ltqa

LONG-TERM QUALITY ALLIANCE

3RD ANNUAL MEETING

"BUILDING BRIDGES ACROSS THE CONTINUUM TO ACHIEVE PERSON-CENTERED CARE"

2013 Conference Proceedings

Monday & Tuesday
December 16 – 17, 2013

Georgetown Conference Center
Washington, DC

Table of Contents

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Welcome from the LTQA President

Carol Raphael
President, Long-Term Quality Alliance

What unites us is our overriding commitment to creating a more responsive, integrated, high-quality and financially sustainable care system.

The Long-Term Quality Alliance (LTQA) counts a variety of stakeholders among its members:

- Federal and state agencies.
- Providers, payers and insurers.
- Research entities and professional associations.
- Service organizations and consumer advocacy groups.

LTQA members come from every corner of the broader health care field. The services we study, design, deliver, finance, champion and use span the entire continuum.

What unites us is our overriding commitment to creating a more responsive, integrated, high-quality and financially sustainable care system that meets the needs and preferences of Americans who struggle with the most complex and the most expensive health conditions.

Chiefly, LTQA is a convener, a think tank and a clearinghouse. Our mission is to identify, exhibit and spread innovative and viable service-delivery models that enhance the individual experience of care, improve the health of populations, and reduce costs. We seek to do all of this in a politically and economically challenging environment.

Nelson Mandela said, "It always seems impossible until it is done."

Our challenges are mighty, but they are not impossible to address. Working together, we can show the way to a better, higher quality and more affordable system of long-term services and supports as well as a better, higher quality and more affordable health care system.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Building Bridges:

An Overview of LTQA's 3rd Annual Meeting

Mark McClellan
The Brookings Institution

We won't enjoy true innovation in care or service delivery until we find innovative ways to build bridges that bring financing together, bring together organizations that previously haven't worked together, and put the focus on the person.

No engineering feat is as complicated as building a bridge. But the art of connecting two distant landmasses—by laying strong foundations in deep and sometimes treacherous waters—can be as awe-inspiring as it is difficult.

Bridge building requires a huge measure of human resources—both physical and intellectual—and a tremendous financial commitment. But the payoffs are enormous: safety for those who will travel the bridge for generations to come, economic growth for both shores, and a strengthened social fabric for families and friends who suddenly find it easier to connect with one another.

Perhaps these benefits explain why bridge building has become such a powerful metaphor for the challenging task of forging new connections among disparate groups to reach common goals.

For two days in December 2013, members of the Long-Term Quality Alliance (LTQA) gathered in Washington, DC to apply the bridge-building metaphor to our own efforts.

We came together to identify innovative approaches to bridging the continuum in order to deliver integrated, person-centered care for older adults and for younger people with disabilities.

We acknowledged that the effective management of chronic conditions is the most critical challenge we face.

We reviewed evidence suggesting that the most effective interventions to help patients manage chronic conditions take place outside of hospitals and doctors' offices. That's where providers of long-term services and supports (LTSS) are helping older adults and people with disabilities avoid serious, debilitating and costly health complications while improving their quality of life.

We heard inspiring presentations about efforts that are currently underway to connect medical and LTSS providers so they can better focus on the person at the center of the care team.

We built bridges of our own with a variety of colleagues who design and deliver

health care, services and supports at the state and local levels.

And, finally, we recommended strategies that LTQA might adopt in order to build bridges between and among care recipients and their families, members of the care team, policymakers and other stakeholders.

We recommended that bridges be built in the following areas:

- **Care coordination**: Care providers in a variety of settings must work closely with each other and with care recipients and their families to develop an integrated, person-centered package of care, services and supports. Incorporating social supports—such as pharmacy services, housing and transportation—into care planning and delivery is a critical first step in addressing social factors that can adversely affect health and present barriers to wellbeing.

- **Data sharing**: Personal health data that is seamlessly shared among all care settings will give providers, caregivers and care recipients the information they need to work together.

- **Payment reform**: Innovative financing models can help the nation better allocate its limited resources across the long-term care and medical communities in order to support appropriate, patient-centered care for every individual while saving health care dollars.

- **Workforce**: A broad spectrum of paid and unpaid caregivers—including family caregivers, volunteers, frontline workers and clinicians—need additional training and support so they can continue helping the recipients of their care remain healthy and independent for as long as possible.

The Road to Real Health Reform

We won't enjoy true innovation in care or service delivery until we find innovative ways to build bridges that bring financing together, bring together organizations that previously haven't worked together, and put the focus on the person.

This is real health care reform. The bridge building that took place during LTQA's 3rd Annual Meeting, which are described in the following pages, suggest that real reform is finally within our reach.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Part I: Keynote Addresses

Modernizing Medicare
by Improving Care for People with Chronic Conditions

Ron Wyden
U.S. Senator from Oregon

Modern Medicare has to improve care for those who are chronically ill. These are the most vulnerable and most expensive of all Medicare beneficiaries.

CSNP Reform

Modern Medicare has to improve care for those who are chronically ill. These are the most vulnerable and most expensive of all Medicare beneficiaries. When Medicare began in 1965, you didn't have cancer, diabetes, stroke and heart disease consuming basically all the Medicare money. That's the case today—and yet, Medicare in 2013 compared to Medicare in 1965 isn't all that different in terms of chronic disease.

Congress tried to get going in terms of acknowledging the challenge and treating chronic disease in 2003. In the Medicare Modernization Act that year, something was created called Chronic Special Needs Plans (CSNPs). They haven't exactly worked out as people hoped. Now less than .5% of Medicare enrollees—that's about 250,000 beneficiaries—currently take advantage of these CSNPs. Nobody says it works very well—seniors say it doesn't work well, group health threw up their hands last summer and said it doesn't work.

I believe that those with chronic disease need to be treated as unique patients and deserve a unique package of services that provides them with better care at lower cost. Right now, those with chronic disease actually get worse, more poorly coordinated care at a higher price.

I offered in the finance committee what I think is the beginning of a new chronic care strategy to get us serious about dealing with what ought to be the foundation for Medicare form.

I was successful in getting into the SGR bill that passed the finance committee CSNP reforms that are going to effectively guarantee to beneficiaries a unique benefit for their unique needs. For example, under the CSNP reform, those seniors would be guaranteed an individual care plan that reflects their actual health care needs. They would see their care delivered by teams of providers that have

demonstrated experience in managing these conditions, and plans that want to specialize in the treatment of these individuals would be able to market these attributes to a willing audience of beneficiaries that can truly benefit.

With CSNP reforms we can get an individual care plan, you can specialize, you can have integrated teams. This is the beginning of a modern approach for taking care of those who are the most challenging, most medically complex, most expensive population.

The Better Care, Lower Cost Act

In January, I and Sen. Johnny Isakson (R-GA), and a bicameral duo in the house-- Rep. Peter Welsh (D-VT) and Rep. Eric Paulsen (R-MN)--will be introducing the next step of chronic care reform that focuses on both seniors and providers: The Better Care, Lower Cost Act. Let me give you the 3 or 4 reasons this bill is needed in order to make that change from the way [people with chronic disease] are cared for today and the future.

- We've got to get rid of some of these shortsighted rules that prevent Medicare plans and providers from focusing on care for the chronically ill. Plans and providers ought to be encouraged to specialize in chronic care and allowed to target the high-risk patients who would benefit most.

- We've got to get nurses and physicians to lead these teams that work closely and intensely with patients. Experience indicates that's the key to getting better quality and better outcomes at less cost. This legislation specifically will ensure that practices and plans that are part of this program would allow all the providers to practice at the top of their license.

- We've got to take care of the total patient. Under our proposal, every senior will have an individualized care plan, and we will use a payment model that allows providers to address each patient's individual medical, psychosocial and functional care needs. A capitated payment for an approach that's integrated.

- Finally, we're going to put a special focus on trying to make sure that this kind of coordinated, team driven approach finds its way into the nooks and crannies in this country that don't have ACOs, bundled payment models, and shared savings programs. As part of this legislation, we're going to put a special focus on bringing these models to areas that have not seen those kinds of reforms.

Now I want to make the connection to long-term care services for those with acute health needs.

