The Health and Aging Policy Fellows Program: Building a Network of Future Leaders
Promoting Aging Policy:
The Health and Aging Policy Fellows Program

Robert B. Hudson, Editor

We are delighted to devote this issue of PP&AR to the work of the Health and Aging Policy Fellows Program, directed by Harold Alan Pincus from Columbia University (in collaboration with the American Political Science Association Congressional Fellowship Program) and supported by a grant from The Atlantic Philanthropies. The program embodies (literally) the goals of PP&AR and the National Academy on an Aging Society (Academy), which houses the publication. Our ongoing intent is to analyze policy options related to aging and make those analyses available to the widest possible audience in order that positive policy changes might result. By placing highly qualified fellows in national legislative and administrative offices, the Health and Aging Policy Fellows are able to work in all three arenas: analysis, dissemination, impact.

Using a somewhat more distal lens, the present program is similar in emphasis and spirit to an earlier program sponsored by The Gerontological Society of America (GSA, which provides a home to both PP&AR and the Academy). From 1974 to 1993, GSA administered the Technical Assistance Program (TAP), which sought to break down the barriers between academia and practice. It offered researchers opportunities to serve in applied settings, and therefore provided agencies—primarily State Units on Aging (SUAs) and Area Agencies on Aging (AAAs)—with direct links to the research community and information relevant to practice. By the 1990s, many TAP researchers’ influence extended to policy makers as well; the types of agencies participating in the program stretched well beyond the traditional network of SUAs and AAAs to include hospitals, research centers, voluntary agencies, federal agencies, Congress, the United Nations, and even a national television network. In light of these earlier efforts and the policy analyses that PP&AR has made available over the past 14 years, we believe this to be an ideal venue for publicizing the policy research efforts of this current generation of investigators supported through the Health and Aging Policy Fellows Program.

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### The Health and Aging Policy Fellows Program: An Overview

#### About the Program

The Health and Aging Policy Fellows Program was established in January 2008 with support from The Atlantic Philanthropies. Directed by Harold Alan Pincus, MD, and his deputy Phuong Trang Huynh, PhD, MPH, the program seeks to provide professionals in health and aging with the experience and skills necessary to understand and impact policy and create a cadre of leaders who will serve as change agents for policies that ultimately will improve the health of older adults.

To maximize flexibility for working professionals, the nine-to-12-month program allows fellows to select between two tracks: residential or non-residential. The **residential** track includes full-time placement in a policy environment. Policy training can be obtained by working in the U.S. Senate or House of Representatives, executive agencies at federal or state levels, or ‘think tank’ organizations. The **non-residential** track involves part-time work on a specific policy project and brief placements throughout the year at relevant sites, and can involve linkages with legislative or executive offices and other settings. Whereas the residential model provides fellows with a hands-on, wide-ranging policy experience, the non-residential model focuses on a specific health policy project tailored to the fellows’ individual interests and backgrounds. Once selected, the National Program Office (NPO), along with staff from the American Political Science Association (APSA) Congressional Fellowship Program, work with each fellow to identify appropriate projects and/or placements.

Fellows also can apply for second-year funding to continue components of their fellowship. Upon completion of the program, fellows are expected to use their newly acquired skills to lead policy changes at local, state, and national levels.

#### Core Program Components for Both Tracks

In addition to policy experience and projects, all fellows receive a core training program that is focused on current policy issues, communication skills development, and professional networking opportunities. Core program components include:

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<th>Component</th>
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<td><strong>1. Mentorship:</strong></td>
<td>Mentoring—provided through a range of sources—constitutes an important component of the program.</td>
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<td><strong>2. Individualized Learning Objectives and Plan:</strong></td>
<td>Each fellow develops a set of individualized learning objectives and a plan that includes their goals for the fellowship year and for future career development.</td>
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<td><strong>3. Health Policy Orientation:</strong></td>
<td>Each fellow participates in the three-and-a-half day AcademyHealth Health Policy Orientation that offers an in-depth introduction to formal and informal policymaking processes, key players within these processes, and critical health policy issues.</td>
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<td><strong>4. APSA Congressional Fellowship Program Orientation:</strong></td>
<td>Fellows participate in the APSA Congressional Fellowship Program’s month-long orientation focusing on the legislative process and current congressional affairs.</td>
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<td><strong>5. Aging Policy Orientation:</strong></td>
<td>Fellows participate in a one-and-a-half day Aging Policy Orientation that includes topics that address the major challenges in health care for the aging.</td>
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<td><strong>6. Weekend Workshops and Team Projects:</strong></td>
<td>Fellows participate in two intensive weekend workshops that specifically focus on policy substance and skill building.</td>
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<td><strong>7. Webinars:</strong></td>
<td>The NPO organizes a series of web-based seminars conducted by experts on designated topics of interest to the fellows.</td>
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<td><strong>8. Annual Leadership Retreat:</strong></td>
<td>At the end of each fellowship year, the NPO hosts a two-day Annual Leadership Retreat for current fellows, alumni, National Advisory Board members, mentors, colleagues from placement sites, and invited experts, at which current fellows present their fellowship work.</td>
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<td><strong>9. Alumni Activities:</strong></td>
<td>The NPO provides post-fellowship support by maintaining an alumni network, organizing alumni meetings, and offering ongoing mentoring.</td>
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What Do They Mean by Health and Aging Policy?

In many ways, gerontology represents the future of health care. The U.S. population is aging rapidly. By 2030, about 20 percent of the United States population will be age 65 or older. These individuals are at high risk for complex health problems, chronic illness, and disability, and they will continue to be the heaviest users of institutional and in-home health care. Over the next 30 years, almost every medical specialty will have an increasingly older patient base.

At the same time, the substantial inequalities that already exist within the older population promise to become even more pronounced. Single, divorced, or widowed women and members of racial minorities and immigrant groups—whose numbers will increase substantially—are especially vulnerable to debilitating chronic health problems, poverty, and unmet health and social needs as they age. As the older population grows, so will the size of this vulnerable fraction of older adults.

The Health and Aging Policy Fellows Program views health in a broad context which extends beyond just health care. It defines health and aging policies as those that aim to improve holistically the well-being of older adults. These can include:

- Policies affecting older adults with multiple, serious chronic conditions;
- Policies affecting the economic security of vulnerable and disadvantaged older adults;
- Policies that promote civic engagement (volunteerism and community engagement) by older adults and caregivers to improve the healthcare system and the well-being of older Americans (especially those with low incomes and people of color).

Partnerships

The Health and Aging Policy Fellows Program partners with the APSA Congressional Fellowship Program that is directed by Jeffrey Biggs, PhD. Founded in 1953, the APSA Congressional Fellowship Program is the nation’s oldest and most prestigious congressional fellowship. The Health and Aging Policy fellows participate in all APSA Congressional Fellowship Program activities.

The Health and Aging Policy Fellows Program has combined with the John Heinz Senate Fellowship in Issues of the Aging to create the joint John Heinz/Health and Aging Policy Fellowship. Each year, one individual is designated the John Heinz/Health and Aging Policy Fellow.

The Health and Aging Policy Fellows Program also is partnering with the Healthy Aging Program at the Centers for Disease Control and Prevention (CDC). For the 2010-2011 fellowship year, the CDC will sponsor a non-residential Health and Aging Policy Fellow to work on a policy project in collaboration with the CDC.

The Health and Aging Policy Fellows Program also has collaborated with the John A. Hartford Foundation, the Practice Change Fellows Program, The Gerontological Society of America (GSA), AcademyHealth, AARP, the American Society on Aging (ASA), the National Council on Aging (NCOA), the American Geriatrics Society, and multiple Executive Branch agencies such as the National Institute on Aging and the Department of Veterans Affairs.

National Advisory Board and Mentors

The Health and Aging Policy Fellows National Advisory Board (NAB) consists of prominent leaders in government, academia, and the private sector who possess expertise and experience in health, aging, and policy issues. NAB members guide program direction, serve on the Selection Committee, and mentor fellows. The list of NAB members can be found at www.healthandagingpolicy.org/about/advisory_board.html.

Each fellow is paired with one or more primary policy mentor(s), chosen from the pool of NAB members and other national experts; the primary policy mentor assists the fellow in building networks of appropriate colleagues and policymakers both inside and outside of government.
Eligibility and Selection
Fellows are selected each year through a national competition based on their commitment to health and aging issues, leadership potential, and interest in impacting policy. The program is open to physicians, nurses, social workers, and other clinicians (e.g., pharmacists, dentists, clinical psychologists) with a demonstrated commitment to health and aging issues and a desire to be involved in health policy at the federal, state, or local level. The program is open to U.S. citizens at all career stages, with priority given to those early or midway through their careers. The program seeks to achieve racial, ethnic, gender, and disciplinary diversity, so applicants from groups that historically have been underrepresented are strongly encouraged to apply.

