



## Integrating LTSS from a Person's Perspective— Across Time and Setting

---

2014 Conference Proceedings  
Thursday, September 18<sup>th</sup>, 2014  
Hyatt Regency, Crystal City  
Arlington, VA

LTQA 4<sup>th</sup> Annual Conference:  
Integrating LTSS from a Person's  
Perspective—Across Time and  
Setting

Long-Term Quality Alliance  
1825 K Street NW, Suite 411  
Washington, DC 20006  
[www.ltqa.org](http://www.ltqa.org)

Edited by G. Lawrence Atkins, Ph.D. and Elizabeth Blair.

The Long-Term Quality Alliance (LTQA) is a community of organizations aimed at improving outcomes and quality of life for persons and their families managing functional limitations due to chronic health conditions. These organizations have come together to share knowledge and experience needed to advance development and continuous improvement of high-quality systems of integrated, person and family-centered long-term services and supports. The Alliance is both a shared learning center and a platform for amplifying and increasing the impact of the work of its member organizations.

## Table of Contents

Opening Remarks .....	1
Keynote: To Be Person-Centered .....	3
Panel 1: State-Federal LTSS Integration Initiatives .....	9
Challenges .....	9
MCOs and Person-Centeredness.....	11
Panel 2: LTSS Integration in Health Plans and Health Systems .....	13
UnitedHealthCare (UHC) .....	13
Aetna .....	15
Accountable Care Organizations (ACOs) .....	17
Panel 3: Measuring Success.....	21
The Need for New Measures.....	21
Person- and Family-Centered Experience of Care.....	22
National Core Indicators (NCI).....	23
Independence at Home.....	23
Moving Forward .....	24
Panel Four: Scaling Up Success.....	27
Making Integration Work for the Small Community Health Plans .....	27
State Leadership to Build Integrated Managed Care Networks .....	28
Promoting Integrated Care for Dual Eligibles (PRIDE) .....	30
Success and How to Spread It .....	32



## Opening Remarks

*Carol Raphael, LTQA Chair*

*Mark McClellan, Brookings Institution, LTQA  
Founding Board Member*

Welcome to our Fourth Annual Meeting of the Long-Term Quality Alliance (LTQA). Many of you are with organizations that are Members of the Alliance or are old friends. For those of you experiencing one of our meetings for the first time, I will give you a little background on who we are and what we do.

LTQA is an alliance of organizations engaged in long-term services and supports. LTQA's members make it unique. They come from every sector, including consumers, providers, payers, academics, policy-makers, and government officials. All of these organizations and individuals are working together through our conferences, roundtables, papers, workgroups, and other activities, to improve person and family centered, integrated, long-term care.

What brings us all together is our commitment to building a stronger health care system that is integrated, responsive, and affordable, and makes the rhetoric about patient and family centered care real. Large-scale social change can really only come from cross-sector coordination and communication, rather than from any one organization's interventions in the system. By bringing together these diverse perspectives, we can highlight some of the best evidence there is on solving critical, practical problems in implementing person

and family centered LTSS, and we can provide a forum for coming up with solutions that require bringing these perspectives together. It is the combination of having an honest broker across different sectors with different perspectives and interests, and also making sure these processes have the best technical solutions and insights available.

The idea of this integrated approach to care, which builds on integrated long-term services and supports, is not new. There is now unprecedented activity across the country about rethinking, remaking, and improving LTSS for persons who need them, along with reforms in payment to ensure that these changes are financially viable and sustainable. This activity is taking place in the context of some broader momentum we are seeing in our health care system to implement new delivery systems and payment models.

What needs to happen is clear conceptually. Fragmented and silo-ed payments that are tied mainly to the occurrence of complications need to be modified and unified behind programs that are successfully integrating supportive care at the person level, to get to the best functional outcomes, fewer complications, hospitalizations, and other barriers to high quality care and good health for people who need LTSS.

CMS is undertaking demonstrations and pilots like the duals demonstration programs, and is testing new approaches. However, these are not likely to be the last word in terms of best way to finance truly person-level effective care. Every day we

are learning more about how to do this-- reducing the uncertainty providers face in taking on accountability for better outcomes and more integrated care, and using that accountability to redirect resources to get to better care.

Panelists are going to discuss successful steps towards LTSS integration, the obstacles, and how to overcome them. You will hear a lot about the challenges in making LTSS integration real, and what we need to do to get there.