This will be the first approach that turns risk selection on its head. Historically, the whole debate about creating choices in health care has been—if you create those choices, all the healthy people are going to pull out of traditional Medicare, and traditional Medicare will shrivel up, because it will have only sick people in it,

ltqa

LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

and all the healthy people will be off enjoying the fruits of innovation and these private plans. This turns that on its head by saying that the choices are going to be reserved for those who are the sickest, who have the greatest health needs, that cost the most as they get what arguably is the poorest care. You would allow specialization and choices for this population. What we're doing here in my view is going to improve the quality of care in Medicare throughout the entire program.

I think this is going to be a huge boon for our innovators, particularly those with new technologies and new therapies. I think this is going to set off new wave of innovation in terms of caring for folks at home. I think that's going to be good for seniors, and I think that's going to be good for our economy as well.

If our country is able to save five percent on the care of [a typical Medicare beneficiary with chronic disease], we are going a long way towards making Medicare solvent for the future.

I want to be clear that the Better Care, Lower Cost Act is not a long-term care bill. But I do believe it sets the stage for the type of long-term care system that's needed in this country. Lack of coordination and innovation are not just problems on acute side of the ledger. They are problems throughout the long-term care space. What's done on the acute side definitely impacts the type of long-term care seniors get, which is why we believe addressing chronic care is so important.

So if the kind of chronic care innovation that we are looking at is put in place, this bipartisan group of legislators believes we are going to advance the cause of long-term care by providing these kinds of integrated teams, which we think will ease the transition from acute to long-term care for patients and their families.

We'll be providing every chronically ill patient with an individual care plan, and that can be used across care settings. We'll increase access to home and community based supports and services, and generate evidence-based quality standards that can help prevent unnecessary hospitalization and premature entry into post-acute and long-term care settings.

Conclusion

I think the foundation we are laying with chronic disease is clearly going to be a plus for long-term care services directly. Medicare reform that starts paying for quality, is more transparent, encourages the development of new technologies—I think that is going to be a plus for those who are focused primarily on long-term care services, and for those who have an interest in chronic care. This is what we need to do to put in place a seamless, more integrated set of services for older people.

That, in my view, is what makes your work so extraordinarily important.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Meeting the Challenges of an Aging Society

Johnny Isakson
U.S. Senator from Georgia

I am very interested in your very best solutions for senior care in the years ahead, including options for Medicare card carriers like me.

At age 69, the rest of my life is about seeing to it that the life of my children and grandchildren is at least as robust, as healthy and as prosperous as my parents left me.

In public policy today, we're going to go one way or another. We're going to be over a cliff where we have less services, lower quality of health care, higher costs, bigger deficits, and a country that's a whole lot weaker, or we're finally going get our arms around the challenges of the 21st century in terms of Medicare, Medicaid and healthcare benefits in this country.

The senior generation of today is getting older. People living into their 80s is not uncommon, and people living into their 90s is not uncommon. We are all living longer, and the exponential rise in cost of that care is tremendous, so it's important that we have innovative ideas to meet the challenges of growing older.

Because of that I've joined Senator Wyden on a couple proposals. Ron and I included an Amendment to provide for reimbursement for coordinated care for chronic illnesses in Medicare. That is a tremendous opportunity for us to get our arms around the quality of care, but also the cost of that quality of care in terms of Medicare.

More often than not there are many seniors that have multiple physicians who aren't talking to each other, who are making prescriptions that aren't coordinated who have care recommendations that aren't coordinated, and one can conflict with the other one.
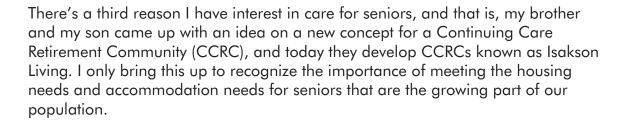
Whereas if you can manage that care you can see to it that the outcomes of the care are better and the overall cost is less. In fact, quality management in health care in almost all cases leads to a lower cost and a better outcome.

The second amendment is an amendment I've been working on for some period of time, and that is to provide for the health care wishes of seniors to be transferable, transparent, and portable as someone goes through those end of life stages in a nursing home, physician care or home health care, so their wishes for the care they want are known and are publicly documented in such a way that the health system knows what to deliver how to deliver it, and the family is not left with the burden of making decisions they don't want to make. That's an important reimbursement that will also lower cost, raise quality of health care and address a coming problem that will only get larger and larger.

There's a third reason I have interest in care for seniors, and that is, my brother and my son came up with an idea on a new concept for a Continuing Care Retirement Community (CCRC), and today they develop CCRCs known as Isakson Living. I only bring this up to recognize the importance of meeting the housing needs and accommodation needs for seniors that are the growing part of our population.

I tell everybody to remember this--the baby boomers that built the condominiums on the coast of Florida and the second home log cabins in North Carolina are getting ready to be the residents of all these CCRCS because they're at that age—they're 62 or older—and it's a huge bubble in population, and there are not a lot of facilities that are accessible or available to them, or some of the ones that are there are only for high-end people that have the capability of buying and affording an expensive proposition.

Making the Case for Federal Expenditures

There are a lot of benefit programs that CBO will show as a cost that by the time you cost it out over time have a huge payback. I'm a big dynamic scorer because you can end up seeing those things that really are expenses that are wasted and those that are investments.

Right now, [Congress is] talking about reforming the entire tax code. Every special interest group in North America and worldwide is coming into my office saying, "whatever you do, don't cut my tax treatment", whether it's the mortgage interest deduction, the charitable deduction, the low and moderate income housing tax credit—you name it.

I say, "don't come back in here until you've done a cost-benefit analysis that shows me that the cost of keeping that deduction in the code will pay a bigger benefit to the federal government." That's the way we're going to have to look at reforming the tax code.

Thinking dynamically is the way to do it. When you are in a program, whether it's the Older Americans Act, delivery of Meals on Wheels, whatever it might be, show the cost benefit analysis. If you can't demonstrate that, you better be prepared to find a new program to work on.

The Low And Moderate Income Housing Tax Credit probably was one of the greatest innovations in the history of the United States tax code in terms of generating private capital to go in low and moderate income housing, and get the stake in the housing such so the purchasers of the tax credit had a vested interest in the project for its lifetime, not just for getting a tax deal when it was built.

Public housing has gone way down in terms of meeting the needs of the housing supply. Low to Moderate Income Housing Tax Credits are building the majority of the housing for people on the lower ends of the income scale. In terms of loans for HUD to build low-income housing, there's going to be continuing pressure on

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

that because there's continuing pressure on every part of the federal budget right now in terms of expenditures. If we can expand the Low and Moderate Income Tax Credit program, and put those incentives to meet the demand, that's the best way to do it rather than trying to get an increase for the fund levels.

Seeking the Best Solutions

As one who has volunteered and delivered Meals-on-Wheels under the Older Americans Act, as someone who has a 99-year-old father-in-law, a 97-year-old mother-in-law and had two wonderful parents I lost far too early in life, I am very interested in you coming up with the very best solutions for senior care, including for Medicare card carriers like me, in the years ahead.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Part II: Blending Medical Care and Long-Term Services and Supports

Kathy Greenlee
Administrator, Administration for Community Living
Assistant Secretary for Aging
U.S. Department of Health and Human Services

Lisa Shugarman
Director of Policy
SCAN Foundation

Melanie Bella
Director of the Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services

Carol Levine
Director of the Families and Health Care Project
United Hospital Fund

The Affordable Care Act accelerated a transformation already underway in the structure and financing of the health care delivery system that is having a substantial impact on how long-term services and supports are provided. It is a tremendous opportunity to rethink and refresh our system of long-term services and supports – to center it on the person and family, to integrate it with medical care, to advance its quality and responsiveness to individual needs. It is also presents many challenges, as new financial and organizational incentives come into play, in bridging the established silos of medical services and social supports and coordinating care across the spectrum of services for individuals in a range of institutional and home and community settings.

