But a study of the program published in the Journal of Health Economics found that the intended users of the programs — the middle class — largely shunned the opportunity. Only the wealthy responded in a noteworthy fashion, says Jeff Prince, co-author of the study and associate professor of business economics for Indiana University Kelley School of Business.

Adoption of the program by a state boosts the use of long-term care insurance by less than 1 percent among those ages 50 to 69, according to the study. The problem is a large one. “Long-term care expenses now are at 1 percent of GDP, which is an enormous figure,” Prince says.

It’s estimated that half of Americans will need long-term care at some point in their lives, but only 10 percent of people 50 or older have coverage, he says.

“As of now, the potential situation is that all these people will spend down their assets on long-term care until they qualify for Medicaid, and then the government is going to have a very large bill on its hands,” Prince says. — PAUL BARR

EXECUTIVE CORNER

There are seven key points to focus on in the effort to salvage the Medicare program and the health care system in general, says Phillip Polakoff, M.D., senior managing director and chief medical executive for FTI Consulting.

1 | Make a commitment to scientific medical research into the aging process.
2 | Increase the supply of medical professionals.
3 | Ensure that personal health is a greater priority.
4 | Use more home-based care.
5 | Better align acute and long-term care.
6 | Establish a more humane and cost-effective approach to death and dying.
7 | Have the political will to sustain those endeavors.
Ready, Set, Grow

Baby boomers will need more and more health care as they age over the coming years. That’s a challenge for the new models of care now being developed. BY PAUL BARR

The last of the baby boomers turn 50 this year, and providers, policymakers and others are scrambling to create new models of care that can withstand the inevitable onslaught of acute and chronic illnesses.

The importance of coming up with concepts of care that improve quality and can evolve over time is magnified by the urgent need to cut health care costs.

Many experts warn that the current fee-for-service system is not up to the task. “We have made exceedingly few preparations for the future,” says Joanne Lynn, M.D., director, Center for Elder Care and Advanced Illness at the Altarum Institute, a nonprofit research and consulting firm.

Baby boomers are hitting Medicare eligibility at a head-spinning rate approaching 10,000 per day. The good news is the generation may be well-positioned for a redesigned health care system that will target, among other things, increased patient engagement and innovative use of technology.

“Boomers are probably the ones who understand all the different players in the health ecosystem better than anyone else,” says Paul D’Alessandro, principal and customer experience practice leader for health industries at PricewaterhouseCoopers LLC.

One big factor health care planners should keep in mind is the large age range of the generation, which currently stretches from 49 to 68. That means risk tolerances and requirements will vary. Just as older and younger boomers differed in their reactions to the shift in retirement plans from defined benefit to defined contribution, they’re expected to behave differently in a redesigned health care system.
“We’re going to look at those in their 60s as people who are very cost-containment focused, more risk averse, and test the models in that way,” D’Alessandro says. On the other hand, “the 50s group is looking at quality and convenience measures. They’re more willing to explore new attributes of a new care model, new financial levers, different patient engagement models.”

Across the age spectrum, boomers typically lead more active lifestyles than their parents and grandparents did. Combined with medical advances, that will lengthen their life expectancies. But longer lives — and a prevalence of unhealthy weight — will expose them to more chronic conditions and other ailments.

**This year’s models**

Before hospitals, health systems, physicians, insurers and other health care stakeholders can get to the point where boomers and other patients are active participants in their care, the new care models have to be put in place. “What we’re seeing now is a whole lot of different models, which represents the fact that the industry is in transition and flux,” says Jonathan Niloff, M.D., vice president and executive medical director for population health at McKesson Corp. Underpinning all the models is a transfer of financial risk onto the provider and the establishment of certain quality standards. There also will be a push to keep care within a given network of providers, known as narrow networks.

The risk transfer and quality components can take many forms, from the very basic shared-savings model in which providers and insurers share in cost savings that are achieved for given care, to the global payment model in which a health system is paid a set amount for caring for a defined population.

Many of the innovations being tested are intended to meet the federal government’s effort to reduce hospital readmissions.