Some of the challenges are technical, like getting information systems in place, and introducing new payment models. Some are more fundamental, such as allowing LTSS providers to describe, with clear evidence, the value of their services in terms of person-level outcomes and cost, and to get to be that integral part in fundamental health care reform, or getting the engagement with health plans and at risk acute care providers to turn this engagement into a feasible business plan.

There is more going on than ever to address these kinds of challenges in moving to person and family centered LTSS integration. Last year's bipartisan Long-Term Care Commission called for person- and family-centered LTSS integration as a key strategy for improving access and quality of care, and the LTQA Board has made it a priority for the Alliance to further the recommendations of the Commission. This is really what LTQA is all about. We are bringing together leaders, experiences, and the best ideas to get effective, integrated LTSS.

## Keynote: To Be Person-Centered

*Nancy Thaler, Executive Director, National Association of State Directors of Developmental Disabilities Services (NASDDDS)*

In the world of services and supports for persons with developmental disabilities (DD), person-centeredness is about a 25-year-old concept. It grew out of frustration that people receiving millions of dollars' worth of services had poor quality of life because nobody listened to them. What we call IEPs (Individualized Education Programs) and IHPs (Individual Health Plans) in the DD field are horrendous experiences of people sitting around talking about what is wrong with you, giving you services that they have, which are often not what you need.

This led to a movement in the DD field to undo all of that. Beth Mount, John O'Brien and Michael Smull constructed ways of having a dialogue, and trained people to engage in conversation and ask people what mattered to them. – It was a faltering movement with moderate success. It changed our language a lot, and it changed the behavior of some people. I see it as an aspirational goal.

So to be person-centered, think about being that person. Imagine yourself in a health crisis--you immediately have an incredible sense of vulnerability. I have a son with a developmental disability, and at one time I was the director of DD services in Pennsylvania. I would go to meetings about his individual plan. I was afraid to go alone.

My power was useless—they had my son. I was at their mercy. Those direct care staff didn't care who I was. It is a very un-empowering, vulnerable position to be in.

The sequence is: I feel vulnerable, embarrassed, frightened, exposed, sometimes like a failure because I can't take care of myself or my family, which leads to me feeling diminished as a person, which undermines my sense of self and self-confidence, which causes depression and stress, which causes bad health problems.

We're learning a lot about neurobiology and the body, the mind, and the intercept of the two. We know what depression and stress do to the body and its triggering of cortisol. The surge of cortisol is a response to the fight or flight impulses in threatening situations. If one cannot fight or run, the cortisol acts on the body. Someone who is seeking help in getting services is in this state from the get-go. If we're person-centered, we appreciate that in the moment.

Dr. Berwick said:

“.....that small thing is what matters. I will tell you: it is all that matters. All that matters is the person. The person. The individual. The patient. The poet. The lover. The adventurer. The frightened soul. The wondering mind. The learned mind. The Husband. The Wife. The Son. The Daughter. In the moment.

- The 90-year-old grandmother, over whom you tower;
- The professor in the MRI machine who has been told to lie still, but

- who desperately needs to urinate and is ashamed;
- The man who would prefer to know and as the man who would prefer not to know;
  - The woman who would prefer to sit;
  - The woman who would prefer to stand; as the man who wants you to call him, “Bill,” and as the man who prefers to be called, “Dr. Gruzenski.”

My very favorite is the professor in the MRI machine. That’s what it means to be person-centered—to intuit that that might be true, and administer to his comfort.

Why is it so hard to be person-centered? It’s because it’s so incredibly inconvenient. It does take more time—more than we think we have. People always choose priorities that we don’t choose, and don’t agree with ours. They won’t follow our deadlines or our clinical therapy protocols.

In the business of human services, objectifying people is a protective mechanism. At the extreme, it’s the doctor who has to objectify the person to cut them on the table. Beyond that, any kind of delivery system goes through the motions. It’s not person-centered. It’s very difficult to engage with people intimately and not exhaust yourself, and not make yourself vulnerable.

Being person-centered requires a review of every process in long-term care. You need to reexamine

- Intake and assessment, or, the 1<sup>st</sup> conversation
- Planning—the 2<sup>nd</sup> conversation
- Service Delivery—the 3<sup>rd</sup> and longest conversation
- Documentation that is easy, not intrusive, and transparent to the person
- Payment and reimbursement rules
- Performance Measurement—the 4<sup>th</sup> conversation

### Assessment: The First Conversation

During assessment, we ask intimate questions, ask people what they can not do when they are already vulnerable and feeling like a failure, talk to the people around them instead of to them, and ask the same questions over and over. We don’t ask what is important to them. Often, all we are doing is collecting data. In fact, I have heard people refer to the assessment process as “data collection.”