The Push for Integration of LTSS and Medical Services

The payment reforms in the health system put in motion by the Affordable Care Act (ACA) and the extension by states of Medicaid managed care programs to long-term services and supports are two major external forces transforming the world in which long-term supports and community services are delivered. These forces are challenging and creating opportunities for the organization and delivery of LTSS and the interaction of LTSS and medical services, whether you view it from a medical/clinical perspective or from a long-term supports and community services perspective.

While the LTSS reforms are driven in part from health system reform, they are not health system reforms. The cost drivers that are driving health system reform and efforts to control Medicare and Medicaid acute care spending are the same

cost drivers we see in LTSS – the very expensive group of older adults and people with disabilities who have chronic health conditions that are accompanied by significant functional limitations. These people live their lives across a spectrum of activities that do not fit neatly in the silos that we use to pay for their care.

The reforms that will meaningfully affect both the cost of an individual's care and that individual's quality of life are broader than simple changes in the financing mechanisms. They encompass availability, affordability and quality of community supports such as housing, transportation, and personal care.   To achieve the full promise of these reforms, the starting point and the ongoing focal point for organizing the medical care and LTSS must be the person and their family; and the organization of that care must build around the person and family and not around the silos of organizations and financing mechanisms employed in delivering that care.

The push to integrate LTSS with medical care comes from the health systems reforms and managed initiatives. The real-life experiences people have with health care, though, begin in the community, transition to medical care systems for an episode of care, and then back into the community.   It is incumbent on the system of community services and supports to take the initiative in addressing the opportunities and challenges that will come with integrating the system of long-term services and supports with the system of medical care.

Opportunities and Challenges of Integration

What is the vision of a system of person-centered care?   This is a system in which individuals' needs and preferences are known and providers are organized to address all those needs and preferences. It is a system that can bring together the medical and supportive services sides of the care process and in which there is a shared care planning process engaged with all of the providers with the individual at the center of the activities.

The opportunities and challenges in developing such a system include:

- Developing and communicating the evidence supporting the value of community services to help health care providers understand the importance of engaging and paying for social supports in order to meet their health outcomes goals.

- Build on the promising and challenging work that has been implementing evidence-based care transitions programs to gain traction with accountable care organizations (ACOs), Medicaid managed care programs, and other targets for LTSS integration.

- Developing the business acumen and leadership in a traditionally-grant-funded community-based service system to negotiate and contract with Medicare, Medicaid, ACOs and private health plans. Health systems (ACOs and others) need organizations that understand the daily needs of people with functional limitations.   At the same time the community organizations need

ltqa

LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

to rethink their business model so that they know how to engage with medical providers.

- Creating the active involvement of families and stakeholders and family caregivers in the conversation to ensure the person and family are at the center of and fully engaged in care planning.

- Creating through ADRC's and the No Wrong Door initiative a seamless point of entry for access to LTSS, which would not derive from Medicaid eligibility, and which would be fully funded.

Solutions: Both Underway and Needed

Building on Success in Care Transitions

The Administration for Community Living (ACL) has spent years implementing evidence-based programs to ease transitions from hospitals and institutions to the home and community.   These programs now form the backbone of the Community-based Care Transitions Program, created by Section 3026 of the Affordable Care Act (ACA).   The aging and disability network has been the resource for years that has answered the 5 pm calls on Fridays from families suddenly notified by institutions that they need to arrange support and services for family members about to be discharged after an acute episode.

The growing capabilities with care transitions afford an opportunity for Aging and Disability Resource Centers (ADRCs), funded by the ACL, and other LTSS providers to demonstrate their value to accountable care organizations (ACOs), managed care organizations (MCOs), and other health care providers who will have accountability for reducing hospital readmissions and reducing acute care costs in other ways – particularly for patients with chronic care needs.

Tackle Integration Challenges Head On in the Duals Demonstrations

Another product of the ACA is the demonstration program from the Centers for Medicare and Medicaid Services (CMS) to pioneer new models for integrating LTSS and medical care for low-income, chronically ill and vulnerable beneficiaries in Medicare who are additionally eligible for Medicaid (so-called Dual Beneficiaries). CMS is partnering with states to launch models for integrated care of Dual beneficiaries. Some of the models will share the risk of beneficiary costs with the government and retain fee-for-service payment for services provided; others of which will assume full risk for the cost of the beneficiaries through capitated payments. There are ten of these Demonstration projects approved as of the end of the year, two of which are operational.

These demonstration projects are intended to bring together medical and LTSS services on an equal footing. Requirements for the care models in these demonstrations are that they have:

- individualized care plans,

ltqa

LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

- interdisciplinary care teams,

- functional assessments that incorporate the persons need for LTSS, and

- strong provider networks that include specialized LTSS providers.

CMS initiatives go beyond these demonstration projects to integrate services for the Duals.   CMS is working generally to better align payment and bridge gaps in payment between Medicare and Medicaid. These efforts include making linked data available from CMS's claims and beneficiary data sets that are organized at the person level and can aid the states in care coordination.

CMS is also working to use care coordination and other support and service interventions to reduce the movement of people between nursing homes and hospitals and to prevent avoidable hospitalizations through Enhanced Care Coordination Organizations that are now operating in 7 states and in over 150 nursing facilities. There are several other initiatives, some of which predate the ACA, to improve care coordination.   Programs include initiatives to develop ACOs, payment reform to provide bundled payments across providers for an episode of care, increased use of Medicaid waivers to advance state experimentation with LTSS, and programs that provide more flexibility for the use of home and community-based cared, including Money Follows the Person, Balancing Incentives, and Community First Choice.

Build LTSS Capacity on the Ground

Building the capacity of LTSS organizations to participate effectively in integration of LTSS and medical care will require advances in developing three types of structural elements:

1. **Financial and administrative alignment** – the alignment of funding (as CMS is doing with the Duals) will drive structural change – if you can align the resources appropriately the systems will restructure accordingly.

2. **Uniform needs assessment** – the foundation for person-centered, integrated LTSS is an assessment that builds from determining the needs and preferences of the individual – and develops common data on medical conditions, cognitive function, environment, and goals for the individual's care – and that enables all care providers to work from the same assessment and care plan for the individual.

   This type of assessment and planning does not take place in a physician's office, so it remains the domain of LTSS providers to lead on a uniform needs assessment instrument. Most states have implemented some form of assessment at the program level but there is no national standard and no in-state assessment that applies across all providers.   These assessments are now rarely shared with medical providers who have no incentive to participate and face physical barriers to trying to work across informations that don't fit.

ltqa

LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

3. **Integrated information systems** – all providers in the system can share information and contribute to the development and execution of a care plan. Currently, few home and community-based providers have well-developed information systems – and LTSS organizations are not eligible for federal "meaningful use" funding.   A more advanced information infrastructure is need for developing a care plan and for measuring quality.

Centering LTSS on Persons and Families

The move toward person- and family-centered integrated care is an effort to build assessment, care planning and care coordination around the person and his or her engaged family members. This is not simply a matter of asking individuals and families their needs and preferences. There are enormous gaps between the perceptions people and families have and the reality of the services that are available, eligibility for services and financial support, and the cost of the services. There are also gaps between professionals and the individuals and families in their views and understanding of they need and what systems are offering and not offering.

Much more work is required to bridge the gap in perceptions and understanding among consumers and their families about what services and supports are available, and how those services are organized, paid for and delivered. In part, the confusion and lack of understanding may stem from the lack of consistency in the language used to describe LTSS. The differences between the terms "long-term services and supports," "long-term care," and "home and community-based services," for example, are not clear even to providers.

The term "care coordination" is equally vague. Consumers and health professionals have different views of what care coordination is and who should be involved in it. Health professionals may view care coordination as a task that the physician manages from his or her office. But family caregivers see care coordination much more broadly. To them, the practical tasks of coordinating care often fall directly on the shoulder of the unpaid caregiver who must ensure that the care recipient's home is fully stocked with supplies, that transportation is available when needed, and that a home health aide arrives when expected.

Erasing these gaps in perception is difficult, but not impossible. Health care and LTSS providers must take time to understand the entire continuum of care, not just their piece of it. They must hear, understand, and incorporate the needs and preferences of care recipients and their families in the assessment, planning, and care delivery.   And then they must take care to explain available options in plain language.

ltqa

LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Models for Blending Medical and Long-Term Services and Supports

A number of programs, described by presenters at the LTQA Annual Meeting, are currently blending medical and long-term services and supports.