The University of Pittsburgh Medical Center health system is testing or already implementing a variety of new ways to treat patients of both Medicare age and younger. “The new models are saying, how do we do a better job, become more efficient, provide the care that’s appropriate using, perhaps, different levels of care from what’s historically been provided,” says Deborah Brodine, president of UPMC Community Provider Services and of UPMC Senior Communities.

“In many cases, what that means is we’re designing and developing different models of care to keep people in their homes, where appropriate, or to keep them out of the hospital generally.”

An operator and owner of skilled nursing facilities, UPMC is putting a lot of emphasis on SNFs as a lower-cost alternative to hospital care. “We view our skilled nursing facilities as laboratories for new models of care,” Brodine says.

UPMC is one of seven organizations working to better coordinate care between hospitals and SNFs as part of a Centers for Medicare & Medicaid Services Innovation Center project. UPMC calls its effort RAVEN, which stands for Reduce AVOIDable hospitalizations using Evidence-based interventions for Nursing facilities.

The RAVEN approach uses of facility-based nurse practitioners to work on resident care plan goals and assess patients who undergo a change in condition.

Historically, SNFs weren’t equipped to handle a patient who took a sharp turn for the worse, such as a spiking fever, and the patient ended up in a hospital emergency department, Brodine says. Having a nurse practitioner on-call can reduce the need to send patients back to the hospital.

RAVEN also uses evidence-based clinical communication tools, telehealth and regional information exchange.

Those kinds of innovations may work better for boomers than for older generations. Dave Caldwell, executive vice president of Humana-owned Certify Data Systems, says members of his baby boom generation are more demanding of providers and more willing to try new approaches that suit their better-informed world view. “We grew up in an age of expectations, not only for ourselves, but also for products and services,” Caldwell says.

The baby boomers are far more knowledgeable about chronic disease, disease prevention and wellness than their parents’ generation was, and they are going to demand more from the system and their providers, he says. That bodes well for the effort to get patients more engaged in their health and care within the scope of population health management.

**Snags and SNFs**

Some new ideas bump up against regulatory restrictions. Atrius Health is an alliance of six medical groups and VNA Care Network & Hospice that is part of a Medicare Pioneer ACO. It has run into regulatory limitations on such things as time-based limits on telehealth care in the home. “While Medicare will cover telehealth as long as patients have skilled nursing care needs, once they are no longer eligible for [home care] through the VNA, they’re no longer eligible for telehealth,” says Richard Lopez, M.D., chief medical officer for Atrius and a physician for Harvard Vanguard Medical Associates. “That doesn’t make sense in the Pioneer ACO model or any ACO model. They still have their underlying conditions.”

Atrius also was one of the providers that received a waiver of another Medicare rule that requires a three-day inpatient stay before skilled nursing care can be provided through the program. With the waiver, the Atrius ACO can admit patients into a SNF directly from the ED.

At the University of Kansas Hospital, officials have tightened the relationship with post-acute by placing a SNF in the same building as its newly reconstructed 29-bed rehabilitation unit. The building design put a lot of emphasis on meeting the demands of patients, such as a state-of-the-art gym, says Patricia Sanders-Hall, vice president of ancillary..
MIXED MESSAGE: Members of the baby boom generation are expected to incur billions of dollars in Medicare reimbursement as they age into the 65 and older category. Yet, they are not big backers of the Affordable Care Act and its push for new care models or fans of government-provided care in general.

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Source: Pew Research Center, 2013-2014

The boomers know what to expect, and we’ve been trying to upgrade their acute experience because of those expectations,” says Sanders-Hall, who also is a boomer. “Very definitely, this is a generation that is demanding more. We’re more informed. We know what to ask for now.”

There are signs that boomers already are more active in their care and in the design of new care models. “We already see evidence of this in their health care and health care decision-making,” says Joseph Agostini, Aetna’s chief medical officer for provider collaborations and large group plan sponsors within Medicare.

As boomers become more technologically savvy, they do more research online and use applications and trackers around exercise, health and wellness.

The uptake on the new models is happening relatively quickly at Aetna, which is collaborating with more than 120 providers on Medicare innovation. Agostini says 20 to 25 percent of its medical costs will be in value-linked coverage in 2014.

