New Approaches to Geriatric Healthcare Will Save and Improve Lives, Revitalize Neighborhoods and Spur Technical Innovation

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Introduction

Philadelphia is ripe for healthcare delivery innovation. The new administration has recognized this via its interest in embedding more health services within the city's schools. Many have already begun to consider the potential for new partnerships among and between health centers and other city agencies, hospitals, medical schools, community-based organizations and entrepreneurs.

Historically, local public interest in healthcare has focused on large public health issues, particularly the prevention of communicable diseases, and providing for children's and young adults' healthcare, including providing immunizations that are part of a larger public health strategy. Conversely, providing geriatric healthcare services has been mostly viewed as a federal government

concern via the Medicare program, and to a lesser extent a state government concern through the Medicaid program, for which states pay about half of the cost of acute and chronic medical care for the poor, including the elderly poor.

This paper maintains that the city of Philadelphia, working directly through its health centers and in coordination and cooperation with the city's hospitals, medical schools, community-based organizations and the private sector, is in a unique position to improve the health and safety of tens of thousands of the city's elders, and that in doing so the city can also economically gain. We begin by noting that:

1. Large numbers of Philadelphia elders are in a healthcare crisis and the demographic trends within the elderly (and the soon-to-be elderly) population indicate that this crisis will worsen absent new policies and programs.
2. Overwhelmingly, the city's elders are insured by the federal Medicare program, the state and federally funded Medicaid program, or both, and as such, the inability to pay providers is generally not a barrier to accessing services.
3. Federal and state officials are eager (desperate) to control the costs of these programs and improve healthcare outcomes and are therefore open to new partnerships and innovations as never before.
4. Philadelphia has a healthcare infrastructure that

could be readily positioned to catalyze and participate in new, geriatric-focused healthcare partnerships that would save and improve the lives of tens of thousands of Philadelphia older citizens.

5. Unlike other areas of public policy which the city would like to address, no new laws or appropriations are needed in order to act. Most of the money necessary to undertake these efforts is available through Medicare and Medicaid. Doing so would likely enable the city and other providers to draw down tens, if not hundreds, of millions of state and federal dollars that would be added to the city's economy.
6. In implementing these efforts new jobs at all skill levels would be created.
7. If creatively implemented, some of this investment could be focused into new geriatric healthcare zones in which new healthcare and associated facilities might be built, and new state-of-the-art, health-enhanced senior housing constructed along with housing for care and service workers working with this population. The impact of this investment would be a source of, and undoubtedly spur, additional neighborhood revitalization.
8. This new focus on the delivery of geriatric services could be leveraged by the city's high tech community by creating opportunities whereby entrepreneurs could demonstrate the efficacy of their inventions, helping inventors overcome a significant barrier to

bringing products to market. In return, marketable products might be manufactured in Philadelphia.

Background

Philadelphia is home to about 186,000 residents who are age 65+, or about 12% of the city's total population. Virtually all of these residents will need increasing levels of acute and chronic healthcare services in the years ahead. Demographically, the "older elderly," those who are 85+ years of age, are the fastest-growing population among the city's elderly, and these seniors will be poorer relatively, and absolutely, in comparison with the emerging younger elderly population. Overwhelmingly, Philadelphia's elderly are insured via Medicare. In addition, roughly 46,000 of Philadelphia's elders are so poor that they also qualify for Medicaid, the so-called "dual-eligibles."

Yet, even with insurance coverage tens of thousands of elderly Philadelphians do not receive the preventive care for which they are eligible; care that would cost them nothing, or close to that, to receive. Reasons for this include poverty and the absence of skills necessary to access providers, geographic isolation and/or medical conditions that limit mobility and access. About 16%, or nearly 30,000 elderly Philadelphians, are effectively "shut-ins," for example. As a result, Philadelphia's elderly population incurs acute and chronic health problems at rates exceeding state and federal averages as well at

rates that exceed comparable cities nationally. For example:

- Older Philadelphians have higher rates of heart disease, stroke, diabetes high frequency cancers, hypertension, respiratory disorders and dementia relative to the state, the nation and comparative jurisdictions.
- Philadelphia elders have the highest chronic disease rate leading to premature death in the nation.
- The preventability of most of geriatric chronic illness episodes and injuries can be seen in the fact that large and disproportionate numbers of Philadelphia elders are:
    - Not receiving immunizations for flu and pneumonia.
    - Untested for heart disease and various cancers.
    - Not screened for osteoporosis.
    - Have higher rates of smoking, binge drinking and overweight/obesity.
- Philadelphia elders will make about 200,000 emergency room visits each year, taxing these facilities, municipal emergency services and taxpayers. Annually about 11,000 senior citizen falls require at least emergency room treatment.

In short, despite high levels of insurance coverage and the presence of a world-class hospital and medical school infrastructure, Philadelphia’s healthcare delivery system, as experienced by tens of thousands of elders, does not

meet their most basic healthcare needs. Worse yet, operating this healthcare delivery system is also incredibly expensive for Medicare and especially Medicaid, where these expenditures represent a huge portion of the state budget.

Philadelphians cannot be satisfied with the state of public health in the city when 98% of neighborhood health centers show disproportionate incidence ratios by race (e.g., racial disparity): 59% of the disparities state black Philadelphians as significantly less healthy, 28% have Hispanics disadvantaged and 11% show Asians as less healthy. However, knowing about these disproportionalities does not yield a health improvement strategy because all of the differently-impacted ethnic subpopulations are widely distributed throughout the city and because the disparities, while real, tend not to be large enough to justify race-based targeting efforts. In other words, the city is in a public health crisis together and a citywide health improvement strategy is what is needed now.

The overriding demographic description of public health in Philadelphia is simply this: 80+% of chronic illness deaths and about 50+% of hospitalizations for all causes are age-related in nature. The 65+ subpopulation live with, and die from, just about all of the chronic diseases, usually, more frequently than do their younger age cohorts. Accordingly, achieving improvements in geriatric health is not only mission critical for the city's health

professionals but crucial for the crucial for the fiscal health of healthcare providers.

New Advanced-aged Geriatric Healthcare Initiatives

Below we call for five new and specific, evidence-based initiatives to improve the health and safety of the city's elders. Per the theme of social innovation, each of these initiatives would rely on the city health center network accepting a new mission of leading and coordinating new geriatric activities largely paid for through new partnerships with Medicare and Medicaid. Additionally, the city's hospitals, medical schools and other nonprofit and for-profit entities would all have new opportunities to participate in new ways of delivering health services to the city's older population.

1. Preventing Fall Injuries Among the City's Elderly

In any given year more than 11,000 city elders visit a hospital emergency department for a fall-related injury. About 3,350 will be hospitalized, with 2,000 to be discharged to a nursing home (where almost two-thirds will require a stay of more than 836 days). In short, 863 persons are projected to be on Medicaid, in a nursing home, for at least two years at a cost of $73 million.

Between 2000-2003, Pennsylvania Medicaid oversaw a large-scale fall prevention program in Philadelphia for 3,000 elders. This effort documented a 60% reduction in nursing home admissions for geriatric falls among the

participants. A reconstituted program for 11,000 elders who are recognized as being at the highest risk of falling (as they had already been to a hospital emergency room for a fall injury) would cost about $9 million to offer and save about $73 million in hospitalizations and post-critical treatment, including nursing home stays, for a net savings of about $64 million.

One approach might be to refer patients to new Fall Prevention Centers. Such centers would coordinate with hospital emergency doctors and be operated by for-profit or nonprofit sponsors. Each center could be expected to produce dozens of jobs and perhaps as much as twenty million dollars in new local economic activity. State Medicaid officials have the authority to enter into partnerships with the city Health Department and/or other geriatric healthcare partners without legislative action, and a program with a proven track record of producing savings would likely be very attractive to state officials eager to reduce the state Medicaid budget.