The Inaugural 2008-2009 Health and Aging Policy Fellows
The first call for applications received an overwhelming response. A stellar class of fellows was chosen in July 2008, and fellows began their fellowship year in October 2008. The fall of 2008 proved to be a fortuitous time for the fellows to begin their fellowship year, as they had the unique opportunity to work in the midst of historic health care reform efforts. The fellows were:

Residential

**Gretchen E. Alkema**, PhD, LCSW (John Heinz/Health and Aging Policy Fellow)
- Vice President, Policy and Communications, The SCAN Foundation
- Fellowship Placement: Alkema served in the office of Senator Blanche L. Lincoln (D-AR)

**Kathryn G. Kietzman**, PhD, MSW
- Keitzman has extended her fellowship for one additional year. She is serving in the office of Senator Debbie Stabenow (D-MI)

**Brian K. Hensel**, PhD, MSPH
- Assistant Professor, Department of Health Services Administration, Beacom School of Business, University of South Dakota
- Fellowship Placement: Hensel served in the office of Senator John D. Rockefeller IV (D-WV)

**Toni P. Miles**, MD, PhD
- Professor, joint appointments in the Kent School of Social Work and the Department of Family and Geriatric Medicine, School of Medicine, University of Louisville
- Fellowship Placement: Miles served as a staffer on the U.S. Senate Finance Committee

**Gregory Hinrichsen**, PhD
- Associate Clinical Professor of Psychiatry and Behavioral Sciences, Albert Einstein College of Medicine
- Fellowship Placement: Hinrichsen served as the Mental Health and Aging Policy Liaison, Office of Mental Health Services, Department of Veterans Affairs

Non-Residential

**Elizabeth (Libbie) Bragg**, PhD, RN
- Associate Professor, College of Nursing, and Research Associate Professor, Department of Public Health Sciences, College of Medicine, University of Cincinnati
- Fellowship Project: Bragg focused on geriatrics workforce issues, Medicare, and health status
patients who stand to benefit from it improving access to transplantation for those older examined both clinical and policy approaches to improving access to transplantation for those older patients who stand to benefit from it

The 2009-2010 Health and Aging Policy Fellows

The second call for applications once again received a large number of applications from highly qualified candidates. The Selection Committee extensively reviewed each application, interviewed finalists in Washington, DC, in June, and eventually chose nine fellows who represent a diverse group in terms of disciplines and career states. The fellows began their fellowship year in October 2009. The fellows are:

Residential

Chad Boult, MD, MPH, MBA
• Eugene and Mildred Lipitz Professor and Director of the Roger C. Lipitz Center for Integrated Health Care, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health
• Fellowship Placement: Boult is serving in the Centers for Medicare and Medicaid Services (CMS)

Kelly D. Horton, MS, RD, CD
• Founding Director, Connect Nutrition
• Fellowship Placement: Horton is serving in the Food and Nutrition Services’ Office of Strategic Initiatives and Partnerships of the USDA

Dorry Segev, MD, PhD
• Director, Clinical Research, Transplant Surgery; Director, OPUS (Older Patients Undergoing Surgery) Training Program; and Associate Professor of Surgery, Johns Hopkins University
• Fellowship Project: Segev examined both clinical and policy approaches to improving access to transplantation for those older patients who stand to benefit from it

Judy Zerzan, MD, MPH
• Assistant Professor, Division of General Internal Medicine, University of Colorado Denver School of Medicine
• Fellowship Project: Zerzan focused on issues related to coordinating benefits for those dually eligible for Medicare and Medicaid, with an emphasis on improving the Medicare Part D benefit. She served part-time in the office of Senator John D. Rockefeller IV (D-WV)

Diane E. Meier, MD, FACP
• Director, Center to Advance Palliative Care and Director, Hertzberg Palliative Care Institute, Mount Sinai School of Medicine
• Fellowship Placement: Meier is serving on the Senate Committee on Health, Education, Labor and Pensions (HELP)

Kathleen Negri, JD
• Elder Law Attorney
• Fellowship Placement: Negri is serving in the House Democratic Caucus

Non-Residential

Steven R. Counsell, MD
• Mary Elizabeth Mitchell Professor, Director, Indiana University Geriatrics, and Scientist, Indiana University Center for Aging Research, Indiana University School of Medicine
• Fellowship Project: Counsell is examining policies to improve care coordination for Medicare beneficiaries
• Fellowship Placement: Boult is serving in the Residential disciplines and career states. The fellows began their fellowship year in October 2009. The fellows are qualified candidates. The Selection Committee extensively reviewed each application, interviewed finalists.

The 2009-2010 Health and Aging Policy Fellows program National Advisory Board Member: “The Health and Aging Policy Fellows program has exceeded all expectations. The quality of the fellows is extraordinarily high. The experiences they have gained working on Capitol Hill, in government agencies or in their own institutions as non-residential fellows, has been very rich. And, the talents and insights the fellows have brought to the policy environment will surely leave a lasting and valuable impact. We are proud at The Atlantic Philanthropies to be associated with this program.”

Source: This overview was adapted from the Health and Aging Policy Fellows Newsletter (September 2009, www.healthandagingpolicy.org/resources/newsletter.html) and from material on the Health and Aging Policy Fellows Program website (www.healthandagingpolicy.org).

Richard A. Marottoli, MD, MPH
• Associate Professor of Medicine, Yale University School of Medicine; Medical Director, Adler Geriatric Assessment Center at Yale-New Haven Hospital; and Staff Physician, VA Connecticut Healthcare System
• Fellowship Project: Marottoli is focusing on the intersection of transportation and health policy with the goal of optimizing the out-of-home mobility and safety of older persons

Heidi Wald, MD, MSPH
• Assistant Professor of Medicine, Division of Health Care Policy Research, University of Colorado Denver
• Fellowship Project: Wald is exploring the impact of CMS’ value-based purchasing initiatives on patient safety outcomes for older inpatients

Kathleen Tschantz Unroe, MD, MHA
• Geriatric Medicine Fellow, Duke University Medical Center and Durham VA Geriatric Research, Education and Clinical Center
• Fellowship Project: Tschantz Unroe is examining rehospitalization of those in skilled nursing facilities and also is serving a part-time placement in the Office of the Assistant Secretary for Planning and Evaluation

Margaret I. Wallhagen, PhD, GNP-BC, AGSF, FAAN
• Professor, Department of Physiological Nursing, and Director, John A. Hartford Center of Geriatric Nursing Excellence, University of California, San Francisco
• Fellowship Project: Wallhagen is exploring Medicare reimbursement policies for durable medical equipment, in particular, hearing aids

Stephen McConnell, PhD, Program Executive, Aging Policy and Advocacy, The Atlantic Philanthropies, Health and Aging Policy Fellows Program

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The American Political Science Association Congressional Fellowship Program and the Health and Aging Policy Fellowship

Jeffrey R. Biggs

In December 2007, Dr. Harold Alan Pincus and his deputy, Dr. Phuong Trang Huynh, approached the American Political Science Association Congressional Fellowship Program (CFP) about the idea of partnering with a new Atlantic Philanthropies-funded Health and Aging Policy Fellowship. Dr. Pincus had agreed to direct this new program, which would sponsor seven to ten residential and non-residential geriatric and gerontology professionals per year. Dr. Pincus brought his expertise and experience as Vice Chair of the Department of Psychiatry at Columbia University, Director of Quality and Outcomes Research at New York Presbyterian Hospital, and Senior Scientist at the RAND Corporation. Dr. Huynh’s background drew on an MPH and PhD in public health and experience serving as the Associate Director of The Commonwealth Fund’s International Programs in Health Policy and Practice.

As with the other career tracks in the APSA Congressional Fellowship Program, the expectation was that the Health and Aging Policy fellows would add value to the personal or committee offices in which they would work, and that obtaining a greater understanding of the policy process would be pivotal in their post-fellowship careers. To aid in the process, each fellow would be assigned an experienced mentor(s) drawn from the Health & Aging Policy Advisory Committee or other leaders in the field.

What then was this new world that the Health and Aging Policy and the APSA CFP fellows would be entering? Nothing in my foreign service, executive or legislative branch career experience, or educational background equips me with any expertise to address health and aging policy issues. However, the diversity of my career experiences does touch on most of the career tracks which comprise a typical class of between 35 and 40 APSA fellows. With the superb mentorship of the 2008-09 inaugural class of Health and Aging Policy fellows, as well as their superb direction under Drs. Pincus and Huynh, I have learned a great deal about health policy in general, and gerontology and geriatrics in specific. This group of Health and Aging Policy fellows arrived with a voracious appetite to learn, and their enthusiasm persisted because they all were placed on either the personal staff of a Senator with a committee assignment on the Senate Finance Committee (a major engine of what has emerged in the conference committee as the Senate health reform package) or on the Finance Committee’s health team itself. One fellow who had previous Hill experience chose to work at the Veterans Administration. In the articles that follow, the fellows will explain their own experiences, but the range of issues on which they worked covered all the bases: health care reform for the individual and small business markets; elder justice and safety; care coordination for elders with multiple chronic conditions and dementia; child and maternal health including prenatal/infant screenings and nutrition; hospice; access to allied health services such as counseling, physical therapy, and other rehabilitative methods; geriatric workforce issues; and fiscal responsibility and sound investment in programs when appropriate.

They selected offices that housed staffs with whom they felt comfortable working long hours, that recognized the value they would add, that placed them in the middle of the office dynamic, that provided a long learning curve and mentorship on how the legislative process works in real time, and where they ultimately were responsible for helping to draft legislation, working with the Senate Legislative Counsel, serving as a liaison to NGOs, lobbyists, constituents and other stake holders, and periodically briefing the Senator one-on-one. It doesn’t get much better than this. They emerged with a well honed “insider’s” understanding of the Congress and health care policy formulation. But this is getting ahead of the story as to how the fellowship tried to equip them for these roles.

I think at this point my best service for this issue of Public Policy & Aging Report would be to provide the broad context by which the Health and Aging Policy Fellowship fit into the broader APSA Congressional Fellowship. Founded in 1953 (with more than 2,300 alumni since then), the APSA
Congressional Fellowship remains as it began—a highly selective, nonpartisan, legislative work experience. The fellowship is devoted to expanding knowledge and awareness of Congress by selecting participants whose ongoing careers can benefit from exposure to this pivotal personal experience. Over the years, the APSA Congressional Fellowship has attracted talented political scientists, journalists, domestic and foreign policy government specialists, and international scholars who were sponsored by the German Marshall Fund of the United States, the Asia Foundation, the American Australian Association, the Fulbright scholarship fellows program, the Native American Hatfield fellows program, the University of Oklahoma Carl Albert Center fellowship, the Robert Wood Johnson Health Policy fellowship, and, most recently, the Atlantic Philanthropies-funded Health and Aging Policy Fellows Program. From the initial class of 50 fellows seven years ago made up of five early-career political scientists and one journalist, the fellowship has now become a true intellectual melting pot with one shared goal: a desire to understand the roles of politics, policy, and process in the Congress, and to participate in the process of policy formulation.

A number of these fellowship cohorts, including the Health and Aging Policy fellows, have their own orientation programs in the early Fall at which they are introduced to the governmental and NGO applied specialists in their field. This provides them with a solid grounding in the state of the nation’s health care, for example, but also helps them begin to establish a critical network of professional contacts for both their fellowship and their ongoing careers. Serendipitously, and in keeping with the Obama administration and the congressional priority on improving the nation’s health care system, the 2008-09 class included five Health and Aging Policy residential fellows, three non-residential fellows who participated in the orientation but pursued projects from their own institutions, and 10 Robert Wood Johnson (RWJ) Health Policy fellows. Unlike the RWJ fellows of a decade ago who came predominantly from university-based medical school surgical faculty, the current fellows represent a broad cross-section of health delivery experts ranging from a doctoral graduate in social welfare, psychology, and health informatics, to a director of clinical geriatrics research, to assistant, associate, and full professors of nursing, internal medicine, occupational health, women’s health services, and pharmacology, to a vice president of the MedStar Research Institute.