Taking a knee, or hip

In addition to being more engaged in their care, boomers likely will be heavier users of the system, which poses a problem for the new models, at least initially. St. Joseph Hospital in New Hampshire experienced those differences first-hand as it enrolled its insured employees in a Pioneer ACO run by Dartmouth Medical Center, says Richard Boehler, M.D., president and CEO of St. Joseph Healthcare and a baby boomer. “If you look at the boomer profile of those in the hospital business, I’m sad to say that we’re all a little bit heavier, we have more chronic conditions, … and we have ease of access to health care,” Boehler says. “That’s sort of the perfect storm for trying to do population management.”

Some procedures are done so frequently among the boomer set that cost savings and quality improvement can be achieved through models such as bundled payment. BlueCross BlueShield of North Carolina has established bundled payment initiatives with selected providers in knee and hip replacement surgeries, an increasingly common procedure. Among those 55 to 64 years old, the rate of total hip replacements per 10,000 people climbed to 25.6 in 2010 from 17.7 in 2006; according to the Centers for Disease Control and Prevention. For the same age group, the rate of total or partial knee replacements climbed to 66.4 per 10,000 people in 2010 from 47.9 in 2006.

BCBSNC did its first knee replacement bundle as part of a pilot in 2011, and continues to add knee and hip replacement bundled payment contracts, says Elaine Daniels, senior strategic contract consultant for the insurer.

The North Carolina Blues has enacted bundled payment contracts with Triangle Orthopedic Associates for both hip and knee replacements, and with OrthoCarolina and Duke University Health System for knee replacements. The agreements include quality components as well. “We want people to say, ‘I want the best knee replacement, and the best knee replacement is with a bundled provider,’” Daniels says.

She noted that because the agreements require all the providers involved to be in a network, care navigators who are overseeing the procedures are creating what is almost a concierge care experience. And the program is reducing costs, Daniels says.

Eventually, she says patients with chronic conditions could be part of a bundled payment approach. “Chronic care is where we can do some wonderful management of members’ health care.”

EXECUTIVE CORNER

Ahead of an expected inflow of boomers into the health care system, hospital officials are paying closer attention to how skilled nursing facilities and other post-acute health care organizations treat patients, given the increasing role post-acute care providers play in care coordination.

Restructuring for better coordination

The best care in the world in an acute care hospital can be negated by a lack of coordination between a SNF or rehab hospital. Hospitals are adding oversight of care at post-acute facilities and changing the relationships of facilities they deal with. “Hospitals are being looked to manage this post-acute care pathway,” says Cindy Reisz, a member of law firm Bass, Berry & Sims.

Adding a SNFist

Hospitals are increasing use of a relatively new clinical role for physicians or nurse practitioners to manage the care of hospital-discharged patients at a SNF or group of SNFs. Sometimes called a SNFist (pronounced sniffest), the clinician’s job is to ensure that a patient’s post-acute care is appropriate, and to also raise the level of care that can be provided in a post-acute care facility. Atrius Health with its accountable care organization decided to use a physician in that role, while UPMC in its new models uses a nurse practitioner. Hospitals also are hiring third-party companies to do the coordination, Reisz says.

Trimming relationships

To accommodate the more intense coordination with post-acute facilities, hospitals and health systems are reducing the number of facilities in their post-acute care networks. That’s going to change the makeup of the post-acute care market as the industry evolves. “The mix is going to change dramatically” among SNFs, nursing homes, rehabilitation hospitals and other providers, says Steve Pacicco, chief executive of SigmaCare, a post-acute care technology company.
As Retirements Surge, New Staffing Models Emerge

About the series
This is the fifth installment in Hospitals & Health Networks’ yearlong series examining the many ways the nation’s roughly 75 million baby boomers will affect the U.S. health care system as they grow into old age. The boomers are quickly leaving the workforce, creating a threatened shortage in all types of workers. Health care reform and other changes may avert a crisis. The series will include articles in the magazine and in our e-newsletter, H&HN Daily. Here’s the complete lineup:

JANUARY
The boomer challenge

FEBRUARY
Chronic conditions

APRIL
The financial impact

JUNE
New care models

OCTOBER
Staffing and management

DECEMBER
Innovation in facilities and care design
Older managers and clinicians aren’t leaving health care as quickly as expected, but eventually they will. What does that mean for the field?