2. Providing Free-to-the-Elderly Preventative Health Services

Medicare covers 20 types of screenings, immunizations and treatments, most of which are 100% free to the elderly patient. These services include pneumonia, flu and shingles vaccinations, Hepatitis B vaccination, PSA testing, smoke cessation and counseling programs, low-dose CT scans for lung cancer, colonoscopies, glaucoma

screening, obesity counseling, cholesterol screening, aortic aneurism testing, annual wellness visits, physician-based health planning for preventative chronic disease and much more. Unfortunately, a significant number of Philadelphia's elderly do not access these preventive services. For example, 46% of elders don't get flu shots, 33% haven't received pneumonia immunization, and about half of eligible men don't get prostate screenings.

Some of the difficulty in accessing preventive services are explicable when one understands that at least 16% of Philadelphia elders are "shut-ins" and in need of mobile health delivery and about 18% of older citizens report lacking a personal physician. But mostly the healthcare community just has not gone out to the locations where elders congregate with an effective message of how they can obtain these lifesaving treatments.

A health center network that was interested in providing these services and effectively communicating the availability of these services backed by new mobile outreach programs using health vans and the like would do much to make these valuable preventive programs available to Philadelphia's elderly. Medicare, and certainly Medicaid, would have strong interest in providing resources to conduct outreach as these interventions reduce high-cost hospitalizations and too often, nursing home admissions.

Targeting the more than 37,000 elders who lack a primary

care physician and therefore are not receiving most of this preventive care would alone likely trigger more than $20 million in new healthcare expenditures within the city including salaries and other items that ultimately yield revenues to the city. In addition, of course, the actual cost of providing treatment is fully reimbursable for the provider, including city health centers.

3. Keep Seniors Living in the Community

Philadelphia is the obvious place for Pennsylvania Medicaid to look to achieve savings in its annual multibillion dollar Medicaid budget. Statewide data indicate that elders constitute 14% of the state's Medicaid enrollees, but 32% of the Medicaid budget, with a disproportionate amount of elderly expenditures being on nursing home care. In Philadelphia, roughly 480,000 persons are on Medicaid, of whom about 10% are classified as elderly. There is no reason to believe that local elders proportionately cost Medicaid any less than the statewide figures, and good reason to believe Medicaid spends more here since prices in the city tend to run ahead of rural Pennsylvania.

The vast majority of Pennsylvania's older residents, poor or not, want to stay out of a nursing home and most current nursing home residents would like to return to the community if they could be properly cared for. This fact, and the need to control these Medicaid costs, is why Governor Wolf's budget proposes to help 5,500 additional

elders stay out of a nursing home. His budget calls for saving $168 million annually by providing services and alternative housing assistance (an average of almost $30,000/case, which can cover a lot of services and rental assistance) to keep elders out of nursing homes. In a separate budget category, $50 million is being set aside to provide additional services to Medicaid recipients of all ages and PHFA is proposing to spend an additional $15 million on home modifications and other assistance. The city should be seeking to actively cooperate with these proposals and stake its claim to these resources.

For example, some elders cannot return home because their home is simply unsafe for them to be in. The City's overwhelmed basic systems repair program might have the expertise to do the repairs but it has neither the financial wherewithal nor the capability to do repairs quickly so that elders can be discharged back to their home. Money from this state initiative could pay for these repairs, as well as the emplacement of other safety enhancements, but the city would need to build a system capable of acting expeditiously.

On the other hand, some elders will need more care than they can obtain at home, but still do not need to be in a nursing home. Here, the city could take the lead in producing a new generation of senior housing that is designed for these frail elders and uses a lower reimbursement rate than nursing homes receive as a subsidy stream to operate this housing. These subsidies

could be combined with existing housing subsidy programs, or in some cases avoid them, in return for Medicaid guarantees of a “patient stream” as units became available over time, ensuring the full occupancy of this housing.

Neither the city’s housing authority, nor much of the nonprofit community has been very interested in developing new senior housing, but such a program could provide them with new development opportunities, or opportunities for new organizations to specialize in developing this housing if properly incentivized. In addition, it is likely that elders living in PHA housing would qualify for this housing, freeing up federally-subsidized housing for families and others.