We are assessment obsessive in our field. We think that we can use standardized assessment to know who people are and what makes a difference in their life. I think we need to separate data collection from assessment. Is there a way to get the data that we need and separate it from the conversation?

### Care Planning: The Second Conversation

In the DD field when we say person-centered planning, we ask what is important **TO** the person, and **FOR** the person. These are two different things, but they are equally important. These things



---

have to be balanced. If you don't do what's important **TO** people, they are not going to cooperate with what is important **FOR** them.

### **Service Delivery: The Third Conversation**

How do you train every employee who interacts with the person to be present, to be mindful? For that person, who probably has another job, and is working 70 hours a week, to walk in the room and just think about Helen. That is where person-centered happens—in that interaction. Training, mentoring, coaching, and rewarding--those are the only tools we have to invest in.

### **Measuring Performance—the Fourth Conversation**

You know this fiasco in the VA where people were not getting care? Nowhere in the articles that I read did anyone ever ask the veterans anything. Had the VA staff asked the veterans what was going on, they would have said, "I'm not getting services." Instead, they were using data coming only from the hospitals.

When you measure performance, ask about the things that are important **TO** people, and the things that are important **FOR** people. If we are doing well in one, and not the other, we are not delivering comprehensive care. National Core Indicators is about 17 years old, and came out of the DD Directors. These get at what is important to **AND** for people. We have 40 states using them. It is the biggest data set on people with DD. It focuses on individual and family outcomes, and basic health and welfare. We have been building a system

that is a person-centered evaluation system.

### **Payment and Reimbursement**

One of the biggest obstacles to doing what is important is the way we fund programs and activities and what we pay for. We pay for services that people don't need, and don't pay for services that they do need. In long-term care, most of this is defined by states.

Every state defines what services they will deliver and how much of it. Often, services that are most important to people they cannot get. Consumer direction is an important alternative --enabling people to have control over the money that is spent on them. It might be a budget, or the power to hire and fire a personal care aide. If I am going to strip down naked and let someone in my bathroom to help me take a bath, I want to say who that is. That is the most intimate part of life. You also have to allow for the unexpected. If you do not build in exceptions, allowances and modifications, it cannot be person-centered.

### **Family Centeredness**

We don't get to define family. People define their own family. Family is defined by the family itself. In the world of aging services, 85% of older family care recipients receive care from a spouse or their children. In the DD world, it's almost 90%. Family caregivers are the nation's long-term care system. What are we going to do to help family caregivers? As Baby Boomers retire at 10,000 a day, supporting family caregivers becomes more and more crucial.

Baby Boomers are going to have to confront the fact that the richness of long-term care today is not sustainable for them. The number of nursing home beds we have and the amount of money we have is not going to grow proportionally with the Baby Boomers. The only solution is family. We have got to make their lives easy and fun, and focus on what helps them.

It's problematic that we narrowly define the Medicaid beneficiary as the one person, as though the other people in their lives didn't need anything. Medicaid is the engine that drives LTSS in this country, and that is families. We've got to find a way to expand our view on this, and expand our relationship to families.

Research tells us that there are two kinds of support behavior that contribute to good family outcomes.

1. Listening to and responding to their priorities;
2. Helping families learn skills to obtain desired resources and supports. Families want to know things so that they can do a better job.

You must take a "life-course" view. There are people who develop a disability very late in life, or mid-life, through an accident, or are born with a disability. These are all very different experiences, cultures, and ways of thinking. In the DD world, we refer to this as the "life course." Once we engage with families, we are with them forever. We need to think about transitions in life. Circumstances are changing constantly, so expect that people's needs will change.

Have an appreciation for the fact that families are in it for the long haul. Oftentimes, by the time a system meets a family, the family has been at it for 20 years already.