BY PAUL BARR

As much as they might want to, the 2.5 million baby boomers working in health care today aren’t going to stick around forever.

After pushing the field to the threshold of transformation — from one that was local and set in its ways to one that is increasingly national, with higher stakes than ever — many of these veteran professionals will bow out before the revolution is complete.

The generation’s departure from the workforce will be gradual, posing both problems and opportunities for the industry. The intellectual capital they take with them will be sorely missed and difficult to replace. However, their exodus may quicken the pace at which hospitals make much-needed changes to their staffing models to meet the demands of the new and still emerging health care landscape.

It’s already clear that predictions of workforce shortages were overblown, as economic and other factors prompted older managers and nurses to remain on the job. “One of the trends we’re seeing is that many baby boomers are not retiring as early as we all had feared,” says Carolyn Jacobson, chief human resources officer for Fairview Health Services in Minneapolis.

In many ways that’s good, Jacobson says, because it gives the health system more time to prepare.

For managers, changes in attitude

Health care managers in the boomer generation have a different attitude from their predecessors about how long their careers should last — and so do many employers.

Some boomers have settled in at the director or vice president level and don’t want to move, says Mark Madden, senior vice president of executive search firm B.E. Smith. “We know the baby boomers have defined themselves by their work, and they’re not leaving as early as the previous generation did,” he explains. “The topic is very hot in our industry, because it is something we haven’t experienced before.”

At search firm Witt/Kieffer, placements of health care executives 60 and older have nearly doubled over a 10-year period, according to managing partner Andrew Chastain. That age group comprised 13 percent of executive placements in 2013, up from 7 percent in 2003.

“The candidate pool is bigger in that area because: (1) there are more of them; and (2) they expect to work longer, because they feel healthier,” Chastain says. And because they expect to live longer, they want to accumulate more financial resources, he says.

An estimated 300,000 people worked as medical and health service managers in health care in 2013, and about 114,000 of those worked for hospitals, according to the U.S. Bureau of Labor Statistics.

Chastain says the retirement slowdown raises some concerns about the next generation’s ability to lead. Will Gen Xers and millennials have the skills and experience needed to take over when boomers finally leave? “What makes us nervous is, as they do start to retire, [will there be problems] with the supply side?” he says.

On the other hand, the types of management skills needed in the near future also may change. The advent of payments based on quality and, eventually, for whole populations may disperse the leadership role within hospitals, with clinicians taking on more responsibilities.

“This whole notion of clinical productivity perhaps requires that we change our notions about what leadership looks like,” says Deborah Bowen, president and CEO of the American College of Healthcare Executives. “It may not be the traditional notion of the CEO title, it may be more about impact and influence on patient care.”

That shift toward the clinical side of the equation is reflected in ACHE’s membership. The roughly 36,000 members and fellows include about 2,000 doctors and close to 5,600 nurses, who together represent more than 20 percent of the organization.
“Proportionately, that population has probably doubled in the last five to 10 years,” Bowen says. “We didn’t always track clinicians because there weren’t enough to track.”

Nurses also sticking around
Given the sheer numbers involved, boomer retirements could pose more of a risk for the nursing profession. So far, that has not happened and, in fact, some new nursing graduates are having trouble finding jobs, according to a study published online by Health Affairs in August.

In 2000, the researchers predicted the United States would have 2.2 million RNs by 2012. In fact, there were 500,000 more than that. The likely causes: a surge in the number of graduates of nursing schools; the recession, which prompted nurses to work longer; and a fundamental shift in the profession’s retirement rate.

“About half of the extra half million nurses whom we didn’t think we would have [resulted] from the ramp-up in education,” says David Auerbach, lead author of the study and senior policy researcher for Rand Corp. And about a quarter of the extra nurses were there because fewer nurses retired than had been expected, Auerbach says.

Those trends could have a long-term effect. “The educational ramp-up is a permanent thing, and that is going to make any shortage resulting from the retiring boomers not as much of a problem,” Auerbach says. “And it’s really even hard to say if there will be a shortage at all if the schools keep doing what they’re doing.”