4. Helping hospitals and physicians improve emergency care for elders

Various data suggest that Philadelphia elders make as many as 200,000 emergency visits a year. Aside from the personal tragedies of those elders who arrive at an emergency room because they were unnecessarily injured or sick due to a lack of earlier access to medical care or other services, and the cost, including to local emergency services, there is a secondary serious problem----many elderly patients leave the emergency department with little or no documented follow-up, unsure of what they need and not knowing where to get necessary services.

There is a need for a greater coordination of care, better transitioning from the emergency department to the community and better triage within the emergency department to minimize inappropriate use of emergency services. The city's health centers can help and should be organized to be a provider or gateway for this assistance.

As indicated above, 18% of the elderly in Philadelphia lack a personal physician and 20% do without medical services because of cost, or perceived cost. From the perspective of hospitals, the current system is failing and likely to get even more expensive with the specter of federal rapid readmission penalties looming. This problem is in part evidenced by the fact that a relatively recent survey of the ten largest Medicare certified home health agencies operating in Philadelphia scored 75% below the state average on reducing re-hospitalizations. The twenty largest agencies, representing well over 50% of home health discharges from Philadelphia-area hospitals, scored 61% below state averages on reducing re-hospitalizations!

If geriatized city health centers were established where elders could go to receive information, additional discharge planning and medical follow-ups, local hospitals, Medicare and Medicaid would all have strong interests in working with and funding the development of this new health center capacity.

5. Better integration of mental health services with

physical health services

At least 30% of Philadelphia elders hospitalized for all causes each year have a mental health condition in addition to whatever may have caused the hospitalization. These mental health problems are vastly under-reported, under-diagnosed and under-treated. Untreated, these mental health conditions result in otherwise preventable suicides, homicides, drug abuse and alcoholism, tax the city's emergency services system, and impose additional costs upon local hospitals and other providers. Mental health disorders trigger a 200% increase in rapid re-admissions and a 311% increase in nursing home admissions. Under new Medicare rules these rapid re-admissions trigger new costs on hospitals.

Doctors and hospitals, understandably, focus on the primary (physical health) diagnosis, but by undertreating comorbid mental health illness conditions, additional and earlier elder deaths occur. Screening for depression, anxiety disorders and cognitive impairment (including drug and alcohol problems) is almost universally a good option for aged chronic- illness patients. Establishing a strong network that encourages and facilitates primary care physicians and emergency care doctors to undertake some preliminary patient screening for these conditions and then refers patients in need to existing providers, or to an updated health center network, including city health centers, is called for.

A new mental health initiative would, like physical health services, attract Medicare and Medicaid administrator attention as such a program would undoubtedly yield better health outcomes and medical cost savings. Getting hospitals, doctors and other providers, including existing mental health providers onboard for such a program would not cost much money, but it would benefit strongly from city leadership.

Meeting the Needs of the City's Elders an Economic Development Strategy

The above five programs would all bring new funding and capacity to city health agencies and their partners, and save Medicare, Medicaid and city emergency services budgets money. Most importantly, these interventions would save lives and/or improve the quality of life for tens of thousands of vulnerable, elderly Philadelphians. However, these programs also could be components of a broader city community and economic development strategy. Below are ways the city could also create jobs, revitalize neighborhoods and catalyze new economic activities while improving and saving lives among Philadelphia's elders.

1. Use health centers as anchors for community revitalization

The city's health centers presumably were located where they are for reasons now-largely known only to

neighborhood historians. What is clear is that these centers have not been successfully used as engines for community investment and redevelopment, but they could be. Building on the presence of these centers in their respective communities the city could:

- Create tax-advantaged healthcare zones around the centers. These zones would offer various tax breaks to medical practices and related services to encourage the opening of new medical arts buildings that offer complementary services to those being offered in the nearby health center.
- Site senior, special needs and other assisted housing proximate to the health centers and require that the plans for these buildings create partnerships with the health center to meet the needs of residents of these developments. Make redevelopment of these sites a priority for the city Land Bank and the processes by which city housing subsidies are awarded. These sites should also be a priority when building a new community-based housing partnership with Medicaid that avoids unneeded nursing home usage, as discussed above.
- Create housing for care workers that these elders will need. Care work jobs are one of the region (and nation's) fastest growing job categories. It is also a category plagued by high levels of employee turnover, and too often, poor quality care, in part because of high levels of employee turnover. By

working with caregiving firms and using employer-assisted housing techniques, the caregiving workforce can be stabilized and improved.