I also want to talk for a moment about the ethical issues of providing supports for people in their homes. Sally Rogers and Geraldine Dawson have an evidence-based research intervention for autism called the Early Start Denver model, which is very family-centered. They say in their book,

"It is crucial to provide ongoing supervision from a clinician with expertise in family dynamics to identify issues as they emerge, to help staff be aware of their feelings and reactions, and to review ethical standards, and act accordingly. "

A lot of things happen when you go into a family home—you may begin to be seen as part of the family. Families may cross boundaries, or begin to ask you for help with things that are beyond the scope of work, or may become emotionally involved. Workers need knowledge and training in family systems theory. You need good supervisors, who do good training, coaching, and mentoring. We need to go back to the old social work model of case studies—asking workers: "what was the most troubling situation you encountered today, how did you handle it, what did you do?" Going back to training the workforce, we need to bring in those old social work skills.

I'll close with Doctor Berwick's quote from a commencement address to Harvard Medical School graduates:

“But, now I will tell you a secret – a mystery. Those who suffer need you to be something more than a doctor; they need you to be a healer. And, to become a healer, you must do something even more difficult than putting your white coat on. You must take your white coat off. You must recover, embrace, and treasure the memory of your shared, frail humanity – of the dignity in each and every soul. When you take off that white coat in the sacred presence of those for whom you will care – in the sacred presence of people just like you – when you take off that white coat, and, tower not over them, but join those you serve, you become a healer in a world of fear and fragmentation, an “aching” world.”



## Panel 1: State-Federal LTSS Integration Initiatives

*Moderator: Gail Hunt, President and CEO, National Alliance for Caregiving*

- *Mary Killough, Deputy Director, Illinois Department on Aging*
- *Gary Jessee, Deputy Director for Program Operations, Medicaid/CHIP Division, Texas Health and Human Services Commission*
- *Venesa Day, Technical Director, Medicare-Medicaid Coordination Office, Center for Medicare and Medicaid Services (CMS)*

This panel will discuss the experiences of state and federal governments with long-term services and supports (LTSS) integration and the challenges and issues that states have addressed as they integrate LTSS. The states that have done this successfully (two of which are represented here) are our most valuable resources because they can provide us with lessons learned from their experience.

### Challenges

There are several challenges that are particularly daunting for states that are transitioning to managed LTSS. Time constraints are often overwhelming – trying to do too much in too little time and not allowing enough time to build the necessary infrastructure and make the transition. Developing the data systems and

interoperability needed to manage care across several service delivery sectors is a major undertaking. Developing staffing capabilities and building networks of qualified personnel can be difficult. Finally, it is challenging to transform the culture and capability of the delivery systems from a fee-for-service mindset (getting paid for services provided) to being able to take risk for performance and outcomes.

### Time constraints

A major challenge in moving to managed care is the lack of adequate time allowed for the transition. Most state legislatures are not sensitive to the amount of time it truly takes to implement managed care. In Illinois in 2011, the legislature directed the state agencies to move 50 percent of the Medicaid population into some sort of coordinated care program that year. There was very little understanding of managed care at that time in Illinois, and the agencies had a huge learning curve once the law passed, with very little time to move forward with the initiative. It was challenging for the agencies responsible to learn enough about the issues, to learn how to involve stakeholders, inform consumers of the change and do training. For the state agencies working on it, it was like living in a house and building it at the same time.

### Information Technology

The most significant barrier to LTSS integration and care coordination is the lack of uniformity and interoperability of information systems. Many states have multiple information systems tied to different programs that cannot

communicate with one another or permit sharing of information among the programs.

Illinois has 30 year-old IT systems and has operated in silo-ed departments for many years. To make it possible to manage care for people across sectors, it was necessary to enable communication and sharing of information among the sectors. The old systems were not that useful in identifying program participants, and it was necessary do a lot of manual work to make sure people did getting dropped in the process. The Illinois Department on Aging formed an entirely new division to deal with data transfer issues, such as identifying which beneficiaries should be in which plan, ensuring they transition to that plan at a particular time or can be identified later if they transfer back to state services, and making sure those transitions are all seamless to the participant.

It will be a tremendous challenge for the States overall to improve the capacity for information exchange, not only between states and Medicaid agencies, but also among the managed care entities. It is important in the process to make sure consumers understand what it is happening. Everyone thinks the transition to managed care is seamless to the participants because they have the same providers as before, but it is not. They don't call the same people for case management services, or for complaints or appeals processes. It is important that people responsible for the transition to Medicaid managed LTSS in the states make an effort to really educate participants and their

families on their options around managed care.