Others say RN demand is, in fact, picking up. Jeremy Enck, vice president of sales for staffing firm Fortus Healthcare Resources, says demand has not been this strong since 2006, and could continue for at least 10 years.

Research that Auerbach has worked on shows that, overall, 37.3 percent of the U.S. nurse workforce is 50 years or older as of 2013, up from 19.6 percent in 1980. Bureau of Labor statistics show that 2.67 million RNs were working in health care in 2013, 1.55 million of them employed by hospitals. Therefore, the new nursing school grads need to replace roughly 573,000 hospital RNs who will retire over the next 15-20 years.

Is there a doctor in the house?
When it comes to physicians, the numbers may be more worrisome. Christiane Mitchell, director of federal affairs for the Association of American Medical Colleges, says many industry groups have come to the conclusion that a physician shortage is already here and getting bigger. “And,” she adds, “most of the groups are in agreement that the primary driver of the shortage is the aging of the baby boomers.”

More Attention Needed
A sometimes overlooked segment of the health care workforce is made up of those with specialized health care training, but without bachelor’s degrees.

These caregivers and support staff — such as home health aides, community care workers, psychiatric aides and licensed practical nurses — are going to take on a bigger role as health care moves out of the hospital and into the home. They also may be able to absorb some of the extra work brought on by the aging boomer generation.

“The health care system would not function without pre-baccalaureate workers,” according to a paper from the Metropolitan Policy Program at the Brookings Institution. The authors of the paper, titled “Part of the Solution: Pre-Baccalaureate Healthcare Workers in a Time of Health System Change,” called for more research to figure out how to take better advantage of their skills.

Joanne Spetz, director of the UCSF Health Workforce Research Center and a professor at the University of California, San Francisco, says these front-line staffers also will be important as more of both short-term and long-term care are administered at home.

Health care employed 3.9 million support staff in 2013, according to the U.S. Census Bureau. “It’s a huge workforce,” Spetz says. — PAUL BARR
That phenomenon has a twofold impact: Boomers will get sicker and need more care as they age, even as doctors leave the workforce in droves, according to the AAMC. It predicts there will be a shortage of 91,000 physicians by 2020 and 130,000 by 2025.

Mitchell notes that medical schools are working to increase their graduation totals and are on track to boost enrollment by 30 percent between 2007 and 2016.

A big sticking point is placing all those new med school grads into residency slots. Residencies largely are funded through Medicare, and the AAMC and others would like to see funding for more such slots. That seems unlikely given that it would require federal legislation and billions of dollars. Adding 3,000 residency slots over five years would cost $9 billion to $11 billion, Mitchell says, and even then would not compensate for the looming shortage.

One of the unknowns is whether or not the demand for physicians will decrease as health care moves toward team-based care and other types of clinicians take on more responsibilities. Most efforts to solve the physician shortage center on increasing the supply, notes a policy analysis published in 2011 by the National Institute for Health Care Reform. That’s a cumbersome process that may take decades to produce results.

Instead, the authors suggested, “policymakers may want to consider ways to increase the productivity of primary care providers and accelerate primary care workforce expansion by, for example, examining how changes in state scope-of-practice policies might increase the supply of nonphysician practitioners.”

However, that option is complicated by the fact that states set their own regulations for doctors and other practitioners. “When you talk about physician shortages, it just depends on where you live,” says Kavita Patel, M.D., a practicing physician and a fellow at the Brookings Institution.

Even getting consensus about how many physicians are currently in practice is impossible. Relying on state data, the Kaiser Family Foundation estimates the number at 834,000, while Census Bureau data put the total at 623,000. Moreover, definitions of physician productivity don’t represent true patient care needs.

“We don’t really have in the United States reliable estimates for the workforce of supply or demand,” Patel says. “All of these numbers are flawed because we don’t really even know what the demand is supposed to be, or should be,” she says.

“Like all things in health care,” Patel says, “we’ve made it onerously difficult.”

Hospital and health system officials are taking a variety of steps to keep ahead of any workforce shortages that might result from the retirement of the large baby boom generation. Carolyn Jacobson, chief human resources officer for Fairview Health Services in Minneapolis, shared some of Fairview’s strategies. “We are watching this fairly closely,” Jacobson says.