The Bridge Model for Care Transitions
Robyn Golden, Rush University Medical Center

Master's-prepared social workers in the Enhanced Discharge Planning Program (EDPP) at Chicago's Rush University Medical Center help ease patients' transitions to home by providing telephone follow-up and short-term care coordination in the days and weeks after a hospital discharge. Through its participation in the Illinois Transitional Care Consortium (ITCC), Rush has used it experience with EDPP to develop and promote The Bridge Model for safe transitions. The model employs Bridge Care Coordinators (BCCs) who work with older adults in the hospital to identify unmet needs and to set up services prior to discharge. BCCs call clients 2 days after discharge and again 30 days after discharge to conduct follow-up assessments, track progress, and intervene to address emerging issues. ITCC was recently awarded a Community-based Care Transitions Program contract to implement the Bridge Model in partnership with the Cook County Area Agency on Aging.

Community-Based Multidisciplinary Care Team
Lois Simon, Commonwealth Care Alliance

Commonwealth Care Alliance (CCA) in Boston receives a risk-adjusted premium to care for older adults who are eligible for Medicare and Medicaid and voluntarily enroll in CCA's Senior Care Options program. Beneficiaries receive primary care and care coordination services from a multidisciplinary clinical team of physicians, nurses, behavioral health professionals and geriatric specialists. The team also includes service coordinators and social workers from the local Aging Services Access Point who perform functional, home environment and family caregiving assessments. These assessments help the multidisciplinary team build a plan of care that matches community services with the needs of the beneficiary.

Aging at Home Medical Practice
Michael Barber, National Church Residences

The Aging at Home Medical Practice places certified nurse practitioners (CNP) in selected supportive housing communities operated by National Church Residences in and around Columbus, OH. The CNPs conduct resident assessments and provide care coordination. CNPs also offer same-day treatment for common conditions, administer vaccinations, order lab work and perform tests to diagnose and treat many conditions. The program's overall goal is to create a healing community in the housing property by helping residents become more engaged in managing their chronic conditions so they can avoid hospitalizations and emergency room visits.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Support and Services at Home
Nancy Eldridge, Cathedral Square Corporation

Cathedral Square Corporation in Burlington, VT, established Support and Services at Home (SASH) in 2008 to strengthen the connection between affordable housing providers and providers of health and long-term services and supports. A SASH Coordinator and a Wellness Nurse in each housing property work with local service agencies to help participating residents manage their health and chronic conditions, and avoid hospitalizations and readmissions. Each participant has a Healthy Aging Plan that identifies health and wellness goals and actions to reach those goals. The SASH team also creates a Community Healthy Aging Plan featuring evidence-based group programs that meet common needs. SASH is now being rolled out across Vermont as part of the state's Blueprint for Health. It receives funding from Medicare's Multi-Payer Advanced Primary Care Practices demonstration program.

The Pharmacy as ACO Partner
Ron Weinert, Walgreens Accountable Care Services

Three new accountable care organizations (ACO), formed by the Walgreens retail drug chain, have been approved under the Medicare Shared Savings Program. As members of the ACO care team, Walgreens pharmacists will have access to Medicare claims data and can reach out to patients to address gaps in care that can be filled at the pharmacy. Pharmacists will also serve as a referral source for patients and can participate in the care plans created by the patient's primary care provider. Walgreens will provide ACO patients with access to vaccinations and health screenings, store-based weight loss and nutrition programs, medication adherence monitoring, minor episodic care by nurse practitioners, and chronic condition management through the chain's Take Care Clinics.

Housing Plus Health Services
Stefani McAuliffe and Sharon Kelly, PinnacleHealth

The partnership between PinnacleHealth, a hospital and healthcare system and Presbyterian Senior Living (PSL), a not-for-profit organization providing retirement and senior care services, began several years ago when Pinnacle and PSL collaborated on a diabetes management program at PSL's Presbyterian Apartments in Harrisburg, PA. The program featured Pinnacle-sponsored education classes, followed by one-on-one meetings between PSL residents and service coordinators to develop care plans focused on diabetes management. The partnership expanded after PinnacleHealth and PSL discovered that residents of Presbyterian Apartments were using the emergency room (ER) to access primary care services. To help residents reduce their ER use, PinnacleHealth now sends a physician to Presbyterian Apartments one half-day per week. A PinnacleHealth nurse navigator and a PSL service coordinator work together to manage transitions from hospital to home and to help residents coordinate their clinical care. ER use and hospital visits have dropped dramatically since the program was launched.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Creating Livable Communities
Kathryn Lawler, Atlanta Regional Commission

In 2009, the Atlanta Regional Commission launched the Lifelong Communities initiative, a multi-part framework designed to help community organizations and local governments find ways to change social, political, and infrastructure policies that can make it difficult to grow old in the region. Lifelong Communities bring together a variety of local stakeholders to:

- Change zoning and other rules that have limited the availability of supportive housing in residential neighborhoods.

- Promote transportation options for people, both young and old, who cannot drive.

- Create a community infrastructure to encourage walking and other healthy activities.

- Support the development of a local health care system that addresses issues of chronic disease and frailty among older citizens.

- Expand information about and access to services.

The Village Movement
Gail Kohn, Age Friendly DC

Villages are self-governing, grassroots, community-based membership organizations that help older people remain in their own homes or communities. Currently, more than 120 Villages are operating across the country, in Canada, Australia and the Netherlands, according to the Village to Village Network. Village members pay an annual fee averaging $600 in return for services such as transportation, yard work and bookkeeping. The village typically has one or two paid employees who connect members with service providers and volunteers. Villages also provide lists of approved home-maintenance contractors, many of whom offer discounts to members. The Washington, DC area leads the country in the growth of senior villages, according to *The Washington Post*. One of the DC area's 40 Villages—Capitol Hill Village—has 256 members and 270 volunteers.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Part III: What Will Real Reform Look Like

Commission on Long-Term Care: A Blueprint for Action

Bruce Chernof
President, SCAN Foundation
Chair, Long-Term Care Commission

The Commission's 28 recommendations lay a very important bipartisan foundation for where we need to go. But they are the beginning of a story, not the end.

The bipartisan Commission on Long-Term Care was established by Congress in January 2013 and given a fairly dramatic charge to "develop a plan for the establishment, implementation and financing of a high-quality system that ensures the availability of long-term services and supports for older people, people with limitations or disabilities, and people who want to plan for their future long-term-care needs."

Basically, Congress gave us 90 days to come up with a way to reshape the service-delivery system, fundamentally rethink workforce, and rethink financing.

The Commission's shared vision statements and 28 recommendations lay a very important bipartisan foundation for where we need to go. But they are the beginning of a story, not the end.

Service Delivery

In the area of service delivery, for example, the Commission envisioned a more responsive, integrated, person-centered and fiscally sustainable system of long-term services and supports (LTSS) that people can access in settings they choose. Our recommendations covered a variety of topics including the importance of:

- Integrating care, with a special emphasis on establishing a single point of contact for LTSS on the care team; and aligning incentives to improve the integration of LTSS with health care services into a person- and family-centered approach.

- Completing a simpler and more usable standard assessment mechanism across care settings.

- Using technology more effectively to knit together providers and families.

- Promoting services and support in the least restrictive setting appropriate for an individual's needs – creating a system with options for those who prefer to remain at home and in the community.

- Creating livable communities that build on models to improve access to services and promote the coordination of health care and LTSS.

- Expanding consumer access and assistance by expanding the "No Wrong Door" approach to helping individuals and family caregivers navigate the LTSS system. We emphasized the importance of providing that information before care transitions occur.

- Improving the focus on quality across all LTSS settings, with particular attention to home and community-based services.

Family Caregiving

I am always skeptical about policy recommendations that contain broad platitudes that everyone signs up for and no one does anything about. That's why I am proudest of the Commission's work around family caregiving. We really tried to make this issue "real" by offering very specific recommendations for a national initiative around family caregiving that would raise awareness and spur action to:

- Make the medical system identify family caregivers in the chart and include them as members of the care team.