We know we need a big overhaul of our data systems that will lead eventually to a system that talks across programs and states. Until then, we have to work with what we have now. To start with, we need to know for one person what care that person is getting on the Medicare side, and the Medicaid side. You cannot have a person-centered care plan if you do not know how a person has utilized the services available to them, and how much it costs.

We also need to have a discussion about how we invest our resources in understanding the data that we have, and making the things we find actionable. If we could find the resources to do baseline analytics, we would be in a much better place. There are states that just don't have the capacity or resources to do the analytics themselves. CMS can provide the data and tell states what it looks on a national level, but if a state does not have the in-house knowledge on what that means for their population, they are really at a disadvantage.

#### State Agency Staff Capabilities

A typical mistake when moving from fee-for-service to managed care is that states implement a fee-for-service system inside of a managed care delivery model. You need to focus on quality and on payment reform, and this will require personnel who have a different skillset than that needed in a fee-for-service environment. You need a workforce that understands data, quality metrics and analytics, and who understands

---

what you are trying to achieve through Managed Care Organizations (MCOs). You also need workers who know the rules and obligations a state has and can hold MCOs accountable to them. MCOs are sophisticated. You will need staff that are able to work with them and say where they are not meeting their requirements. You need to focus on program integrity and contract oversight. You cannot transition a benefit to an MCO and expect that they'll know everything there is to know about it. If the state does not provide hands on assistance around what it envisions for the delivery of behavioral health or long-term services and supports, these services will not be delivered in the right way. The state does not simply turn everything over to an MCO and walk off.

#### Provider Ability to Assume Risk for Performance or Outcomes

There is a lot at stake for MCOs in a pay-for-performance program. Not only are they at risk, and receiving a capitated payment to provide care for their members, but the state will take 4 percent of their capitation back if they don't meet quality performance goals. That really gets their attention. Four percent for some MCOs is \$40 million a year. You work together as partners, and it really helps to improve the system. If state oversight of managed care is done well, MCOs are held to many mandates and requirements.

Providers need to be ready for the transition, and should be made aware that they will not continue to provide services as they always have. They may find themselves at the center of a partnership.

An MCO may create incentives for them, or they may realize shared savings from reductions in acute care utilization. Providers also need to be informed about whether they're going to be a network or not, and they must learn how to market themselves. Often the LTSS providers have been working as contractors to the state for so long that they have forgotten how to market themselves.

#### **MCOs and Person-Centeredness**

There is a perception that managed care is fundamentally incompatible with person-centeredness. However, there is nothing person-centered about our fee-for-service system. The fee-for-service system views individuals one-dimensionally—they are on an elderly disability waiver, or a behavioral health waiver. Providers have to decide whether a person is elderly, mentally ill, or disabled in order to figure out what category they fit into. People are complex, though, and often do not fit neatly into a category. Managed care provides an approach for addressing a myriad of needs in a team approach. We look at the person holistically and look at their health, LTSS needs, and behavioral health needs, instead of having to fit the person into one category that can be served through one program.

It can be challenging to collect data and perform assessments in a person-centered way. Person-centered planning has to be flexible, because each person's goals are unique. The goals of a woman in her 80s will be very different from those of a young person who has a disability and is focused on acquiring the skills to support himself. Serving a variety of populations and needs

in a managed care system requires a substantial amount of flexibility in the way the system is built. Having the data is important – to understand needs, develop person-centered care plans, and measure outcomes. Having good data capabilities will help assure communities and stakeholders that the movement to managed care is not just to save money but also to improve outcomes.

A capitated model is not fixed – it has to change as the needs and services change. States have to be prepared to amend the managed care contracts more than once a year because you are always learning. There is always something—you may want to add a new benefit, or you want to be clearer in your contract about what you meant when you said x or y.

Managed care is not just the integration of acute care services—it is the integration of acute care and managed long-term services and supports. Where most MCOs fail is their lack of experience and knowledge about LTSS, because that is the most important part of the entire system. Managed care is about preserving a person’s ability to be independent and stay in their community, and to deliver a plan that is person-centered and continues to change as their needs change. If you cannot effectively plan for LTSS, you are not going to curtail acute care utilization, or utilization of hospitals and emergency rooms, and you won’t be able to divert people. As you are trying to think about how integration works well, look to those states that have done it.

There is work still to be done. We as a nation do not have good quality measures

related to LTSS. That’s an area where we need to come together quickly, because it is the most important part of the system we’ve built, and it is the area where we have made the least progress.