**Education**

Fairview has formed partnerships with the University of Minnesota, St. Catherine University and Augsburg College to meet quarterly to assess what the organizations should be doing to address shifting supply and demand.

**Management**

Fairview recently has been dipping into the ranks of the for-profit sector to meet its changing management needs. “The work that health care leaders are doing now mirrors much more closely what’s happening on the for-profit side,” Jacobson says. “So, having folks who have been through a lot of change, paying attention to the bottom line, all of those kinds of qualities, are becoming much more important to us in our leadership roles.”

**Physicians**

“Physicians are hard to find,” Jacobson says. Part of Fairview’s effort to limit the effects of a physician shortage involves trying to get nurses who are working at the top of their licenses within its developing team-based care programs. As part of that, Fairview sponsors nurses to become trained as nurse practitioners.

**Nurses**

Jacobson says one of the things Fairview has done is to create grant and loan incentive programs for nurses with two-year degrees to earn four-year degrees. Fairview has Magnet status and needs to keep a certain number of four-year degree nurses to maintain it, she says.
For Baby Boomers, health care where and when they want it

BY PAUL BARR

About the series
This is the sixth and final installment in Hospitals & Health Networks’ yearlong series that examines the many ways the nation’s roughly 75 million baby boomers will affect the U.S. health care system as they grow into old age. This month, the topic is health care innovation, and how it might ease the pressure created by the boomers’ entrance into the health care system as seniors. The series includes articles in the magazine, blogs in our e-newsletter, H&HN Daily, and online videos.

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Innovation in facilities and care design
Like movies, restaurant reviews, shoe shopping and practically everything else American consumers are interested in these days, health information and health care itself are becoming instantly available anywhere a mobile device can connect to Wi-Fi — and baby boomers are a major driver of that trend.

As they confront the medical issues that come with aging, boomers want to know more about their providers and have more direct input into decisions about their care. And the health care industry is quickly moving to meet those demands.

Health data can be transmitted to caregivers via mobile devices or in-home monitors. Internet video allows for consultations with clinicians in more convenient locations than the medical office or hospital. Technology allows patients to learn more about their personal health and the quality of their providers, and it will enable them to receive more and more care in the venue they most prefer: their homes.

The vast boomer generation can be split into older and younger cohorts with differing views of technological innovation, according to research conducted by PricewaterhouseCoopers. The older segment, those 56–68, takes a more measured approach. "They're very cost-conscious," says Paul D'Alessandro, principal and customer leader for health industries at PwC. They're the most interested in alternative care services, such as retail clinics, telehealth and other new forms of care delivery. "They still want a human involved in the process and, ideally, they want a doc or a nurse involved," he says.

On the other hand, younger boomers are more interested in such new technology as remote monitoring and wearables, and new forms of data collection and analysis. "They're kind of data junkies around their health," D'Alessandro says. They not only recognize that the data have value, but they view data as a form of currency.

No matter where they land on the generational spectrum, all boomers expect more out of old age than their parents did. "They want to be well physically, emotionally and spiritually until they die," says Kevin Svagdis, president of Morrison Senior Living. And they expect health care providers and other services to help them do so.

Read on for a sampling of the ways that hospitals and other providers are testing and using innovative clinical approaches to serve a patient population that, led by the boomers, is demanding more.
Historically, patients have left health care decision-making to doctors and nurses. But now, boomers are arming themselves with information and sharing it with the rest of the world. That makes some providers nervous.

When physicians affiliated with University of Utah Health Care, Salt Lake City, asked whether something could be done about online ratings websites that posted negative reviews of them, health system officials came up with an unexpected solution: They posted reviews on their own site.

“Doing so fit with the system’s effort to be transparent and consumer-friendly. ‘We have these data already; why not share them?’” says Brian Gresh, senior director of interactive marketing and the Web.

Initially, physicians were not thrilled, even though the data already had been disseminated internally. But, posting the unfiltered Press Ganey ratings helped to reassure them that patients would not rely on Yelp-like sites alone when choosing a doctor.

University of Utah Health Care only posts star ratings for doctors with at least 30 qualifying surveys. That provides more balance and credibility than other ratings sites, which often rely on just a handful of reviews for a given doctor.