2. Declare an intention to make Philadelphia the "Silicon Valley" for the elderly

New senior medical technologies are regularly coming into existence and additional technologies are needed. One "routine" barrier to the introduction of new technologies is that entrepreneurs have difficulty arranging for demonstration studies that test the efficacy of their products. Subject to appropriate federal and state regulation, those elders participating in various health initiatives could also be offered the opportunity to participate in the testing of new products, helping local entrepreneurs overcome a key market barrier. In return, efforts could be made to have products produced in Philadelphia, adding new high-tech manufacturing jobs to the city's economy.

Nationally, no community or state has declared its intent to become the nation's geriatric healthcare technology center. Philadelphia has the medical, engineering and manufacturing infrastructures that are needed to be the Silicon Valley for geriatric innovation, and it also has land on which research and manufacturing facilities could be built. Philadelphia has a population in need. It has entities such as the Ben Franklin Partnership and University Science City that could be harnessed to bring in hundreds

of millions of dollars in new capital to develop this new industry here. As Philadelphia continues to repurpose itself for the 21st century why not make this a key strategy on which to base the city's economic future? To further this approach, the city could:

- Create an Office of Economic Development within the Department of Health that is charged with increasing healthcare investment and access. Advanced-aged Geriatric care and increasing the city's biotech and related sciences R&D capacity should be key priorities.
- Create a "Mayor's Working Group on the Expansion of the Healthcare Industry" consisting of leaders of the major hospitals, medical schools, etc., plus health center leaders and leaders in biotech, assistive tech and related industries, as well as the Office of Economic Development within the Department of Health. The purpose of the group would be to create a healthcare industry strategy or plan for the City that maximizes employment, investment and development opportunities through increases in service, research and manufacturing activities related to healthcare, and ultimately facilitates the City goals of increasing tax revenues and population.
- Convene a conference that brings together city health center and community development leaders and others in the medical professions to discuss how the health and community development sectors can

work together in ways that yield health and community development outcomes.

In addition to taking these actions, city leadership should also be focusing on the nearly $500 million dollars in Governor Wolf's proposed budget to encourage the growth and expansion of urban- and technology-based economic development, including healthcare technologies. The city can and should play a catalytic role to ensure that Philadelphia businesses get their share of these incentives. More importantly, however, city leadership can spark new partnerships that yield new solutions that better address the healthcare and associated problems of the city's, and the nation's, aged population.

3. Link new geriatric-based health, community and economic development strategies with new educational opportunities

There should be one or more new public or charter high schools designed to create a workforce and a leadership pool for biotech industrial expansion, as well as training for direct care service opportunities. Miami-Dade County in Florida has established BioTech High School; Philadelphia should have at least one, too. With all of the clamoring regarding charter v. public schools, and the role of the private sector in education, creating such a school (or schools) to bring the city's technology communities, educational communities and foundation communities

together to educate the city's children for the jobs of tomorrow would be a worthy achievement on its own.

Conclusion

Philadelphia has all the components necessary to be a national leader in elderly healthcare innovation, but we have not yet organized our public, private and nonprofit sectors in ways that enable us to provide better and oftentimes less-costly care for our vulnerable elders or take advantage of the economic benefits that would derive from better geriatric healthcare policy. With the arrival of a new mayor and health commissioner in the city and a governor still early in his administration (and facing a huge budget crisis) the public sector stars are aligning with the city's large and diverse healthcare sector to begin the conversations necessary within government and with the private and nonprofit communities for the reinvention of how the city, and ultimately the nation, can better respond to this growing public health concern.

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