## Panel 2: LTSS Integration in Health Plans and Health Systems

*Moderator: Tracey Moorhead, President, Visiting Nurses Association of America*

- *Catherine Anderson, National Vice President, Health Care Policy, UnitedHealthCare Community & State*
- *Marcia LeBlanc, LTSS National Director, Aetna*
- *Terrence O'Malley, Internist, Geriatrician, Partners HealthCare*

The movement toward integration of long-term services and supports (LTSS) with medical care is well underway. There has been significant growth in recent years in the number of health plans and health systems -- Medicaid managed LTSS plans, Duals Demonstrations, and ACOs -- looking for ways to incorporate and share risk with long-term service and supports providers. This movement has created tension between payers and community providers. Community-based organizations are concerned about their readiness to participate in the managed care networks, their ability to share risk with payers, and the potential threat to their business. Plans weigh the benefits and costs of contracting with existing community-based organizations or developing services internally.

This tension notwithstanding, there are many opportunities emerging for plans and existing community providers to partner, improve care, and improve outcomes in whatever population is being served. Service delivery is changing, and managed care organizations (MCOs) are rapidly evolving to develop more person-centered delivery models. Long-term services and supports are critical to the success of the managed care organizations that are helping to break down the siloes and fragmentations of care that fee-for-service payment models have created; and to the success of the delivery and payment reform initiatives that the Affordable Care Act (ACA) created to improve health care outcomes and lower costs.

- In this panel, we will first get a good sense of LTSS integration that's occurring in some of the leading managed care organizations in this country;
- Second, identify motivating factors driving integration.
- Finally, discuss key challenges that MCOs and LTSS providers have identified.

We have three different models of LTSS integration to discuss today.

### **UnitedHealthCare (UHC)**

UnitedHealthCare has been a leader in this area and has achieved a lot, but is not done.

Changes over the last 5 to 7 years around transformation of provider roles, and expectation of state partners has substantively changed how UHC thinks about integration.

UHC's state focus has been all about Medicaid and Duals Demonstration contracts. Of the 24 states in which UHC has Medicaid managed care plans, half include LTSS in the contract. In some cases, the LTSS is fully integrated, as in Kansas. In other states, such as Tennessee, LTSS is close to fully integrated. There is a wide spectrum, though, of what integration looks like, and there is no single, uniform approach. Variables such as differing delivery systems, expectations of stakeholders, access to services, and geography all have a broad impact on program structure in a given state.

A whole-person model has to be integrated across all services—acute, behavioral, physical, social, and functional. Even if a UHC plan is not at risk for the services, it has an obligation to help the person coordinate and access care in an integrated fashion. That includes services that fall outside the managed care benefit design, but are inclusive in what an individual needs to be successful.

The most effective models are those that have a fully-integrated benefit design. Some states have chosen to carve out benefits. That approach continues to maintain fragmentation. While the plan can do its best to bridge the gaps, those are not the most effective approaches.

It is important that plans have flexibility in how they use benefits. It is the plan's job to pick and choose the right benefits to meet each person's needs. It needs flexibility in program design to achieve that.

Health plans do not have to have all of these services within the plan. When managed care plans started out, they did not have the understanding they have today of how to leverage services that exist in a community or marketplace. Every community is different. Contracting with Area Agencies on Aging might work in one community or state and not another. Plans have to work hard at figuring out who does what in a community, what they are good at, what they want to be good at, and how the plan can help them be successful in an integrated model. It's not just about the person and the benefits available to them in the model design, it is about putting the pieces together in a delivery system as well.

Many stakeholders are passionate about protecting the delivery system and having services stay where they have always been. That is often not the best solution, particularly if the only goal is to avoid disruption. There are many ways to avoid disruption and still integrate services through the use of community-based resources. There should be flexibility for the health plan to identify what these organizations are good at and to avoid creating more fragmentation.

The health plan's role is as an integrator of benefits and services. It should be removing barriers and filling gaps in services. It is important that it not be replacing services

---

of experienced organizations, but filling gaps that exist in marketplace.

Relationships between entities should be unique to leverage the strengths of each organization. Health plans are good at being health plans. They should respect and foster the skills and experience that are unique to other parts of the delivery system.

Finally, there needs to be adequate payment to fuel innovation. Managed care should be bringing innovation to the market. Plans should have the head room to make investments in innovation whether it is in technology, benefits, or creative solutions for housing and employment. The job of the program itself is to make sure there's adequate funding to support and incentivize that.