The 2009-10 class includes 19 health policy fellows (four residential and five non-residential Health and Aging Policy fellows and 10 RWJ Health Policy fellows) who are equally diverse. The group includes a professor of medicine, epidemiology, and biostatistics, an associate director of the National Registry of Emergency Medical Technicians, a professor of nursing, a founding director of Connect Nutrition, a director of a center of advanced palliative care, and an elder law attorney.

We are now in the second banner year for health reform. The conventional wisdom suggests that a conference committee will resolve the differences between the House and Senate versions of health care reform, and that that version ultimately will be passed by both chambers for a presidential signature. Should that prospectus prove accurate, a number of the 2009-10 health policy fellows have concluded that there is a more valuable learning curve working on the staff of the executive branch which would begin implementing the new legislation. Such assignments thus far are in the office of the Assistant Secretary for Preparedness and Response (ASPR), the Centers for Medicare and Medicaid Services (CMS), the office of the Secretary of Health and Human Services (HHS), the office of the Chief of Staff/Counselor for Public Health and Science, the office of the Assistant Secretary for Planning and Evaluation (ASPE), the USDA/Food and Nutrition Services, the Office of Strategic Initiatives and Partnerships, and the office of First Lady Michelle Obama’s Initiative to Reduce Childhood Obesity.

With an unprecedented number of health policy fellows having secured assignments in the executive branch, it becomes important—particularly important for a fellowship focused primarily on the Congress—that all of these fellows participate in the bi-weekly Wilson Seminar Series, which is intended to enlarge an understanding of the federal legislative process beyond that of a single office. The 2009-10 series opened on the floor of the House with a talk by the Hon. John V. Sullivan on the role of the House Parliamentarian. Other discussants over the course of the year will include the directors of the three major House Press Galleries, syndicated Washington Post Pulitzer Prize-winning columnist Dave Broder, representatives of the Congressional Budget Office, representatives of the Government Accountability Office, Charlie Cook of The Cook Political Report, former Press Secretary to President Clinton, Mike McCurry, and Library of Congress specialist in constitutional law Lou Fisher.

One potential risk that the health policy fellows
run is that they will become too narrowly focused on one aspect of policy to the exclusion of a far broader array of legislative concerns, and as a result, will lack the understanding to determine why healthcare might not receive the congressional interest they think it deserves. This has been particularly true during the 111th Congress’ major policy initiatives surrounding the economic meltdown, the economic stimulus package, cap-and-trade and other variations of energy policy, defense issues including Iraq and Afghanistan, education, and health care reform.

As difficult as it is to find a common denominator among such career variations of a typical class of 35 to 40 Congressional fellows, the Fall intensive orientation attempts to provide a broader context for health policy fellows. The orientation is also a persuasive argument for the benefits of connecting with other fellows, as exemplified by the number of alumni who regularly give orientation presentations. Of the more than 75 speakers this year, 23 were former fellows or Advisory Committee members.

While a portion of the orientation includes political “over the horizon” presentations, there are also more pragmatic discussions focused on the tools the fellows will require once they secure their assignments. These include two days of advanced Senate and House legislative procedures and sessions like: “Do Deficits and Budgets Make a Difference?”; “The Congressional Appropriations Process”; an on-site orientation to C-SPAN; observing Supreme Court arguments; panels of former fellows describing the interview process and maximizing the fellowship experience; panels of House and Senate full-time staff describing how personal office and committee staffs operate; and Congressional Research Service (CRS) presentations on utilizing the services available.

During the orientation, there are a number of half-day and full-day sessions that help the fellows determine what type of assignments would best fit their ongoing careers, explore the advantages and disadvantages of the Senate versus the House and personal offices versus committee staffs, prepare their resumes and cover letters, begin faxing and emailing their submissions, and visit congressional offices in search of an interview. Even for the best prepared fellows, this is invariably a relatively high-anxiety exercise because it generally has been years since most of them have had to “peddle their wares.” Even for the most resilient of egos, it can be disheartening to encounter a lack of response, a shortage of office space, or to discover that some other free-labor individual already has been accepted. One-on-one mentoring sessions with fellowship staff are a constant feature of the assignment process. Yet, the fact remains that there has never been a congressional fellow who did not find an assignment.

If there is a saving grace in this initial stage of the fellowship, it is the comfort of fellow colleagues sharing their experiences and knowing that once assigned, they will have a network of colleagues with whom to spend the next 10-plus months. Life might be easier if fellows simply were assigned offices in advance, but that would hardly assure the right match between each fellow’s assessment of her/his own needs and an office’s decision that an individual fellow will provide the value-added to ensure a productive experience. Historically, the fellowship has proven to be a pivotal experience in each fellow’s life, and finding the appropriate assignment helped make this happen. The Health and Aging Policy fellows participate in every aspect of the APSA Congressional Fellowship from the orientation through the bi-weekly Wilson Seminar Series. They, like political scientist or international fellows, have their own particular focus, but they all participate under the same tent and benefit from their collaborations with each other.

At a higher level, all APSA Congressional fellows arrive with their own version of a commitment to public service. He could have had the Congressional Fellowship in mind when former Speaker of the House and member of the fellowship’s Advisory Committee, Thomas S. Foley noted: “In a cynical age, I still believe that we must summon people to a vision of public service. For, in the end, this ethic determines more than anything else whether we will have citizens and leaders of honor, judgment, wisdom, and heart.”

Jeffrey R. Biggs, PhD, is the director of the American Political Science Association Congressional Fellowship Program in Washington, DC.

Endnotes:
1. For a list of the Health and Aging Policy Fellows Program National Advisory Board members, please see http://www.healthandagingpolicy.org/about/advisory_board.html.

2. Speakers include: Andres (1982-83 political scientist fellow), Vice Chairman of Public Policy and Research for Washington, D.C.’s Dutko Worldwide; David Auerswald (1998-99) political
The American Political Science Association Congressional Fellowship Program

scientist on the faculty of Washington, D.C.’s National War College; Arthur Burris (2000-01), political scientist and Majority Deputy Staff Director of the House Budget Committee; Michelle Chin (2006-07), political scientist and Legislative Assistant to Senator John Cornyn (R-TX); Rich Cohen, CFP Advisory Committee and National Journal Chief Correspondent; Chris Deering (1984-85), political scientist and George Washington University professor; Ron Elving (1984-85), journalist and Washington Editor of National Public Radio; Mike Franc, CFP Advisory Committee and Heritage Foundation Vice President for Government Relations; Meghan Gordon (2008-09), journalist and Platts/McGraw-Hill Associate Editor; Brian Harvey (2001-01), Federal fellow and sanofi-aventis Vice President for Regulatory Policy; John Haskell (1997-98), political scientist and senior fellow at the Georgetown University Government Affairs Institute; Susan Kalasunas (2008-09), Federal fellow and research analyst at the Social Security Administration; Kathryn Kietzman (2008-09), Health and Aging Policy fellow; Simon Rhodes Lomax (2006-07), journalist and Bloomberg News Washington Bureau; Tom Mann (1969-70), political scientist and Brookings Institution W. Averell Harriman Chair; Marie Michnich (1984-85), RWJ Health Policy fellow and RWJ Director of the Institute of Medicine; Norm Ornstein (1969-70), political scientist, CFP Advisory Committee Chair and American Enterprise Institute Resident Scholar; Alan Romberg (1974-75), State Department Foreign Affairs fellow and Henry I. Stimson Center Distinguished Fellow; Colleen Shogan (2006-07), political scientist and Library of Congress Congressional Research Service Director of the Government and Finance Division; Neil Simon (2005-06), journalist and Communications Director of the U.S. Commission on Security and Cooperation; Jim Thurber (1973-74), political scientist, CFP Advisory Committee and Director of American University’s Center for Congressional and Presidential Studies; Deborah Trautman (2006-07), RWJ Health Policy fellow and office of the Speaker of the House; Ken Vogel (2005-06), journalist and POLITICO reporter.
Connection Power: Influencing Health Workforce Policy for the Aged

Elizabeth J. Bragg

The Health and Aging Policy (HAP) Fellowship is structured so that fellows can choose to do either a residential or a non-residential fellowship. While the residential track requires fellows to move to Washington, DC for the year, non-residential fellows can stay in their own cities and travel to and from Washington, DC for training and meetings throughout the year. I chose the non-residential fellowship track.

The fellowship training started in October with a three-day health policy orientation conducted by AcademyHealth, an organization established in June 2000 to improve health and health care by generating new knowledge and moving knowledge into action (AcademyHealth, 2010). This behind-the-scenes-decision-making-in-Washington workshop, run by actual policymakers, provided an excellent overview of the federal government. The AcademyHealth policy orientation was followed by a day-and-a-half orientation to the HAP Fellowship program that included a reception to introduce the fellows to leaders in the health and aging field, congressional staff and health policymakers in Washington. A week later, on the day after Obama was elected President, I returned to Washington for about one month of intense training provided by the American Political Science Association (APSA) Congressional Fellowship Program. I remember waiting in a long line with another non-residential fellow to get a copy of a special edition of the Washington Post that covered Obama’s election. There was so much excitement that day; that energy set the stage for my first year of fellowship training.

To prepare us for our fellowships, we received intensive training and support from the APSA Congressional Fellowship Program and actually are considered APSA Congressional fellows. For over 50 years, the APSA program has been expanding public understanding of policy making to improve the quality of scholarship, teaching, and reporting on American national politics (American Political Science Association, 2010). As a HAP fellow, I attended this orientation along with about 40 other APSA fellows who included political scientists, journalists, lawyers, Robert Wood Johnson fellows, and government employees. Not only did the APSA program provide a multitude of lectures by well known policymakers and previous congressional fellows, it also organized trips to institutions important to policymaking such as the Nations’ capitol, C-SPAN, the Supreme Court, and the Institute of Medicine (IOM).

After a month of orientation and training in Washington, DC, I returned to Cincinnati to my regular job as a researcher in the Geriatrics Workforce Policy Studies (GWPS) Center. This Center is funded by a grant from the John A. Hartford Foundation to the American Geriatrics Society to provide high quality longitudinal information on the status of geriatric medicine training and practice that will help guide future national policy.