“It’s allowed us to tell our physicians, ‘We have your back, you look really good,’ ” Gresh says.

The physician ratings also have boosted the organization’s online presence. “It draws a huge amount of traffic to our site,” Gresh says, noting that in Google search results, the system’s ratings now rank higher than those of the ratings sites the physicians were so worried about.

Other health systems are following in the University of Utah’s footsteps. Matt Gove, chief marketing officer at Piedmont Healthcare in Atlanta, says his organization also posts physician comments, editing them only to remove vulgarity or to keep protected information safe.

“If someone has a bad experience, we post it,” Gove says, adding that, after some initial skepticism, physicians are now “surprisingly positive” about the concept.

Health care innovation doesn’t have to come out of an academic medical center, a well-funded foundation or a technology-focused startup. Las Vegas is home to a forward-thinking retirement development that is integrating a spectrum of health care facilities, incuding an acute care hospital, into the $1.2 billion project.

The Union Village senior residence development, based in nearby Henderson, Nev., aims to accommodate 1,500 residents as they traverse the various levels of care, whether it’s moving from acute care to rehabilitation, or from a skilled nursing facility to assisted living or their own home, says co-founder Craig Johnson.

“What you have here is all of these step-down, subacute care options integrated on one campus,” Johnson says. Anchoring the site will be a 142-bed Henderson Hospital, part of Las Vegas-based Valley Health System, which is owned by Universal Health Services.

Having the ability to transfer patients between settings within a single campus benefits everyone, Johnson says. The traditional model involves transferring patients to different sites, sometimes miles away. That can be hard on patients both physically and emotionally, difficult to coordinate among providers, and all too often results in lost records or miscommunication.

At Union Village facilities, patients will be transferred by wheeling them down the hall.

Planners identified 17 types of health care partners that will work together in an integrated way. All are enthusiastic about the village concept, Johnson says. “What started out as an idea has been embraced by every single health care group with whom we’ve talked. The validation has been incredible.”

Despite the large presence of health care facilities, Johnson says, developers are trying to focus first and foremost on overall wellness. “When a senior comes to the wellness village, we’re going to be all about working with him or her to stay out of the hospital as long as possible,” he says. Telehealth and related monitoring technology will aid in that effort.

In addition to residential and health care space, Johnson says, the developers plan to add retail companies and a hotel on the site.

With the boomer generation aging quickly, the health care system will rely on innovation to improve care and lower costs.

“It’s the intersection of care design and technology that is going to provide some increased capacity in the system,” says Jonathan Niloff, M.D., vice president and executive medical director for McKesson.

The Mayo Clinic Center for Innovation is one source of much-needed creativity. It has assembled a 5,000-square-foot Healthy Aging and Independent Living Lab attached to a continuing care community, with the goal of helping seniors to live longer and more independently.

The lab allows Mayo researchers to test ideas in a real-world environment, says Barbara Spurrier, administrative director of the Center for Innovation.

A lot of its current work involves delivering care without the patient’s having to leave home. “We’re trying to do it in such a way that people can live their best lives and the technology doesn’t get in the way, so it’s simple and easy,” says Spurrier, co-author of the recently published innovation guide, Think Big, Start Small, Move Fast.

For instance, testing initially relied on user-friendly Skype for patient communication. “We knew people were already connecting with their kids and their grandkids through Skype, and we didn’t want them to go out and buy an expensive technology,” Spurrier says. “We’re trying to make it real simple and easy. Patients need to be able to connect with things like home computers without having to add a lot of bells and whistles.”

The program is now working to build a well-living lab with an expanded scope of study. In addition to testing technology in the home, it will look at lesser-studied subjects, such as air quality and lighting. The research could be scaled up to encompass community settings, such as offices and schools.

“We’re pretty excited about that,” Spurrier says.
There's More Action

ew models of care targeting the period after a patient has been treated in an emergency department or discharged from a hospital are among the most-watched areas of innovation. Reworking post-acute care to include wellness and prevention are among the most effective strategies.

Tandem365 and New Hanover Regional Medical Center, Wilmington, N.C., offer examples of how post-acute care can be improved. Tandem365, Grand Rapids, Mich., is a joint effort of four continuing care facilities and an ambulance service. It provides high-cost patients with targeted care.