### **Aetna**

Aetna is another leader in integrating long-term services and supports (LTSS) and medical care.

Its focus has been on “defragmenting” care wherever possible. The plans start by looking at the whole person and identifying that person's needs. The plan can directly cover a service if it is a covered benefit in the plan. If the plan can purchase it from a community-based organization and it is covered by a waiver or the Older Americans Act (OAA) and the person can go there for service, the plan can help to coordinate it.

Aetna integrates LTSS with acute care programs and behavioral health programs. They prefer to carve-in behavioral health, although they sometimes must coordinate

outside service providers to get members needs met.

Aetna is especially concerned with supporting members and caregivers and preserving the support system that already exists in order to ensure their ability to be cost effective with finite resources.

Aetna's approach to ensuring a person-centered strategy is to have an individualized case manager who is there to guide the person through the care spectrum. That case manager is well trained, and specific to that individual based on their needs. It may be a nurse if the person is medically complex, or a social worker if the person has social needs. All case managers are trained in the unique qualities of the member population as well as requirements of the program, and how to assess members in a conversational manner.

A guiding principle for person-centered care is to use an integrated holistic approach that centers on the individual in assessing their needs, and ensures support for the member in the least restrictive environment in accordance with their wishes.

Aetna strives to ensure that they are working with members to enable each one to live with his or her condition in as healthy a manner as possible. In assessment, Aetna helps each member identify his or her goals, and identifies someone who can assist them to meet those goals. The assessment looks at bio-psycho-social needs, and personal and cultural preferences. It identifies social supports that can be preserved, and

ensures that those supports are still available, or whether those supports need their own supports in order to continue providing care. As a member's needs dictate, Aetna may do additional assessments. Everyone in a home- or community-based environment, for example, would receive an environmental assessment to ensure home safety.

Another key element of person-centered care is the ability to intervene early when there is a change in condition or circumstances. If the individual goes into hospital, Aetna works to make sure the care plan is modified to meet their post-hospital needs. Will the individual need additional services when they are discharged? Does the care plan now include drugs that were prescribed in the hospital and exclude drugs that are no longer appropriate?

Aetna is always looking to the nursing home population to identify those that are appropriate for community care. Sometimes people go into a nursing home because they don't know that there's another option. The health plan needs to ensure that people have a home to go to, and that it is modified appropriately. Those coordination efforts take time, and Aetna is always working to ensure that once the individual has a care plan, it is implemented well.

Aetna also tries to engage members early, by identifying strengths and capacities, and always addressing critical needs, whether they are behavioral, environmental or social. The health plan uses motivational interviewing to increase members' ability to share goals and preferences.

Aetna works to employ evidence-based practices, to provide access to full continuum of care, and to support, not supplant, the member's support system.

Members and families are the nucleus of an integrated care system. Case managers envelop that whole array to assist them in getting their needs met. Case managers also assist members with grievances and appeals. They work with networks and providers—those individuals are eyes and ears of LTSS programs. They see what's going on in those homes. It is the health plan's collaboration with those providers that make this work. If a member has an opportunity to go home rather than to a skilled nursing facility, then the health plan should do what it can in supporting the individual to take that opportunity.

When Aetna sets up its initial networks, the networks tend to be very broad because the health plan wants to ensure that providers who have been serving members are still able to see them. Over time, the health plan is able to identify quality providers and narrow the network. The health plans continue, though, to use medical providers outside of the network. When a member has a need that the health plan did not anticipate, the plan has to look outside the network – both the medical and the LTSS network -- to meet those needs.

There are a lot of challenges to making integration work. Bringing multiple organizations in different sectors of the care system often leads to lapses in communication and information flow across the sectors that result in gaps in an

individual's care. Aetna works to mitigate these challenges to effective integration through:

- *Member-driven care teams* that bring together providers across the spectrum of services and develop a single care plan, identify needed services, and coordinate care.
- *Back up and contingency plans* that ensure the care team knows who is going to provide care if the primary caregiver is not available. Every member in an HCBS environment has a backup plan for if there's a gap in care. We know who is going to step in.
- *Risk and mitigation agreements* that ensure members understand, with the help of the care team, the risks in their health choices. .
- *Cost-effectiveness studies* that ensure the health plan is using its finite resources appropriately. Aetna is always looking at the cost of care in a home- and community-based environment compared to a facility. If the person has a high rate of cost in comparison to the nursing facility, Aetna watches that care plan more closely. There is often an opportunity to reduce the services a person uses as their health improves.
- *Attention to quality* to ensure the health plan can intervene early and improve its programs. The health

plans need to measure quality, keep a close eye on provider and member satisfaction surveys, star ratings, and NCQA ratings. It is a constant improvement process.