My goals for the year did not include working in a member of Congress’ Washington office, but rather learning how best to increase my effectiveness advancing policy issues related to aging. I also wanted to continue to learn about the policy making process, particularly as it deals with the workforce to care for an aging population. Both of these goals connect directly with my primary work in the GWPS Center. To do this, I felt I needed to develop key contacts in public policy agencies and organizations that have a role in collecting data and developing policy in the geriatrics workforce arena. Funding from my fellowship allowed me to focus one day per week of my time on these goals throughout the year.

Involvement in policy proposals

After my initial intense training in Washington, DC, I planned trips of two to three days to Washington every six to eight weeks. During these trips, I arranged meetings with a variety of policymakers and influential leaders in organizations related to health and/or aging. Since I did not have any positional power (i.e., no placement in a congressional office), my goal was to develop connection power and to build reciprocal relationships so that in the future I might be a source of information and knowledge for these individuals. I wanted to build long-term, trust-based relationships. I knew that the more I could connect with relevant and diverse sources to create and share new knowledge, the more the knowledge would thrive (Hagel, Brown, & Davison, 2009); and
if I didn’t connect, others with different agendas and ideas would. Another goal of these meetings was to educate the policymakers about the HAP Fellowship. The agencies and individuals I met with included the health legislative aide to Senator Sherrod Brown (D-Ohio), aides to the Senate Special Committee on Aging, a congressional staffer in Speaker Nancy Pelosi’s office, the National Institute on Aging, the National Institute of Nursing Research, AARP, the Association of American Medical Colleges, the Agency for Healthcare Quality and Research, and the Robert Graham Center for Policies Studies in Family Medicine and Primary Care.

The fellowship training opened my eyes to the importance of information processing, which is the collecting, assembling, interpreting, and prioritizing of signals from the environment. Policymakers are limited by the information they have, whether it is an oversupply or an undersupply (Workman, Jones, & Jochim, 2009). There is so much information bombarding legislators, congressional aides, and other policymakers that the supply and prioritization of information are crucial. By developing long-term, trust-based relationships, I hope that I am viewed as someone who can provide accurate information to policymakers when they need it. I learned how to streamline information so the most salient points are obvious. This past year, I provided information for an IOM fact sheet—that followed up on the IOM’s *Retooling for an Aging America* report—regarding gender and minority physicians in academic training programs for geriatrics; I also provided data to the Senate Committee on Aging regarding medical schools’ requirements for geriatric training of their medical students.

**Influence of the HAP fellows**

Because our fellowship started out with a month of training in the APSA fellowship program, we were able to build relationships with and inform the approximately 40 non-HAP fellows about our interests and work in advancing policy related to aging. Once the intense APSA training was over, these fellows were dispersed in congressional offices as well as other government agencies (e.g., the General Accountability Office). During the fellowship year, many of these fellows met informally weekly for coffee, and attended some formal sessions arranged by the APSA program. If an issue related to aging arose in their offices, they already had a connection with HAP fellows on whom they could rely for information or guidance. Just being part of the APSA congressional fellowship program added to the credibility of our HAP fellowship program because of the longevity and respect held by many policymakers regarding the APSA fellowship program. Indeed, many current policymakers and influential individuals were themselves previous APSA congressional fellows.

Because we were HAP fellows, several of us were invited to the 16th Annual Princeton Conference with the topic, “How Will We Meet the Health Services Needs of an Aging America?” This exposed many individuals outside of our fellowship to the program, and consequently several of us have been invited to the upcoming 17th Annual Princeton Conference on “Examining End of Life Care: Creating Sensible Policies for Patients, Providers, and Payers.”

In some ways, I probably have had a less concentrated dose of the experience than the residential fellows. But because my background includes a PhD in political science, and because I teach health policy courses to master’s students, I follow the political scene. Still yet, the experiences I had and the knowledge I gained during the fellowship clearly have altered the way I teach health policy. Now, students in my courses follow various political websites varying in political persuasions, subscribe to “The Hill” email updates, and watch markups or congressional hearings on C-SPAN or on other political news sources. Prior to and since becoming a HAP fellow, I continue to work on issues related to the geriatric and primary physician workforces.

**Most rewarding and challenging aspects of the fellowship**

One challenging aspect of being a non-residential fellow, covered approximately one day per week by the HAP Fellowship program, was staying connected to the policy process and carving out my fellowship time. I had several strategies, however, to help with this concern. On a weekly basis, I connected with another non-residential policy fellow to discuss our accomplishments and hold each other accountable regarding goals and tasks for the week. I also had a long-time colleague and a wonderful mentor—who was previously the head of the FDA—who were available to help me refocus. Additionally, I already spend most of my professional time involved in geriatric workforce issues, so my fellowship work built upon my everyday priorities.

There were many rewarding aspects to the program. The training that is provided is top notch.
The speakers at the workshops are involved actively in policymaking and many regularly appear on national radio and television or are quoted in newspaper stories and magazine articles.

The communications training provided in workshops for the HAP fellows was extremely valuable. I have improved my communication skills greatly and have used some of the skills I learned in helping the American Geriatrics Society develop a brief document to use for a recent White House visit.

One of the most rewarding aspects of the fellowship has been getting to know the other HAP fellows, the other congressional fellows in the APSA program, the HAP program directors and board, and the program directors of the APSA congressional fellowship program. I have developed relationships with these individuals that will last forever. These fellows now have completed their fellowships and have taken positions across the country, and yet we remain connected.

**Career plans**

I was able to extend my fellowship for nine additional months with a buy-out time of about a half day per week. I continue to focus on workforce issues for health professionals caring for the elderly—particularly physicians—and am considering utilizing the Medicare database to determine what data is available regarding the practice of geriatricians and reimbursement issues for primary care providers. As such, I continue my work with the GWPS Center and continue to connect the work I do as part of my HAP fellowship with the work I do in the GWPS Center.

**Elizabeth Bragg, PhD, RN, is an associate professor in the Department of Public Health Sciences, College of Medicine, at the University of Cincinnati. She is a registered nurse with a PhD in political science.**

**References**


Impact of Reform in the U.S. Health Care Markets on Health Disparities

Toni P. Miles

As a biomedical researcher, my work focuses on factors leading to the development of frailty in late life. As my research evolves, I am increasingly interested in policies regulating health care delivery. In my role as a university professor, I came to view health policy as a barrier to the implementation of evidence-based change in clinical care. When the Health and Aging Policy (HAP) Fellowship was announced in January 2008, I took a chance and applied for the residential program. At the time, I was convinced that Washington needed to hear from professionals with “real world” experience. When I received the acceptance notice in July, I was thrilled!

With the backdrop of the 2008 Presidential campaign, the world seemed full of opportunities to make real changes. I wanted to learn about health care policy more broadly, not just aging. In my reading about the Hill and health care legislation, I came across the white paper on health reform developed by Senator Max Baucus (D-Montana) and the Senate Finance Committee Health Team. Their analyses and the proposals for policy change appealed to my sense of attainable health care reform. To get the placement, I attended Finance Committee hearings and spent a month interviewing with nine members of the staff. I began working in January 2009, one week after President Obama was sworn into office. The week I began my placement, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) was being debated on the floor of the Senate and the American Revitalization and Reinvestment Act (aka the Stimulus Bill) was being debated in the Finance Committee. The HAP Fellowship is embedded with the larger Congressional Fellowship Program managed by the America Political Science Association (APSA). Training alongside APSA fellows during the first few weeks of the program gave me the interdisciplinary exposure I needed to refine my health policy goals. In addition to my conversations with the seven other HAP fellows, I spent many hours during the training in discussions with the APSA political scientists, journalists, diplomats, lawyers, and visiting foreign scholars.

My training in medicine and neuroscience, however, left me ill equipped to understand public policy and its role in resolving health disparities. During my time as a fellow, I had the pleasure of learning from policy experts with a similar focus. This was a magical experience that I will not soon forget. The Health and Aging Policy Fellowship was instrumental in improving my ability to see beyond clinical issues (Miles, 2008; Miles, 2005; Miles, Hanson, Kidd, Connor, & Jortani, 2008) and health care workplace issues (Miles & Furino, 2005), and to appreciate the benefits and barriers created by federal legislative efforts (Miles, 2009). After completing this fellowship, I want to continue to spend my career enlarging the health disparities research frame to include public policy.

I was privileged to work at the epicenter of health reform as a staff member of the Senate Finance Committee’s Health Team. Chairman Max Baucus’ chief concern was developing a consensus and crafting a bill that would garner the votes of a majority of the 14 committee members. As anyone who followed the debate will recall, this committee was the last to produce one of the five separate bills—three from the House and one from the Senate Health Education, Labor and Pensions Committee—that were melded into the two pieces of legislation approved in the House and Senate. At the end of Finance Committee deliberations, a bill was approved by all committee members in the Democratic Party and one Republican: Olympia Snowe (R-Maine). As of this writing in January 2010, a conference committee is negotiating a single compromise of the House and the Senate versions for final passage in each chamber. Ultimately, the President can sign only one version of health care reform.

The Senate Finance Committee bill—Affordable Health Care for America Act (S. 1796)—is thought by many to be the foundation for any final bill signed by President Obama. The hallmark of this bill is its extensive regulation of the health insurance markets. As I watched the town hall meetings in the summer of 2009, it became clear that legislation is not made in a vacuum. Law evolves out of a combination of perceived need, envisioned solutions, and political will. Just enacting a public law is no guarantee that...
a need will be addressed. Once legislation is made into law, it still can be stymied by challenges through the court system. In our country, implementation of a new law is dependent upon a consensus process. If its passage is the result of a broad consensus, then the process of change will begin with a broad basis of local support. On the other hand, legislation marked by a contentious process will be followed with opposition to its implementation. Legislation reforming the U.S. health care markets is being crafted in a contentious environment. It is clear to me that any potential for market reform to reduce health disparities will be stymied by the larger societal argument over the need for any new health reform policies.

As a fellow, my job was to find answers to committee members’ questions. The time pressures are tremendous, but offices on the Hill have all necessary data and every expert at their fingertips from which to find answers. The staffer’s challenge is to find the best answer as quickly as possible. After one of the hearings, the Senators wanted to know how Medicare payment policies contributed to geographic variation in health care costs. I found an immediate answer to that question but I was left with a question of my own. How does medical fraud contribute to the geographic variation? I have been chasing that question ever since.