- Include family caregivers and their needs in the assessment and care-planning processes. As a physician, this is a critical issue for me. At the end of the day, we build these lovely care plans without having a good sense for what tools families need to implement them.

- Ensure that family caregivers have access to relevant information, including the care recipient's electronic health record.

- Encourage the development of interventions, including respite options, to support family caregivers.

Workforce

We need to integrate direct care workers into the care team. This is another area where a lot of lip service is given and a lot more needs to be done to make it real.

The Commission's recommendations call for revising scope-of-practice policies in order to broaden opportunities for delegation of care tasks to workers with demonstrated competency. We are sending families home from the hospital with responsibilities that we are not willing to delegate to individuals who are technically part of the care team. It is time to call that question.

In September 2011, the AARP Public Policy Institute released Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. The SCAN Foundation and the

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Commonwealth Fund helped support the project.

The scorecard identifies 16 functions that can easily be delegated. In states that delegate these functions, there is no evidence that there is any difference in quality or outcomes compared with states that don't delegate.

What are the political drivers that keep us from delegating? We need to be really honest about this and try to address these issues in a more direct way.

In the area of workforce, the Commission also called for:

- The creation of meaningful career ladders and lattices for direct care workers that improve worker access to career advancement opportunities and improved compensation.

- The collection of data, on the federal level, about the LTSS workforce.

- Improved standards and a certification process at the state level for home-care workers.

Financing

Seventy percent of people over the age of 65 can expect to need long-term services and supports during their lifetime – with an average duration of three years. In light of these statistics, we have to think differently about financing this care, including what roles the public and private sectors should have in solving our financing challenges.

The Commission on Long-Term Care spent a great deal of time thinking about financing. We considered a range of different approaches, but we did not agree on a single financing approach. We did not have enough data to make responsible recommendations and, given the time available, we weren't able to do the kind of analyses that were going to get us all the way home.

The Commission report describes two different approaches to financing. One leans more heavily on private solutions. The other leans more heavily on public solutions.

The Commission adopted a shared vision statement for financing that was very clear about the importance of public programs. We agreed that the private solutions available right now are broken. They don't work for most people. We need a different set of solutions and tools that will help people plan for their care while insuring against catastrophic needs.

Next Steps for the Commission Report

Preparing a bipartisan report with 28 recommendations in 90 days proves an important point: this problem is not intractable. However, there is real work to be done.

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Financing alone won't fix the problems we face. That's why the majority of Commission's recommendations are in the service-delivery area. Today, many of those recommendations are, at some level, in the control of members of the Long-Term Quality Alliance (LTQA).

How are we going to do something meaningful to fundamentally change the delivery system. I have three observations on that point:

- It's not just about advocacy—it's also about action. Where are the points where we can create action? What is it we do that is different?

- It's not "yes but," "it's yes and." We hear a lot: "yes it's a good solution, but it doesn't work for this or that." It is part of the reason our issues seem intractable. "Yes that's an important issue and let's think about how to build on it."

- We need to think a lot about outcomes and not just tactics. Why are we doing what we are doing, what do we want to get from this?

How can we build on the Commission's report to fundamentally change the service delivery system? The Commission is a bipartisan foundation and it needs a voice and I hope LTQA can be one of them. Here are three areas where we could make an exponential difference:

- Uniform assessment: There isn't a uniform assessment tool that really links providers and families together in a meaningful way. Some work has been done, but we are just not there yet. This is a place where LTQA could make an exponential difference.

- Family: Putting families at the center of care planning and delivery is another place for exponential and disruptive change. We need to get very real about what the family support network looks like now and how we can strengthen it.

- Quality: A care transition occurs when the social support system fails to address the ongoing needs of people with serious chronic illness and functional limitations. We could be most effective in solving these problems if we could walk in the footsteps of the people who look to us for care. We need to focus on meeting their needs and preferences early enough so we can prevent transitions from occurring in the first place.

The bipartisan Commission on Long-Term Care is the beginning and not the end. I would ask you all to be the voice to build on the Commission report.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Extending the Workforce—Bringing Others into the Fold

Henry Claypool
Executive Vice President
American Association of People with Disabilities

Gail Hunt
President and CEO
National Alliance for Caregiving

When we refer to the long-term care workforce, we are talking about paid direct-care workers and unpaid caregivers who provide highly personal and intimate assistance with tasks like getting dressed, using the bathroom, or preparing meals. These caregivers help an extraordinarily diverse population of individuals in a variety of settings with very diverse functional support needs. We can bucket their issues and needs on the basis of what they derive from: intellectual and developmental disabilities, cognitive impairment, behavioral health conditions, or physical disabilities due to injury, chronic illness, or aging.

The long-term services and supports for functional needs are vital to the health and wellbeing of a population. A person-centered approach to LTSS is extraordinarily broad. It encompasses all of what is going on in a person's life, including the resources and the barriers to health and independence that exist in the surrounding community, and it incorporates what the person wants and needs. Developing a person-centered approach is an elaborate process. It is different than taking a patient-centered approach to developing a care plan. There is a tension that exists between these two perspectives

Those who work in clinical settings need to stretch to think about not just what housing is, but what it is like to live in low-income housing and how do you provide the right kind of clinical support to someone going back to an environment that is challenging. Their family, housing and community environment is the reality for this person who is a patient in a clinical setting only 10 percent of the time but 90 percent of the time is in their person-centered world in their home and community setting with a variety of factors acting on them that can frustrate achieving health outcomes dictated by a primary or acute care clinician.

The clinical team is largely in control of the process. But the direct care workforce is the link in a person-centered approach to giving people the right types of supports in the community. Is there a way to facilitate a process to incorporate the direct care workforce and the home and community based services, into this broader care coordination process? Where is the impetus going to come from to integrate the direct care workforce into the care team?   Is the clinical team going to do outreach to the community organizations, perhaps finding ways of integrating the information that is secured by the direct care workforce into their clinical realm?   I do think the direct care workforce is a huge resource, and we

haven't given enough thought to how to build a structure for their inclusion in a broad care coordination strategy.

We can begin by building a knowledge base among those working in clinical settings about community-based long-term services and supports (LTSS). The next step is to incorporate the direct care workforce and other providers of home and community-based services into the clinical team.

Direct care workers can become a valued resource for that care team because they work in the "real world" where the people they assist actually live. They can offer incredibly helpful insights into that world. However, they need a career pathway that helps them learn skills that are relevant to the clinical team's interests. Direct care workers would bring even more value to the care recipient and the care team if they had a different set of skills that is not just clinically oriented. Organized labor does have an approach to building this workforce up. That's one approach to making sure that this group has a better voice at the table—not just the negotiating table. By working with them we may find new ways to build this workforce's skills. Might we have certain incentives to encourage workers to learn more about how to manage chronic conditions? Could we develop a training curriculum to allow the direct care workforce to be more valued in the broader effort to bring about a patient-centered, person-centered approach to allowing this population to stay well and live in their homes?

The Role of the Family Caregiver

We need to talk about how to bring the family caregiver into the conversation. But we need to begin that conversation by asking these caregivers whether they are actually willing and able to provide the level of care that the LTSS system expects from them.

Family caregivers provide about 80 percent of the long-term services and supports that are delivered each day in this country. We are pushing more of the responsibility onto the family caregiver but not giving them the support that they need. The AARP Study on Home Alone points that out. Family caregivers are not just offering assistance with activities of daily living and instrumental activities of daily living these caregivers are also carrying out a variety of medical/nursing tasks that were once only provided in hospitals. They are doing so without the training and ongoing support they need and deserve.

The Commission on Long-Term Care came out with so many recommendations regarding family caregiving.   The Commission placed an emphasis on patient and family-centered care—we've talked about person and patient-centered care, but family-centered care should be an additional way to look at LTSS because so often it is the family caregiver that is expected to actually provide the care.

The Commission said that HHS and accrediting bodies should require that the family caregiver be taken into account in the care team.   They should ensure that the caregiver has access to important information through technology. Should EHRs be interactive not just with the patient but with the family caregiver to enable

ltqa

LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

family to provide important information and helping with shared decision-making. Patient centered care is not just about designing a plan, but helping with shared decision-making. It is about evaluating the risks and potential benefits of what is being considered. There is a lot more technology being developed—technology design needs to pay more attention to caregiver. Many of these are not designed with the caregiver in mind, but with the technology in mind.