Central to the concept is a personal emergency response system that is the first place an enrollee in the program should go for health-related issues. With one touch of a button, a patient can get anything from a telephone consultation to an ambulance ride to the ED.

The goal is to keep patients where they’re most comfortable. “The majority of people want to stay in the home in which they’ve lived for 30-some years,” says Brandee VanVuuren, business process specialist.

New Hanover Regional Medical Center also targets high-use patients, adopting the relatively new concept of community paramedicine to bring wellness and primary care into the home. While approaches to community paramedicine vary, the basic concept is that paramedics receive additional training to provide in-home patients with preventive and consultative care.

The incentive to focus on select patients emerged from the revelation that close to 30 percent of 9-1-1 calls were for nonemergencies and that in one year, the 10 biggest users of 9-1-1 accounted for 702 responses, says David Glendenning, education coordinator for EMS. “So the same 10 people traveled back and forth to the hospital 702 times,” Glendenning says.

After a pilot project, the system received grants aimed at patients with congestive heart failure, a second and third year.

Readmission rates for CHF patients fell to 9 percent, compared with a national average of about 20 percent, Glendenning says.

Getting Buy-in

The baby boom generation can easily become bored, so getting them engaged in their care may be an uphill battle. Scripps Health, San Diego, one of the more active health systems in testing, developing and using advanced technology, is helping to develop a software-based program for managing cardiac rehab patients. The program, called Care4Today, is designed to make it easier for caregivers and patients to do the somewhat tedious work of coming back from a heart attack or other heart problem.

The program combines high-tech monitoring with low-tech brochures and hands-on education.

“It provides more efficient tracking of patients, it provides more efficient recruitment of patients and, ultimately, more efficient feedback to providers on how their patients are doing,” says Christopher Suhar, M.D., director of Scripps Center for Integrative Medicine, the division testing the program.

The program monitors and tracks patients’ blood pressure, pulse, blood sugars and telemetry, and includes an educational component for patients. "The ultimate goal is a state-of-the-art software program that will digitize cardiac rehab, and it’s pretty exciting,” Suhar says.

In addition to giving the caregivers a systematic approach to managing rehab, the model creates incentives for patients to stick with it as well. “It almost becomes second nature to you,” says Michael Roche, a patient who had been enrolled in the program at Scripps. “It is like your social life.”

For more on the Scripps effort, watch an online video interview with Suhar, Roche and another patient who enrolled in the program, at the Boomer Challenge, found in the Special Reports section of hhnmag.com.

EXECUTIVE CORNER

Patient-centric mobile health technology will play a fundamental role in the success or failure of the health care system in caring for the aging baby boom generation. Knowing what happened with a patient’s care in just the hospital or physician’s office is no longer enough.

“The technologies that we’re seeing more as time goes on are the technologies that can follow a patient through the whole continuum,” says Karlene Kerfoot, R.N., chief clinical integration officer with API Healthcare.

Providers will have to spend more time with a growing population of aging patients and, since they’re already fairly busy, technology will have to make care more efficient. “They don’t have any more hours in the day,” says Martha Thorne, senior vice president and general manager for Allscripts.

The types of mHealth applications that might ease the stress of treating boomers fall into three overlapping categories — telehealth, remote care monitoring and sensing technology — according to analysts at Healthcare Information and Management Systems Society.

TELEHEALTH is getting a lot of attention from payers, says David Collins, senior director of HIMSS. They view it as an option for making population health management more efficient by providing better care in a cost-effective manner.

REMOTE MONITORING also is drawing interest from hospitals, which are subject to stiff readmission penalties by Medicare. Remote monitoring makes it easier to check in frequently with patients. Some health systems are using a new discharge toolkit that includes computer tablets and other tools. The toolkit costs $1,000, far cheaper than a penalty for readmission, Collins says.

The technology to use SENSING DEVICES to monitor patients 24/7 exists, but the large amounts of data that are produced create problems. “I think there’s value there; it’s just balancing it and figuring out how much data to capture,” Collins says. “It’s going to work as a supplemental tool, but it’s going to take some work for it to become a standard.”