Fraud, waste, and abuse in public programs are issues with both a political and a policy edge. Titles IV and V of the Finance Committee bill are devoted entirely to provisions designed to enhance the integrity of government health care programs and to combat medical fraud. Together, these sections consist of more than 200 pages of the 1,500 page bill! Within these sections, many policies are devoted entirely to Medicaid. By virtue of their socioeconomic status, Medicaid recipients are the country’s most vulnerable population. Based on the intensity of legislative attention and the population characteristics, I began to wonder if fraud contributes to health disparities in the U.S. It is frightening to consider a criminal element preying upon the most vulnerable during a time of sickness. Findings from both anthropologists and criminologists, however, would say that predatory behavior is highly likely under these circumstances. During my fellowship, I became aware of evidence that medical fraud may be a contributing factor to health disparities.

Evidence from governmental initiatives: Medicare Fraud Strike Forces

The Medicare Fraud Strike Force (Strike Force) was launched in March 2007. This collaboration brings together U.S. Attorneys’ Offices and the Department of Health and Human Services (HHS) with local law enforcement agencies. The Strike Force was created specifically to handle chronic fraud and emerging schemes. Its goal is to prosecute individuals and entities that do not provide legitimate health care services and who exist for the sole purpose of defrauding government health care programs. To date, targeted providers have been associated with fraudulent claims to Medicare for durable medical equipment: power wheelchairs and orthotics, “compound” medications for use in therapies, HIV infusion clinics, tube-feeding, and fraudulent billing companies. Prosecutors now are expanding the scope of targeted schemes to include home health agencies and independent diagnostic testing facilities.

For the Strike Force, a successful case resolution results in return of stolen funds to the Medicare Trust Fund. The program does not include legal redress for individual injury associated with the fraud nor does it engage in class actions on behalf of groups that are systematically damaged by fraudulent schemes. Medicare Strike Forces have launched investigations in Miami-Dade County, Florida, the Los Angeles metropolitan area, the Detroit metro area, the Houston metro area, and New York City. Since the Strike Force operations have begun in Miami-Dade County,
there has been an estimated $1.75 billion reduction in durable medical equipment (DME) claim submissions, and $334 million DME claims paid by Medicare in Miami-Dade County. There are no comparable data available for the other areas of Strike Force activity.

As shown in Table 1, the Medicare Strike Force operates in areas with high concentrations of minority groups. The data from Miami-Dade County clearly demonstrate reductions in Medicare claims for DME. There are no existing statutes that mandate redress of harm induced by medical fraud nor are there new ones in the evolving reform legislation. Do we also need to develop policy that measures injury and mortality associated with fraudulent medical practice? How much of the gap in health outcomes for the uninsured, underinsured, and impoverished populations is attributable to failures in the delivery of services or receipt of care with sub-standard medication and devices? Currently, data exists to estimate the effects of fraud and law enforcement activities on health disparities. Clearly, the development of a Medicare Strike Force suggests that medical fraud is chronic and widespread.

Is there evidence that medical fraud has the potential to cause poor outcomes for specific conditions? There is ample evidence from successfully litigated Whistleblower Cases that vulnerable older adults are subjected to injury from medical fraud. Consider one example: in January 2009, Eli Lilly, a large pharmaceutical company, paid a total of $1.4 billion to settle civil and criminal charges it defrauded Medicare and Medicaid by off-label marketing of a popular drug Zyprexa. Off-label marketing occurs when a pharmaceutical company obtains FDA approval for a specific use of a new drug, but then asks doctors to prescribe it for other uses for which it did not seek or obtain FDA approval. Zyprexa was approved by the FDA for treating schizophrenic or bipolar illness. In court, the government won the argument that Eli Lilly widely promoted the use of this drug to nursing home patients to treat dementia, which is not an approved use by the FDA. It is illegal for pharmaceutical companies to suggest that physicians prescribe drugs for uses other than that which the FDA has approved. Of the settlement, $800 million was paid under the False Claims Act and $515 million was levied as a criminal penalty.

In 2007, Joel Hesch warned of this type of fraud in “Drugging the elderly into silence” (Hesch, 2007). Impoverished, elderly nursing home patients are most likely to be dually eligible for Medicare and Medicaid. Among health policy wonks, these patients are lovingly referred to as the dualies. By virtue of their poverty, their prescription medications are covered by a combination of federal and state dollars. The recovery of fraudulently obtained funds is a strategy that can lower the costs associated with care for this vulnerable group of citizens. Currently, however, there is no class action legal redress for the illness induced by the medications. Poverty, advanced age, and cognitive impairment are all risk factors for suboptimal outcomes of diabetes. Whether or not diabetes induced by the use of chronic medication is a widespread problem requires further research. It is clear, however, that the emergence of medication-induced disease is real and that health disparity populations are exposed to the problem.

A final word on the value added from my time spent as a fellow. My office was located in the Senate Dirksen Office Building directly across the street from the National Capitol Visitor’s Center. This sparkling new facility was a frequent site for briefings where staffers could feed the need for food and quality data simultaneously. Both were sorely needed during our long days—sometimes 12 or more hours. During the process of health reform, people like me are able to attend graduate-level presentations by nationally recognized experts. In this venue, listening to entrepreneurs, administrators, researchers, and policy wonks, I slowly became aware of health care quality initiatives. These initiatives are led by a variety of groups including the National Health Quality Forum (NHQF), the Agency for Health Care Research and Quality (AHRQ), the Premier Health Alliance, the Institute of Medicine, and large healthcare delivery systems such as Intermountain Health and Geisinger. I know that I will miss this intellectual feast. For me, the take-away message from all of these sessions is that quality improvement in health care delivery will be a key element in the battle to combat medical fraud and potentially will eliminate health disparities. In my post-fellowship life, I intend to engage my home institution in the movement towards quality care.

Toni P. Miles, MD, PhD, is a professor, jointly appointed in the Kent School of Social Work and the Department of Family and Geriatric Medicine, School of Medicine at the University of Louisville.
References


Impact of Reform in the U.S. Health Care Markets on Health Disparities

Linda Krogh Harootyan, MSW, Deputy Executive Director and Senior Director of Professional Affairs, The Gerontological Society of America, Health and Aging Policy Fellows Program
National Advisory Board Member: “With health care reform taking center stage on Capitol Hill, the Health and Aging Policy Fellows program could not have launched at a more opportune time. By serving in key offices, the fellows bring a new perspective on aging into policy discussions. The program has also allowed them to re-examine their careers and look towards more policy-focused positions.”
Brian’s Excellent Adventure

Brian Hensel

I spent from December 2009 to December 2010 working in the office of Senator Jay Rockefeller of West Virginia. I chose Senator Rockefeller’s office because of his longstanding leadership in health care issues, including long-term care and end-of-life care. The Senator has a longstanding commitment to seeing coverage of long-term care replace the current system in which most people spend down private resources to poverty levels in order to maintain or access services through Medicaid. He is Chair of the Senate Finance Subcommittee on Health, and he chaired the Pepper Commission in 1990, which attempted to move long-term care coverage onto the health reform agenda. I had been a home health, nursing home, and hospice administrator during my career before pursuing doctoral training, and I thought Senator Rockefeller’s office would offer me opportunities to be involved in those and related issues. I was right. Moreover, I am happy to say that I underestimated the involvement I would have. I appreciate this opportunity to reflect upon my experience.

Given the Senator’s seniority and long involvement in health care issues, he was involved in a number of issues within the reform effort, all of which he fought for both publicly and behind the scenes. During my fellowship, his most public advocacy was on behalf of Medicaid, the Children’s Health Insurance Plan (CHIP), and the need for a public option.

During my fellowship, I focused mainly on three issues: health information technology (HIT), end-of-life care, and long-term care. I contributed in three primary ways. First, I assisted in successful efforts to include some of the Senator’s HIT priorities in policy proposals, one being to include in the stimulus package a study of the availability of open source electronic health record (EHR) solutions to providers, particularly safety-net providers. Second, I provided analyses of long-term care options within the larger health reform package. This included staffing a hearing on long-term care coverage that the Senator held as chair of the Subcommittee on Health. Third, and in the area in which I was most involved, I contributed to developing the Senator’s comprehensive legislation on advance care planning and end-of-life care: The Advance Planning and Compassionate Care Act of 2009.

The major stakeholders vis-a-vis facilitation of open source software solutions in EHRs were companies whose main business models were based on an open source approach and companies whose main business models were not. Support for this legislation came from the former and push-back to it came from the latter, who were concerned with the short-term costs of long-term care reform.

The main obstacle to improving advance care planning and end-of-life care was distortion of the legislation as “Killing Grandma!” and “Death Panels,” and the consequent confusion it created among a portion of the public. The provision would have paid physicians for their time in talking to patients who sought counsel in advance planning, which outlines the patient’s care preferences should he or she be dying and unable to express his or her wishes at the time. The provision was motivated by the fact that these are difficult and private conversations between a physician and patient, and as such are appropriately lengthy and therefore expensive. Prior to my fellowship, I had observed in the news these kinds of political tactics in opposition to an idea. Being closer to them in Washington brought a certain surrealism that made me yearn even more for honest, factually based debate of important issues.

Working on this legislation was the most rewarding part of my fellowship. The timing of my fellowship—a year focused on health reform—of course contributed greatly to such an experience. There were many other rewards, not least of which simply was being in our nation’s capitol, taking an underground Senate train to the beautiful Capitol, and drinking in history at every turn. My family benefitted, too. My wife travelled from home and my daughters from college when they could, each spending over a month in DC, falling in love with the city. My eldest daughter, who attends college in Michigan, spent a
Brian’s Excellent Adventure

month as an intern for Senator Levin. This allowed us the rare opportunity to take the metro together from our apartment on Dupont to Union Station, and walk to our respective Senate offices.

The training and support provided by the American Political Science Association’s Congressional Fellowship and the Health and Aging Policy Fellowship were invaluable. For example, a group of fifteen of us had an hour audience with David Broder of the Washington Post. I knew, and never forgot, that I was being given a rare and wonderful set of experiences.