The last thing that the Commission mentions is to encourage caregiver support—especially respite options and more volunteers that can help.

AARP has come out with a study of states that have caregiver assessment of some sort. Thirty states have some kind of caregiver assessment, but it is all over the place. For example, when it comes to using technology, caregiver assessments do not always ask if the caregiver is willing to use a particular device. They are more likely to focus on the need to train the caregiver in using the device, regardless of whether the caregiver is willing.

The Department of Veterans Affairs (DVA) has a wonderful family caregiver program to support caregivers of post-9-11 veterans. The give tablets to family caregivers and encourage them to communicate with the VA about what concerns they are having; what training they need; what they need to know more about. I think that's a great example of a merging of technology and family caregiving. I think it is something to which we need to be open.

LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Models for Extending the Workforce

Two programs, described by presenters at the LTQA Annual Meeting, are working to extend the LTSS workforce.

Incorporating Case Workers into the Primary Care Team
Emily Brower, Atrius Health

The accountable care program at Boston-based Atrius Health relies on case workers from local Aging Services Access Points (ASAP) to deliver social supports to patients participating in the organization's Pioneer Accountable Care Organization, its Medicare Advantage Plan and the Community Care Alliance One Care plan, which serves dual eligibles under the state's One Care: MassHealth plus Medicare program. The partnership's success is due, in part, to the fact that Atrius treats ASAP staff as authentic members of the care team. Atrius encourages point-to-point communication between ASAPs and local primary care practices; involves ASAP staff in multidisciplinary care team meetings so they can provide insights about high-risk patients and recommend services to support these patients; and depends on ASAP staff to coordinate needed community-based services for specific patients.

Delivering Behavior Health Services in the Home
Mark Snowden, University of Washington

The PEARLS program, developed by researchers at the University of Washington in Seattle, provides in-home therapy to people with mild depression. Trained depression care managers—usually service coordinators or other workers without formal medical training—conduct a comprehensive assessment and deliver eight sessions of problem-solving and behavior activation therapy to program participants. During therapy sessions, participants are encouraged to identify their own problems and develop a strategy for addressing those problems, most often through physical activity, social interaction and engagement in enjoyable activities. A psychiatrist trains and supervises the depression care managers. A six-month study at the University of Washington showed that the program helped participants reduce their depression and hospitalizations for all causes. Forty programs in 18 states now use the program to serve several thousand participants. The program costs about $630 per person. The State of Washington funds PEARLS through its Medicaid Waiver Program.

Using Technology to Prevent Hospital Use and Promote Continuity of Care

Karen Wolk Feinstein
President, Jewish Healthcare Foundation of Pittsburgh
Founding Co-chair, Pittsburgh Regional Health Initiative

Farzad Mostashari
Former National Coordinator for Health Information Technology
Visiting Fellow, Vice President and Director of Economic Studies
The Brookings Institution

Majd Alwan
Senior Vice President of Technology
LeadingAge

Kelly Cronin
Health Reform Coordinator
Office of the National Coordinator for Health Information Technology

What are the essential services and system requirements for a health care system that stretches across all settings of care, including post-acute, rehabilitation and long-term care?

Research has demonstrated that the long list of essential services includes such components as care management, clinical pharmacy services, patient engagement and behavioral health screenings and interventions that are facilitated by systems such as health information technology (IT), quality improvement training and performance incentives.

Ironically, public and private payers have not traditionally reimbursed providers for any of these essential services or system enhancements. One thing our data tell us is that people who cycle in and out of hospitals are people in skilled nursing facilities and at the end of life. If you want to keep complex patients out of hospitals, you have to move into the long-term care environment.

Recent legislative initiatives—including the Health Information Technology for Economic and Clinical Health (HITECH) Act, which became law in 2008, and the Affordable Care Act, which took effect in 2010—recognized the important role that technology can play in the delivery of high-quality, low-cost services and supports.

Clearly, technology alone won't fix our health care system. But it can facilitate and enable innovation that can help us address the persistent challenges with new approaches that were not possible before.

This time is different than last time we tried to tackle health-care costs. We have

tools that we could only dream about before. Furthermore, payment is changing, and it creates new opportunities and incentives to achieve better health at lower cost. This will have an effect on all parts of our health care system, and on how patients care for themselves, as well.

When safer care is incentivized, there are technological tools that can help us improve safety within home and health care settings. For example, now that there are strong incentives to prevent hospital readmissions, there will be adoption of tools that help: segment the patient population to identify individuals who are at the highest risk for readmission; monitor those patients more carefully to detect emerging health issues so we can intervene early and prevent health crises; and share data about patients in real time to avoid duplicated and disjointed care.

All of these tools have one thing in common: they rely on data, including better assessments. The better data you have—about a patient's health and functional status, medications and family caregiver supports and socioeconomic status—the better these tools will work.

We are seeing more incentives and payment adjustments tied to measurable quality outcomes. Attaining those outcomes will require an ability to change workflows and implement protocols that help reduce unnecessary variation. That requires better teams that can work together better.

Incentives and information are changing, and culture and workflows need to change in order to take full advantage of the possibilities we have. New technologies that facilitate patients and caregivers as members of the care teams will do the most to change the prevailing medical culture. One of many available apps helps individuals and their caregivers identify and organize multiple providers, procedures, diagnoses, and medications. As stage two of Meaningful Use rolls out in the next 12 months, patients will have the ability to view, download, and transmit their medical records from their Medicare and Medicaid providers.

Collecting and using data to improve quality across care settings can yield tremendous payoffs, including stronger care teams that have the information they need to work together more effectively.

Health IT in LTPAC Settings

More long-term and post-acute care (LTPAC) settings are recognizing the need to explore and adopt health IT so they can conduct resident and client assessments, participate in accountable care, achieve benchmarks for value-based purchasing, meet growing consumer demands, and help a growing number of older adults fulfill their desire to remain at home.

How do LTPAC providers make sense of all the technology options at their disposal?

In 2009, LeadingAge and its Center for Aging Services Technologies identified

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

three models of technology-enabled care delivery models that promise to engage LTPAC providers in the future:

- Integrated coordinated health care models like accountable care organizations (ACOs) and the Program of All Inclusive Care for the Elderly (PACE).

- Home and community-based Support Services models, including home care services that are enabled by such technologies as remote monitoring and telehealth, where services are delivered on an as-needed basis.

- The traditional campus models of long-term services and supports (LTSS) that use technology both to drive internal efficiencies, perfect home care delivery processes, and deliver services to the broader community.

Several key enabling technologies facilitate care coordination across all of the future models.

- Interoperable **electronic health records** (EHR) allow the meaningful digital exchange of health information among all members of the care team, including the family caregiver and the care recipient.

- **Advanced EHR features,** such as clinical decision support systems, can drive quality initiatives by facilitating medication management, falls prevention, and pressure ulcers prevention.

- **Telehealth** devices placed in the home collect biometric data—such as blood pressure, weight and glucose levels—as well as responses to assessment questionnaires aimed at ascertaining wellbeing and explaining abnormal readings.

- Other **remote patient monitoring** devices use sensors to assess activities of daily living and sleep, and aid in the detection and early treatment of emerging health conditions such as urinary tract infections.

- **Care Coordination tools** allow the shared care planning between virtual care team members, including the family caregiver. These tools allow us to follow up on the execution of care plans and provide acute care providers with insight about the support network and supportive services available to the individual.

These technologies are real. All we need are operational models and the alignment of incentives to facilitate the adoption of these technologies.

Federal Incentives for Health IT Adoption

All over the country, organizations are using Health IT to improve continuity and care delivery across long-term and post-acute settings. We are at a pivotal time where we are working to figure out which policies can make these pockets of innovation more mainstream, so that providers in all of these settings can work more collaboratively.

ltqa

LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

One of the policies that will help that in the next few years is the federal Medicare and Medicaid EHR Incentive Program, which provides financial rewards to hospitals and physician practices that make "Meaningful Use" of EHRs. Despite their inability to participate in this program, LTPAC settings are affected by interoperability standards that the three-stage "Meaningful Use" program requires.