A somewhat unexpected reward of the fellowship was the relationships forged with other Health and Aging Policy Fellows. They are bright and talented, but more important to my experience, they are caring and open. I always will feel a special bond with them. Being away from family, and being in the stressful push and pull of a fellowship, they provided a necessary support system.

The pace of Capitol Hill can be frantic, even more so as a health policy fellow during a window for health reform that was last opened 15 years ago. I hit the ground running and, to a large extent, learned by trial and error. With the able guidance and forgiving support of the health staff I worked for, any potential consequences of my errors were minimized. They gave me the opportunity to contribute in their formulation of substantial policy around the Senator’s priorities. The amount of work they accomplish is truly impressive, as is their knowledge and understanding of policy, procedure, and politics. These, too, are relationships I will not forget.

So what’s next for me to do after such a singular experience? I accepted a position as faculty in health administration at the University of South Dakota. I started here, in Vermillion, about a month ago. The program, within the School of Business, provides a health care specialization for MBA students and a major for undergraduate business students, and serves students in other disciplines across campus. It has a strong focus in long-term care, making it a good fit for me. One of the program’s goals is to develop a Long-Term Care Institute that would include policy work and also research in the use and potential of technology in care and chronic disease management. Moreover, it offers unique opportunities to work with the state and with large providers--acute and long-term care--in Sioux Falls. I will weave my policy experience into my teaching, research, and collaborations.

Brian Hensel, PhD, MSPH, is an assistant professor of health services administration at the Beacom School of Business at the University of South Dakota in Vermillion, South Dakota.
Approximately 8.8 million Americans are enrolled simultaneously in Medicare and Medicaid. Known as “dual eligibles,” these low-income seniors and non-elderly people with disabilities are among the nation’s most vulnerable of populations (Kaiser Commission on Medicaid and the Uninsured, 2009). Most dual eligibles have very low-incomes and substantial health needs: 71 percent have an annual income below $10,000, and over half are in fair or poor health, twice the rate of the general Medicare population. High-cost and frail Medicare beneficiaries are concentrated among the dually eligible with nearly one-quarter of dual eligibles living in nursing homes. The dual eligibles can have problems obtaining necessary health care because of difficulty enrolling in both programs, poor coordination between their Medicaid and Medicare benefits, and difficulties obtaining needed prescription drugs (Bella & Palmer, 2009). The dual eligible population is the most expensive population covered by public programs; between Medicaid and Medicare, $196.3 billion was spent in 2005.

Since last January, when I started in Senator Rockefeller’s office as a fellow, I contributed to bills to improve health care quality, to create an independent Medicare advisory board for Medicare payment policy, to reform Medicare Part D including changing out-of-pocket costs, and to improve care coordination for the dual eligible population. Parts of each of these issues have been highlighted throughout the health care reform process. My primary interest and policy issue has been drafting and revising the Medicare Benefit Protection and Improvement Act that seeks to improve and streamline care for the dual eligibles and to improve Medicare Part D. Parts of this bill, which addresses four major policy problems, have been included in the Senate health care reform bill.

First, to address the poor coordination between the Medicare and Medicaid programs, this bill would create a new Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services. The goal of this office would be to integrate benefits and improve the coordination between the federal government and the states for individuals dually eligible for Medicare and Medicaid. This is essential because currently care for dual eligibles is fragmented between the two programs and beneficiaries can have difficulty understanding what is covered under their benefits.

Second, to address issues of drug affordability and drug benefit stability, this bill would make prescription drugs for Medicare Part D enrollees more affordable and accessible by creating a Medicare-operated prescription drug plan open to all Medicare beneficiaries. This Medicare-operated plan would be a national stand-alone Part D plan that beneficiaries
Duals, Drugs, and Delivery Systems: Health Care Reform in DC

could choose. It would create a formulary based on patient safety, efficacy, and value. The high expense of care for dual eligibles is due partially to prescription drugs covered under Medicare Part D. This Medicare-operated plan would create fair-market competition and therefore would lead to less costly drug choices for Medicare recipients. It also would be a robust default plan for beneficiaries who do not choose a Part D plan.

Third, Special Needs Plans (SNPs) — the Medicare Advantage managed care health plans for dual eligibles — are one existing way for insurers to better coordinate care and provide benefits for the high needs of the dual population. This bill improves SNPs by directing the National Committee for Quality Assurance to develop quality standards for SNPs. SNPs also would be required to provide clear information about their drug coverage, drug utilization management, and standards in care coordination for enrollees to consider before signing up.

Finally, there are several administrative, regulatory and financial barriers to providing better health care for the dual eligibles. This bill would implement a number of technical fixes to facilitate enrollment in Medicare and Medicaid to streamline enrollment systems and provide better financial assistance to low-income Medicare beneficiaries. This multi-pronged approach is designed to lead to vast improvements in the care and coordination of services for low income seniors.

This year has been a remarkable learning and transformative experience, especially because I had a front seat in watching health care reform evolve. I learned how to investigate and write about an issue in a short period of time, and made connections with aging stakeholders such as the Medicare Rights Center, the National Senior Citizens Law Center, and other key advisors for policy change. I learned the most from the exceptional seasoned staffers in Senator Rockefeller’s office, including the ability to juggle issues, how to evaluate and react quickly to emerging policy issues, and the politics of when to advance an issue and when to wait. This year also has increased my passion to continue working to help the dual eligibles, the most vulnerable and expensive population to care for.

Since becoming a fellow, I have started part-time work at the Colorado Department of Health Care Policy and Financing as Medicaid Medical Director. Seeing both the federal and state views of health care reform have highlighted the different federal and state perspectives in health care financing and delivery. It is striking to note the gaps in federal and state program communication and coordination of benefits for Medicare and Medicaid. Since each state’s Medicaid program is a little different, these gaps are likely even larger than I’ve experienced. The issues with Medicaid enrollment and medical and pharmacy benefits I encountered in my state work overlapped with the issues of quality and Medicare and Medicaid reimbursement rates I encountered in my work in Senator Rockefeller’s office. My state work especially has highlighted the problems many dual-eligible seniors have with obtaining benefits and figuring out Part D prescription benefits. The most rewarding part of my fellowship has been the ability to link my federal and state experiences and work on issues I feel passionate about. Being a Health and Aging Policy fellow has advanced my understanding and ability to use policy to improve health care for the dually eligible population. As a fellow, I was able to leverage my Medicaid expertise and apply it to federal level policy and now I plan on continuing work with Colorado Medicaid to advance the health care for dual eligibles. The legislation to create a Federal Coordinated Health Care Office for the dual eligibles is in both the Senate and House health care bills so it is likely that positive change is on the horizon for this population. I would encourage other clinicians, researchers, advocates, and citizens to speak up about aging issues they are passionate about to continue to reform health care.

Judy T. Zerzan, MD, MPH, is an assistant professor in general internal medicine at the University of Colorado Denver, and medical director of Colorado Medicaid.

References

In 2007 and 2008, I was an American Psychological Association (APA) Congressional Fellow working on aging legislative issues in the office of Senator Ron Wyden (D-Oregon). Following that—from 2008 to 2009—I was a Health and Aging Policy Fellow with a placement in the Office of Mental Health Services, Department of Veterans Affairs. In this article, I discuss aging and health policy informed by experiences in the congressional and executive branches of the federal government and also by many years as a geropsychology researcher, teacher, and practitioner.

**APA Congressional Fellow, Office of Senator Ron Wyden**

When I began work in Senator Wyden’s office in 2007, one of his major legislative priorities was health care reform. Senator Wyden’s health care reform plan, The Healthy Americans Act (S. 391/H.R. 13210) is a bi-partisan approach to health care reform. The legislation is known also as the “Wyden-Bennett” bill, which reflects primary co-sponsorship of the bill by Senator Robert Bennett (R-Utah). In many ways, Senator Wyden was in the vanguard of health care reform activity that has been so evident in the 111th Congress. Senator Wyden’s membership on the Finance Committee and the Senate Special Committee on Aging well-positioned him to offer his own vision on health care reform.

My primary role in the office was to handle aging legislative issues which, of course, overlapped with health issues. A recurring activity was staffing the Senator on the Committee on Aging, which involved reviewing advance testimony for Committee hearings, preparing his remarks and questions, and being present at hearings to provide him with consultation. I organized a Committee on Aging hearing for the Senator, “Scrambling for Health Insurance Coverage: Health Security for People in Late Middle Age,” which outlined the challenges of obtaining and paying for health care both for this age group and for small businesses that want to provide health care to employees. The hearing underscored one dimension of the need for national health care reform. Mindful of the important role of long-term care in health care reform, Senator Wyden tasked me with researching a variety of proposals for public and private financing of long-term care. I also worked on legislation proposing a Medicare pilot program for provision of home-based, coordinated primary care to adults with multiple chronic illnesses, “The Independence at Home Act, “ (S. 1131/H.R. 2560). In conjunction with a coalition of groups, our office successfully stewarded a resolution on end-of-life planning through the Senate (with both Republican and Democratic co-sponsors)—at a time when end-of-life issues were less politicized than they became in the subsequent Congress. Another project I had was to disentangle the many strands of the complex medical billing processes, write a report, and offer recommendations to the Senator—an effort that reinforced the message that the health care system was broken and it was time for reform.

Office colleagues and I met with major stakeholders relevant to health care reform to discuss legislative and regulatory issues: health care and disease-specific advocacy groups, aging advocacy organizations, insurance companies, long-term care organizations, manufacturers of health-related products, professional organizations, small and large businesses, federal and state departments concerned with healthcare, research institutes, and individual citizens wanting to share their personal views. As has been evident in health care reform efforts in the 111th Congress, numerous constituencies exist with overlapping and sometimes sharply conflicting interests and concerns. I believe the existence of so many constituencies mirrors the largely uncoordinated patchwork of private, state, and federal efforts to deliver health care in the U.S. It has been formidable to understand, much less change, one or more pieces of the health care system. It was striking to me that, with the exception of aging advocacy groups, the topic of older adults was rarely part of the health care conversation despite the fact that the lion’s share of health care is delivered to older people. The lack of attention to the critical role of aging issues in health care is reflected in the virtual absence of training in aging for most health and mental health care professions. The arrival of 75 million baby-boomers into older adulthood has triggered concern about who will provide care to them, as outlined in the 2007 Institute of Medicine report, *Retooling for an Aging America* (Institute of Medicine, 2008).
An especially refreshing aspect of working in Senator Wyden’s office was that he was keenly aware of the issue of aging in health care. In earlier years, Wyden helped to cofound the Gray Panthers in Oregon and worked on aging advocacy. It is rare that a legislator has a long history and familiarity with aging-related issues. His interest in aging issues and membership on the Senate Aging Committee were key reasons that I chose his office for a fellowship placement. My experience in the Wyden office exceeded my expectations. I was given substantive responsibility of handling aging legislative issues. Despite the fact that the legislative arena was new territory for me, my career in aging was especially valuable for critically analyzing policy issues and nesting them in prior day-to-day experience in the health care and aging fields. The challenge was to master an enormous amount of new information (“drinking from the fire hose” was a favorite expression among Capitol Hill staff), summarize that information in one-page memos, offer policy recommendations, and then grapple with a new issue. The long, cautious, and deliberative process of academe ran against the grain of the legislative imperative to make a decision quickly and stake out an unambiguous position. On a personal note, it was gratifying for me to work in a Senate office at this stage of my life, since as a teenager, I had been a Senate page—a role that I found enormously interesting and that broadened my life horizons. Ironically, Senator Wyden’s office was in the Senate Dirksen Office Building, which was named after the famous Senator and orator for whom I ran errands as a page.

Health and Aging Policy Fellowship — Office of Mental Health Services, U.S. Department of Veterans Affairs

The favorable experience of working in the Senate whetted my appetite for more policy-relevant experience. The Health and Aging Policy Fellowship afforded an opportunity to work in the executive branch of government in the Department of Veterans Affairs, Office of Mental Health Services (OMHS). OMHS provides guidance on the delivery of mental health and related services throughout the Veterans Health Administration (VHA) health care system. It was an especially exciting time to be in the office; OMHS was in the process of implementing the Uniform Mental Health Services Handbook that outlines a comprehensive set of mental health services to which veterans in the VHA system are entitled. In recent years, Congress has been especially concerned about mental health issues as increasing numbers of veterans are returning from Afghanistan and Iraq with mental health problems. Commensurate with its concern, Congress appropriated a substantive increase in funding for VHA mental health services. Of note is the fact that the two individuals who head OMHS, Ira Katz, MD, PhD, and Antonette Zeiss, PhD, are leaders in the fields of geriatric psychiatry and geropsychology, respectively.

On leaving my APA fellowship, I was keenly aware of the challenges faced by the U.S. healthcare system: an uncoordinated “system” of care that delivered services the quality of which are not well monitored, used a largely outdated paper medical record, relied on a highly complex billing model for which the United States pays twice as much as other western nations, and housed almost 50 million people who have no health insurance. Further, the health care delivery model is ill-suited to older adults who often have multiple chronic health conditions and who receive care from health providers who have little or no training in aging.

I realized on arrival that I only had broad familiarity with the VHA healthcare system. I had many geropsychology colleagues who worked in VHAs, was well aware of the high quality internship and postdoctoral geropsychology training that was available, and knew that the VHA appeared to have carefully planned for the aging of its World War II veterans. Within a few weeks of working in the OMHS office, I had a realization: the VHA is a single-payer national health care system with (1) a sophisticated model for projecting health care utilization and costs; (2) an electronic medical record (from which data can be cleaned); (3) in-house capability for researching and monitoring health care quality outcomes; (4) an established system of employee continuing education; (5) emphasis on continuity and coordination of care; and (6) a medical and allied health training structure through which many of America’s health care professionals have passed. Further, the VHA is a major health care provider to older adults, who constitute about half of VHA patients.

During the fellowship year I worked on a number of projects: (1) developing an assessment instrument to evaluate delivery of health care services to veterans with dementia; (2) evaluating existing programs to train staff to better handle behavioral problems among veterans with dementia residing in VA
nursing homes (called “community living centers”); (3) evaluating evidence on what might be unique risks for suicide among older veterans and possible action plans; (4) implementing a congressionally mandated pilot program to expand mental health services to veterans residing in highly rural areas; and (5) exploring ways in which VHA medical centers could establish better collaborative relationships with local, county, and state mental health agencies and the aging services network.

The major stakeholders of the VHA health care system include the American public, veterans, the Congress (notably the House and Senate Committees on Veterans Affairs), the executive branch, and veteran service organizations that advocate for veterans. The VHA is in the public eye in a way that most private health care systems are not. If a problem arises in a single VHA medical center, it can be the focus of national press attention—and sometimes attendant inquiries from legislators or relevant legislative committees. The consequence is that the VHA healthcare system can be and often is scrutinized in a way that private health care systems are not.

Being a fellow in the VHA OMHS afforded a unique opportunity to learn about a health care system and understand the many advantages that accrue from it. The challenge was to understand the many pieces and players in the VHA system. Taking a placement in the OMHS was appealing to me because it afforded a view of health care from the executive branch perspective. It also was appealing because the two individuals who lead the OMHS are both seasoned in the field of aging. I believe a gerontological perspective yields a holistic and humane view of older adults—a perspective that is increasingly recognized as a sound paradigm for the delivery of health care services to all age groups.

The experiences of being APA Congressional and Health and Aging Policy Fellows have allowed me to build a substantive understanding of a wide range of public policy and aging issues. I have a better appreciation of the important roles that are played in both the congressional and executive branches of government in establishing and implementing health care and aging policy. Personally, I found the experience empowering; it reaffirmed the ethos articulated in younger years by my baby-boomer age cohort that each of us has the potential to make the world a better place.

Gregory A. Hinrichsen, PhD, is a geropsychologist who was on staff at The Zucker Hillside Hospital, North Shore Long Island Jewish Health System for 25 years. He is associate clinical professor of psychiatry and behavioral sciences at the Albert Einstein College of Medicine.

References
I have visited Washington, DC more than most Americans: as a GSA conference attendee, federal grant reviewer, and an occasional panelist for a federally funded project. I know the Metro system, am well versed in the afternoon snack menu at DuPont Circle’s Kramer Books, and feel a special attraction to the Jefferson Memorial at night. My September 30, 2008, arrival in Washington, however, on the eve of the financial meltdown, commenced a dynamic and transformational 12 months of professional and personal growth that coincided with an ever-changing U.S. political and policy landscape.

I came to Washington as the John Heinz/Health and Aging Policy fellow with an interest in improving service delivery and payment policies that drive care for vulnerable elders who wish to remain living in community settings. I have worked with older adults my entire professional life, first as a licensed clinical social worker in community-based services and then as a researcher evaluating the integration of medical and social care services for chronically ill older adults living in the community. I got a small taste of the policy world by working on state-level projects addressing health care delivery system change and fall prevention. As a social worker with a systems perspective, however, I had incomplete operational knowledge of the policy process. I craved to learn more about how Washington really worked, including where legislation, rules, regulations, and finally the dollars truly originate from at the federal level and how these processes ultimately impact state policy along with the research and practice worlds. I desired insider knowledge—the kind that one cannot gain from reading books or hearing about the policy process second-hand. Knowing my personality, successful learning at a nuanced level meant that I had to be imbedded in the policy and political domains, hence my interest in a congressional fellowship program that offered an in vivo experience.

I had few expectations of what I would experience in a congressional fellowship and I certainly held no appreciation for the magnitude of work I would encounter during the most critical time in aging and health care policy in the past 40 years. I was honored to receive both the long-standing John Heinz Senate Fellowship in Issues of the Aging and the brand new Health and Aging Policy Fellowship. After interviewing with several Senate offices, which was a condition of the Heinz Fellowship, I chose a placement in Senator Blanche Lincoln’s office (D-Arkansas). Working for Senator Lincoln was ideal for me because she is a long-standing advocate for improving service delivery for older adults with chronic conditions, increasing geriatric expertise in our health care workforce, and improving systems to prevent, detect, and treat elder abuse.

One particular piece of legislation I worked on was her long-standing chronic care coordination bill. Working with multiple stakeholders, we updated the bill language and renamed it as the RE-Aligning Care Act (Reaching Elders with Assessment and Chronic Care Management and Coordination Act of 2009; S. 1004). The hallmark of this bill, built from Ed Wagner’s Chronic Care Model, is that it serves as a template for changing the way our current health care system operates. Right now health care delivery and Medicare fee-for-service payment often focuses on one body part or one disease state at a time. This situation may be efficient for individuals with an acute crisis event, but is rarely useful or cost-effective for individuals with multiple and complex chronic conditions. Health care providers are not incentivized to be mindful of the whole person let alone any non-medical aspects of care. In light of the large body of research on social determinants of health, it is remarkable that our health care system largely ignores an individual’s social and environmental circumstances, which may have great influence on his or her ability to self-manage multiple and complex medical conditions. In addition to the various health system changes offered in the bill (e.g., comprehensive geriatric assessment, coordination of care, health information technology), a major component is the inclusion of linkages to community-based services through the care coordination process. Information about and referral to community-based services, such as home-delivered meals, home modification programs, and chronic disease self-management support, can be the difference between older adults with chronic conditions and resultant functional impairment being able to live independently in the community and having to utilize higher, more costly levels of institutional care.
Working in collaboration with the Senator’s health care, tax, legislative, and political advisors during health care reform legislation was an experience beyond my wildest dreams. In addition to working on bills as stand-alone legislation, I was fortunate to collaborate with Senate Finance Committee staff to include many of my boss’ priorities in the Senate’s health care reform package. Senator Lincoln’s health legislative assistant and I worked hard initially to get a pilot version of her chronic care bill included. Although this specific effort did not materialize, we were able to infuse language from her chronic care bill into language on the proposed “Innovation Center” within the Centers for Medicare and Medicaid Services (CMS), which states that additional consideration will be given to projects that address the key elements of person-centered care coordination. The language that is drawn directly from Senator Lincoln’s bill includes individualized assessment focusing on the needs and preferences of the older adult, engagement with the appropriate medical and community-based care providers using a team-based approach, and centering the older adult and family or other informal caregivers in the middle of the care team. It will take me a long time to digest fully the enormity of living in and through this health care reform effort, a perspective that likely will evolve over time.