Under Stage 2's Transitions of Care Measure, eligible hospitals and health care professionals will begin exchanging data with skilled nursing facilities and other settings across the long-term continuum during care transitions. This means that LTPAC settings must begin thinking more critically about how they will receive data from other settings and how they might change workflows to ensure that they are using that data to enhance coordinated care planning and delivery. Although LTPAC providers are not recipients of the incentive dollars, the standards and interoperability structure is still being expanded to serve their needs.

Additional technology-related opportunities in store for LTPAC settings include the following:

- The Office of the National Coordinator for Health IT (ONC) is conducting an active dialogue with the health IT community about the possibility of implementing a special certification program for EHRs that are designed to meet the needs of LTPAC settings. There is strong support for this EHR certification in the provider community.

- The advent of ACOs is spurring LTPAC settings to strengthen their health IT infrastructures so they can become important ACO partners and members of the provider network. Successful partnerships will depend on the ability of LTPAC settings to use data from other settings to coordinate care for ACO patients.

- Value-based purchasing (VBP) provides skilled nursing facilities and home health agencies with a compelling reason to adopt health IT. This adoption will become a requirement for VBP measures focusing on medication reconciliation and transitions of care.

- State Innovation Models (SIM) initiative awards provide an opportunity for care integration. Many testing states are prioritizing long-term care to be part of multi-payer accountable care communities and primary care integration models.

- Initiatives aimed at engaging family caregivers and their care recipients in care planning and delivery will place new emphasis on ways to use health IT to provide families with the support they need to care for a loved one.

ltqa

LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Available Educational Resources

ONC is promoting provider education and outreach as a way to accelerate health IT adoption. For example, a recent issue brief on *Health IT in Long-Term and Post Acute Care* explores how LTPAC providers can get more involved in ACA-supported technology initiatives.

In addition, LeadingAge CAST offers a number of tools to help providers explore and adopt technology-enabled care. These tools include an Aging Services Technology Study, and toolkits aimed at helping providers choose the telehealth and EHR systems that are right for them.

Models for Using Technology

Several programs, described by presenters at the LTQA Annual Meeting, are using technology to prevent hospital use and promote continuity of care.

Remote Monitoring
Monte Coffman, Windsor Place
Sarika Aggarwal and Karen Longo, Fallon Community Health Plan

Windsor Place in Iola, KS and Fallon Community Health Plan in Worchester, MA are both using remote monitoring technology to track vital signs and activities of daily living among clients with chronic disease who live at home. The data helps the organization's caregivers stay abreast of a client's health and functional status so they can intervene early when readings and results indicate an emerging health issue. A three-year study by the University of Kansas showed that the remote monitoring system at Windsor Place saved $26,000 per person per year. The cost of the service was $2,100 per person per year. Fallon's system of bed, refrigerator, door and other sensors helped reduce moves to higher levels of care for 19 older adults with multiple chronic conditions who used the system during a test.

Facebook for Health
Sally Okun, PatientsLikeMe

Often referred to as the "Facebook for Health," PatientsLikeMe is a free, social networking website that allows its members to learn from one another as they attempt to manage their chronic conditions. Close to a quarter of a million patients—mostly women, aged 45-60, with four or five chronic diseases—are registered on the site. Sixteen million structured data points—describing patients' symptoms, side effects and health status—now exist in the PatientsLikeMe database. In addition to engaging patients in their own care, the data collected by PatientsLikeMe could eventually be transferred to patients' electronic health records where it could be viewed, with the patient's permission, by clinicians and caregivers. Aggregated data from the site could also be shared with researchers studying chronic conditions.

IMPACT
Larry Garber, Reliant Medical Group

In Feb. 2011, the Office of the National Coordinator for Health Information Technology awarded a $1.7 million Health Information Exchange Challenge Grant to the State of Massachusetts for a project entitled, "Improving Massachusetts Post-Acute Care Transfers (IMPACT)." The purpose of the grant was to:

• Facilitate the development of a national standard for data elements that should be exchanged across the continuum during transitions of care.

• Develop software tools called "LAND" and "SEE" that would allow organizations to acquire, view, edit and send these data elements.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

- Integrate the data elements into existing databases.

Keystone Beacon Community
Jim Walker, Siemens Medical Solutions, Inc.

KeyHIE Transform, a software tool developed through the Keystone Beacon Community, extracts clinical information from two federally required patient assessments: the Minimum Data Set (MDS) for nursing homes and the Outcome and Assessment Information Set (OASIS) for home health. The software then converts that data into the standardized format of a Continuity of Care Document (CCD). Nursing homes and home health agencies can share the CCD data with other care providers within a regional health information exchange, regardless of the health IT tools they have in place. The Keystone Health Information Exchange offers subscriptions to KeyHIE Transform that range from $499 to $899 a year, depending on the number of residents living in the nursing home or the number of Medicare patients receiving services from the home health agency.

Community Health Accreditation Program
Karen Collishaw, Community Health Accreditation Program

The Community Health Accreditation Program (CHAP) is an independent, nonprofit, accrediting body for community-based health care organizations. Using "deeming authority" granted by the Centers for Medicare and Medicaid Services (CMS), CHAP surveys agencies providing home health, hospice and home medical equipment services to determine if they meet the Medicare Conditions of Participation and CMS Quality Standards. In 2007, CHAP moved from a paper-based to an automated system featuring an integrated database that promises to increase the reliability of its accreditation process. Tablet computers have helped streamline the survey process and allow for the collection of meaningful data that helps surveyed agencies identify their strengths and challenges, and compare themselves with similar organizations. The new system facilitates communication between CHAP and its agencies and provides seamless integration with the CMS data system.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Redesigning Payments at the State and Local Level

Anne Gauthier
Senior Program Director
National Academy for State Health Policy

Barbara Gage
Managing Director
Engelberg Center for Health Care Reform
The Brookings Institution

We've heard a great deal over the past two days about the pockets of innovation that exist around the country and about the regions that still lack access to cutting-edge care delivery models. Clearly, it is time to move innovative models of care delivery and payment into the mainstream, particularly for the long-term care population, which has the greatest needs that cross all kinds of organizations and providers.

New models of care delivery will help us accomplish this goal. Data collection and analysis will also be essential to our success. But we won't be able to move forward without a payment structure that supports the integration of quality care and breaks down the traditional silos that are especially prominent in the LTSS world.

Innovation happens at the federal, state, and local levels, and all are important. Supporting policy at higher levels and models at the local level are both critical for moving forward.

Payment Models: What is at Stake?

How do we adequately cover the costs of providing services and supports to the post-acute population? To answer that question, we must take a closer look at those costs.

One in five Medicare beneficiaries is hospitalized every year. Among those beneficiaries, one in three will move to a post-acute care setting after their hospital stay. How this large group of beneficiaries actually uses post-acute services varies by their age, health status, and also the condition with which they went to the hospital.

Beneficiaries enter the hospital for a variety of reasons, ranging from a joint replacement or pneumonia to a stroke or congestive heart failure. The reason for the hospitalization will determine the number of services used, what those services cost and, most importantly, the likelihood that the beneficiary will recover all function or remain frail.

Because patients who enter the hospital for a joint replacement tend to be younger

35

and healthier than other beneficiaries, they have a higher likelihood of returning home after hospital discharge. This is true even for the 20 percent of joint-replacement patients who undergo an intensive rehabilitation regime immediately after their hospital stay. Yet, it's important to keep in mind that these patients still use a substantial number of skilled nursing facility days and home health days.

Only a third (33%) of patients who enter the hospital with simple pneumonia will go on to post-acute care. But when they do move to the more intensive level of care provided by skilled nursing facilities or home health agencies, the cost of care increases substantially.

The High Cost of Readmissions

If the patient is readmitted to the hospital, those costs increase even more. Any insurance model must either be prepared to cover these costs or find ways to prevent readmissions.