My experience as a Heinz/Health and Aging Policy fellow provided me with a solid appreciation for the vast and ever-changing political, procedural, and policy environment that governs federal-level policy making. It filled in the missing piece of my career mosaic, allowing me to unite gerontological practice and research with policymaking into a coherent career vision. The fellowship experience directly prepared me for my new role at The SCAN Foundation. The SCAN Foundation seeks to redefine and elevate the discussion around long-term services and supports as a national priority, develop and champion realistic policy solutions at the federal and state levels, and support promising programs integrating medical and human services so that older people of today and tomorrow can age in ways and locations of their choosing. My responsibilities include applying communications and policy strategies to our mission of advancing the development of a sustainable continuum of quality care that truly supports older people with functional needs and their families in the most dignified and independent manner possible.

Without reservation, participation in the Heinz/Health and Aging Policy Fellowship was the single most enriching experience in my professional life. I cannot speak highly enough of the opportunity it affords those who simply are curious about the federal policy making process, as well as those who want to comprehend fully the fundamental interplay between politics, procedure, and policy. Enter with caution, however, as this new knowledge can trigger a bad case of “Potomac fever.”

Gretchen E. Alkema, PhD, LCSW, is the Vice President of Policy and Communications at The SCAN Foundation in Long Beach, California.

John Rother, JD, Executive Vice President of Policy and Strategy, AARP, Health and Aging Policy Fellows Program National Advisory Board Member: “The first class of Health and Aging Policy Fellows is an impressive interdisciplinary group of professionals who have had the rare opportunity to be a part of what will be considered an historic time for health care reform in the United States. The program provides a hands-on experience in the policymaking process. I believe the fellows will continue to have an influence in policy well beyond their fellowship year.”
As life expectancy increases and our population ages, one popular media response to this newfound longevity has been to proclaim: “60 is the new 40!” It is a phrase that epitomizes one of many ways in which notions of age and aging are socially constructed in our society (skewing positive or negative) and often reflect the most persuasive rhetoric of the day. My recent experience as a Health and Aging Policy fellow has brought the implications of these social constructions into sharp relief, especially in the context of aging policy and health care reform. The cultural relativism of the meaning of age has me wondering if in our efforts to reshape our health care delivery system, does age really matter? There are old people who are healthy and young people who are not. Why then define health and health care provision by age? Of course, existing policies reflect previously set age-based parameters. But the current health care reform debate provides an opportunity to reconsider. This just might be our chance to posit an alternative view and begin the process of reframing the ways in which we think and talk about age in the context of health policy.

One approach to improving health care for older adults is to integrate discussions of aging into the broader health care policy debate, normalizing and mainstreaming it instead of making it something that happens “over there,” at the far end of the life course. If we were to refrain from framing the health care needs of older adults as set far apart from the needs of other age groups, we might begin to see the increased adoption of broad-based health policies and reduced intergenerational tension and competition for scarce resources.

Indeed, my recent foray into the land of federal health policy making has got me thinking about how we might begin to integrate older adult issues into health care reform efforts in a more productive way. One of the major obstacles to infusing aging into the debate is the existing “silos” that seem to rear their ugly heads regularly in two distinct but related forms: 1) conceptual silos, which reflect ways of thinking about older adult issues in isolation, and 2) practical silos, which are the ways of conducting business that result from this narrowly bounded conceptualization. As Health and Aging Policy fellows, and as members of the larger gerontology community, I believe we can make significant gains in advancing aging policy within the health care arena by streamlining the ways in which we conceptualize and position the interests of older adults. While such re-conceptualization is necessary, however, it is not sufficient; the practical changes to health care systems—how we finance, organize, and deliver care—must follow.

Before I elaborate on these emergent ideas, however, I would like to set the context for this discussion by describing what this all looks like from the perch of the Health and Aging Policy Fellowship in the United States Congress. My placement was in the office of Senator Debbie Stabenow (D-Michigan). She is an extremely active member of Congress who currently serves on four legislative committees (Finance, Budget, Agriculture, and Energy and Natural Resources) and is Chair of the Democratic Steering and Outreach Committee. The Senator has been extremely dedicated to the health care debate and has played a major role in developing the health care reform bill reported out of the Senate Committee on Finance. At the same time, she has had to manage multiple competing priorities in a year of dramatic change, which included the transition to a new administration and an economic downturn unparalleled since the Great Depression. As such, her attention constantly was focused on the pressing economic concerns of the day, both across the nation and in the state of Michigan, which has been particularly hard hit by the ongoing struggles of the auto industry and has the highest rate of unemployment in the country.

I was interested in this specific placement for several reasons. First, as a Health and Aging Policy fellow, I wanted to work for a committee or member directly involved with the shaping of health care reform legislation. Because Senator Stabenow is a member of the Committee on Finance, I expected that a position in her office would give me an opportunity to contribute directly to this legislative initiative as it moved through the political and legislative processes. Second, the Senator has a graduate degree in social
work (my PhD is in social welfare) and I thought it would be instructive to observe her use of social work training in the course of her legislative and political work. I envisioned that I would be able to bring the Senator’s leadership example back to the classroom as an inspirational model for future social workers. Finally, I felt that it was important—especially in a personal office—to work for someone whose values I expected I would generally agree with.

In my role as fellow, I served on the Senator’s health team and worked on an expansive range of health care topics, gathering and synthesizing information as needed. I was also responsible for a more specific portfolio of issues concerned with aging, mental health, chronic care, and health care delivery systems. My work was multifaceted but much of it involved researching, analyzing, developing, and advancing specific legislative initiatives.

The Fellowship gave me the opportunity to bring my areas of expertise to the table and to work aging-relevant issues into the agenda wherever feasible. I was well positioned to make the case for the Senator to support policy initiatives of promise for older adults. For example, I advised the Senator to bring the White House’s leadership example back to the classroom and, more specifically, to Michigan. I also had to demonstrate that the policy was feasible, cost effective, and would successfully improve the social problem it sought to address.

In the course of my fellowship year, I learned that virtually everyone has a stake in health care reform. I had the opportunity to meet with many of them: consumers and providers, special population groups, educators and scholars, small businesses, large manufacturers, and corporations—including hospitals, durable medical equipment suppliers, information technology firms, pharmaceutical companies, and more. What was striking to me is that, by and large, the interests of the medical industry and institutionally based health care still drive the debate. While there is much discussion of moving health care delivery to a more person-centered model, specific and robust provisions for home and community-based services (as just one example) generally remain on the periphery of the debate. While some attention has been paid to care transitions between institutional and community-based settings, attention to the role of informal networks of care and social support (i.e., family caregivers and community providers) is quite limited.

It is my view that policies that truly support a person-centered model of care will, by design, begin the process of re-conceptualizing health care provision for older adults by accounting for the differential effects of age, gender, ethnicity, culture, geography, education, and socioeconomic status. To make this happen, we need to work with existing systems (including leaders, staff, providers, and consumers) so that they are not threatened by a new way of doing business. It is a challenge to reach consensus among such a diverse group of stakeholders with a wide range of financial and other interests. Getting all the players on board will require identifying and responding to perceived risks, illuminating the benefits of establishing cooperative agreements, and offering incentives that support systems change. Only then will the promise of integrating medical and social models of care be realized.

I suggested earlier that one of the fundamental barriers to advancing significant policy initiatives for older adults in health care reform is the existence of silos—both conceptual (ways of thinking) and...
practical (ways of doing business)—that work against such innovation. There are a number of ways in which the Health and Aging Policy Fellows Program is particularly well positioned to contribute to the dissolution of such barriers.

First, a fundamental function of the program is to raise awareness of older adult issues. Each fellow can contribute to this effort by bringing his/her own brand of professional practice and research expertise to bear and ensure that aging is part of the discussion. This process might involve changing ways of thinking about aging. For example, it might mean working against ageism and negative stereotypes to demonstrate that like other age groups, there is tremendous diversity among the aging population, particularly with respect to health status.

Fellows also can bring attention to numerous parallels between older adults and other population groups. By making these linkages, they can illuminate the many health care lessons to be learned from older adults about systems of institutional and home and community-based care, the delivery, organization, and financing of health care, and the role of consumer direction and informal care networks. These examples might be used to inform policies for others with chronic conditions (e.g., the younger population with functional disabilities, mental illness, or developmental disabilities), and to start the process of moving beyond age-defined health policy. Indeed, some provisions in the current Senate health care bill hold promise for the restructuring of health care delivery by function and health status (e.g., the CLASS Act, the Medicaid Health Home) rather than by age.

Finally, the collective influence of the Health and Aging Policy Fellows Program has the potential to affect change in the way policies affecting older adults are conceptualized, drafted, designed, and implemented. By design, the program has supported a cadre of professionals and academics who approach aging and health care issues from multiple perspectives; this diversity heightens their credibility while strengthening their message. The very structure of the program provides an example of systems integration that may be instructive in rethinking ways of doing business in aging and health care policy. The benefits are evidenced by the added value of having a multidisciplinary cohort in different settings (e.g., Senate or House personal or committee offices, executive agencies) who are positioned uniquely to influence the debate. Through intra-group discussions, the fellows are able to draw from and build on each other’s expertise and advance policy ideas that have the potential to account better for the scope and complexity of the issues at hand. The program is also well-designed to support the continuation of policy work initiated during the fellowship year. I was very pleased to be awarded support for a second year that has enabled me to extend the scope of my policy work and engage in additional, related projects. The continuity of this work—and of the professional network I’ve developed—has been sustained further by my participation in intensive workshops which bring together current and previous fellowship cohorts, advisory board members, and national mentors.

In conclusion, my experience as a Health and Aging Policy fellow in the thick of national health care reform efforts has given me a bird’s eye view of how policy making tends to reflect and reinforce a “silo” approach to aging and health issues. I have become increasingly cognizant of what is largely neglected in discussions of and proposed responses to our nation’s health care needs, and more specifically the interrelated health and social needs of our older adult population. These observations have strengthened my belief that the successful advancement of viable and effective aging policy requires careful collaboration and dialogue across and between the system silos represented by academia, professional practice (both health and social services), and policy making. The Health and Aging Policy Fellows Program offers the ideal nexus of these distinct arenas, and provides the opportunity to foster cross-disciplinary thinking and dialogue, to integrate a broader systems perspective into policy solutions, and advance initiatives that are most likely to engage stakeholders and effectively respond to the health care needs of older adults.

Kathryn G. Kietzman, PhD, MSW, is a 2008-2010 Health and Aging Policy fellow.
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