How likely are readmissions? The patient with pneumonia who has a low probability of using post-acute care after hospital discharge is also twice as likely as the average Medicare beneficiary to be re-hospitalized within 30 days of discharge from the hospital. And the cost of that readmission is significant—about one and a half times higher than the original hospitalization.

ltqa

LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

Models for Redesigning Payments

Several programs, described by presenters at the LTQA Annual Meeting, are working to redesign payments at the state and local level.

Medicare Special Needs Plan
Lynda Hestrom, OptumHealth

The Evercare special needs plan, part of the OptumHealth division of UnitedHealth Group, provides individualized care to Medicare beneficiaries who live in nursing homes and opt to become Evercare members. Nurse practitioners work with the nursing home, the nursing home resident and his or her family to coordinate care across settings. OptumHealth is now working to develop a more integrated community-based version of Evercare that relies on partnerships with community-based service providers, like area agencies on aging and health care providers; uses the telephone to conduct disease and case management; and collects data to help identify program strengths and challenges.

Rebalancing Long-Term Care
Andrew Allison, Arkansas Department of Human Services

The Medicaid program in Arkansas spends 60 percent of its funds to pay for institutional care, and only 40 percent of its budget to fund home and community-based services. The state's Department of Human Services is leading a multi-payer effort to flip those numbers. In a recent study, the department found little correlation between what the state pays per day for nursing home care and the level of residents' service need or the quality of the care they receive. The state is working to rectify this situation by developing a comprehensive package of payment reforms that use a universal assessment to ensure that a beneficiary receives appropriate services; improve consumer education and awareness of care choices; and eliminate the mismatch between an individual's need for services and the setting in which they are served.

Local Funding for Aging in Place
Suzanne Burke, Council on Aging of Southwestern Ohio

The Council on Aging of Southwestern Ohio provides one-stop, one-telephone-call access to community-based services in five counties surrounding Cincinnati. About 17,000 seniors in the region who are not eligible for Medicaid receive a package of services paid for with funds from a $20 million county-based property tax levy dedicated to keeping seniors in their homes. The levy, which must be reauthorized by referendum every five years, traditionally receives a 75-percent approval rating from voters. Recipients of care have a family-based care plan that includes a wide range of services, including home care, home modification, respite care, caregiver support, medical transportation, assessment and care management.

Part IV: Next Steps

LTQA's Role in Facilitating Transformation

G. Lawrence Atkins
LTQA Executive Director

I come to my position as executive director of the Long-Term Quality Alliance (LTQA) after serving as staff director of the bipartisan Commission on Long-Term Care. So it is no surprise that one question is foremost in my mind:

How can LTQA pick up where the Commission left off?

LTQA is a community of people who are at the forefront of the reform movement that has been taking place in the worlds of health care and long-term services and supports (LTSS) for the past few years.

You know from experience that the reform I speak about is not taking place in Washington, DC. Instead, your states and your local communities are seeing the bulk of innovation.

A revolution is taking place across the country. It involves coordinated care planning and delivery, health information technology, payment reform and many other cutting-edge initiatives. Fueled by the Affordable Care Act, these initiatives are starting to take hold at a fairly intensive pace.

Despite this success, however, we are frustrated. As many of you have observed, innovation is taking place in small pockets around the country. Our next challenge will be to find ways to ensure that this innovation moves out of these geographic pockets so the transformation of health care and LTSS becomes a common experience for all Americans.

How can LTQA help this happen?

- By spreading the word about scalable innovations.

- By bringing together innovators who are working, day in and day out, on their innovative piece of the puzzle.

- By offering those innovators an opportunity to quantify their own efforts and compare their work with the work others are doing.

- By helping these innovators figure out how all of their efforts can be brought together to form a cohesive whole—a whole that transforms pockets of innovation into a truly person-centered system of health care and long-term services and supports.

38

LTQA's diverse membership puts it in a good position to facilitate this convergence. We have an incredibly strong platform on which to build. Let's use it.

Recommendations for Action
A Synthesis of Discussions from Annual Meeting Workgroups

Imagine you had an opportunity to redesign the current systems of health care and long-term services and supports so they would work together to support the health and wellbeing of vulnerable populations living in the community.

- Which population would you target and why?

- What type of redesign initiative would you put into place and why?

- What types of obstacles might you have to address?

- What types of approaches would be helpful to succeed?

- Is it worth it? Why?

Participants in LTQA's 3rd Annual Meeting pondered these questions during a work session that connected them with other stakeholders from their geographic regions.

Several common themes emerged from those work sessions. Participants envisioned a large-scale, systems-change initiative that was based in local communities, made use of technology and data to improve quality and reduce costs, was implemented by well-trained and well-supported caregivers, and used resources in the most efficient manner possible. Here is a synthesis of the discussions.

A Large-Scale and Inclusive System

It's time to move beyond the current practice of creating small pockets of innovation that are supported by short-term grants. Instead, the nation needs to undertake a large-scale initiative to create an integrated system of health, long-term and post-acute care that focuses on improved communication and collaboration among providers and keeps the needs and preferences of the consumer and his or her family as its central focus.

This initiative—and the system it creates—must have its roots in the communities where people live. Communities should be encouraged to show their commitment to the initiative by supporting it with local tax dollars.

The design and the reach of this integrated system of health, long-term and post-acute care must be as broad as possible. For example, the system should be targeted to a wide variety of individuals, at all levels of socio-economic need. It should make a deliberate effort to serve members of the "gap population"—those

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

individuals who are not eligible for public benefit programs, but who cannot afford to buy health and long-term services and supports.

In addition, the system must address the full spectrum of health concerns experienced by the target population, and should acknowledge that health and wellbeing are strongly influenced by the circumstances in which people are born, grow up, live, work and age.

A System Strengthened by the Use of Technology and Data

Technologies that connect individuals and providers in whole new ways can lead to better care across the continuum for vulnerable populations.

Technology could help consumers manage their chronic conditions while enhancing their safety and preserving their independence. It could help providers monitor care delivery and quality of care by measuring the success of care teams in reaching positive outcomes in areas that matter to patients and their families.

Data is key to implementing any quality standard. Steps must be taken to create a strong system of data collection and analysis and to involve a broad range of providers in that system.

Well-trained Caregivers

Technological advances must be coupled with greater attention to improving the skills and working conditions of those who provide hands-on care in residential and community-based settings. These efforts should involve:

- Expanding the role of direct care workers in delivering person-centered long-term services and supports and helping consumers and their families access community resources.

- Developing training and education programs that enhance the knowledge base of both direct care workers and family caregivers.

Efficient Use of Resources

The overriding goal of any effort to integrate the worlds of health care and long-term services and supports should be to deliver better care at a lower cost. Therefore, effective and efficient use of resources must be a hallmark of any new system. This might be accomplished by:

- Developing new models of care, like the Village model or the Continuing Care at Home model, which offer a menu of modestly priced services that individuals can access while remaining in their own homes.

- Fostering partnerships between long-term and post-acute providers, managed care organizations, accountable care organizations and hospitals to reduce expensive hospital readmissions.

ltqa
LONG-TERM
QUALITY ALLIANCE

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

A Role for LTQA

The Long-Term Quality Alliance (LTQA) can play a critical role in convening and educating the stakeholders who will carry out these ambitious system-building plans.

To date, LTQA has played an important role in explaining why system reform is necessary. Now the Alliance must demonstrate that a reformed system can, in fact, offer better health outcomes as well as a return on investment to funders, implementers and consumers.

Armed with this evidence, LTQA would be well positioned to champion the development of a system-building initiative that could promote proven strategies for implementing person-centered and family-centered services and supports to a broad range of Americans.

ltqa

**LONG-TERM
QUALITY ALLIANCE**

3RD ANNUAL MEETING

BUILDING BRIDGES
ACROSS THE
CONTINUUM
TO ACHIEVE
PERSON-CENTERED
CARE

DECEMBER 16 – 17, 2013

ltqa
LONG-TERM
QUALITY ALLIANCE

For conference information or to register, please visit
www.ltqa.org

BOARD AND ADVISORY STEERING COMMITTEE 2013

LTQA

Our mission is to improve the effectiveness and efficiency of care and the quality of life of people receiving long-term services and supports by fostering person- and family-centered quality measurement and advancing innovative best practices.