### **Accountable Care Organizations (ACOs)**

Accountable Care Organizations (ACOs) face a different set of challenges in integrating medical care and LTSS. UHC and Aetna are integrated health plans that are incorporating LTSS. ACOs are junior health plans, in many ways. These are health care organizations that are moving in the direction of taking risk for the total cost of care. They are going to have to somehow organize and mimic health plans.

Inevitably, ACOs will incorporate LTSS, if for no other reason than that services and supports are so essential for addressing priorities of highest risk, complex individuals, who are going to bankrupt ACOs that do not pay attention to them. Right now, though, integration is really difficult, for several reasons.

One is that ACOs are distracted. They have to think about being an ACO. They have to know about return on investment, cost per beneficiary, and the LTSS world cannot speak that language. The community-based LTSS organizations do not know what it costs to provide a service, and do not know the benefit the service generates. They want to sell this service to the ACO, but they are not sure how much it costs, and they cannot articulate what it does -- it is not hard to understand the ACO's uncertainty about buying it.

What we have is a failure to communicate. Most ACOs are not ready for this discussion. They are focused on organizational and financial challenges of just being ACOs. It is difficult to get a group of people from different parts of the medical care system together to discuss how to divide up a common payment. It takes years of understanding, mutual trust, committee work, policies, procedures, and oversight. It is a very complex operation to become an ACO. Compounding that, the groups that will form the ACO need to learn to talk to each other. They need to develop an information technology platform that will enable them to exchange information and send information with the patient as he or she moves from point A to point B. Large health care systems are investing huge amounts of money in implementing integrated software like Epic, which will not be scalable or replicable in many places.

The systems developing ACOs are also concentrating on building up Patient-Centered Medical Homes, and struggling with how they can address high-risk patients. The high-risk patients all use a large volume of services; have frequent Emergency Department (ED) visits, frequent crisis plans, frequent interventions, and frequent changes of team and site. They are a difficult group—this 5% that is going to drive 50 or 60% of spending of entire ACO.

There is a huge barrier that separates the LTSS world from the health care system, which is that the health care system is supported by the HITECH Act and Meaningful Use. They have certified electronic health records (EHRs), and are

exchanging Continuity of Care Documents (CCD) using Clinical Document Architecture (CDA). LTSS is not in that loop, and they have no way to connect. Not only does LTSS not have a connection, but home care, skilled nursing facilities, and other post-acute settings, do not. What we need is a shared platform that is low-cost. It will be web-based or health information exchanges (HIE). That's going to be our shared, common infrastructure. You need to be able to get on and off in a low cost way. You need to use a standardized vehicle to get info from one place to another—those are the trucks. Within those trucks, you have to have cargo that's of value to the person on the other end. Not only that, but it must be in a clear, consistent format.

There also has to be a compelling business case for exchange—what does this do for me? What does it save in terms of beneficiary cost or mean for patient satisfaction? Once the HIEs build out across the country, there will be a backbone. Until then, there will be web-based solutions for information exchange. There is a free web-based model to get on and off HIE—it will use the latest trucks and exchange the most current cargo. It is inexpensive, open-sourced software that allows non-EHR users to send and receive standardized messages. Consolidated CDA documents are the required health care data exchange standard mandated by Meaningful Use Stage 2. If we as LTSS and the rest of the world acquire the same format, we will be able to communicate too.

The datasets we require have gone through final approval. HL7 is responsible for getting standardized interoperable data through an

---

international consensus process. This standard is now standard exchange for post-acute care, and will be a part of Meaningful Use - Stage 3.

The final piece is to develop the business case. LTSS will need to make a case for its value, and for being plugged into ACOs. That is the challenge for LTSS. This leads us to the next panel—what are the outcome and quality metrics we need to use? How do we measure the effectiveness of LTSS? That is the next phase.

Medicare and Medicaid are two separate programs, and CMS is doing yeoman's work in creating the duals demonstrations, but those demonstrations will touch only a small proportion of the population that is dually eligible.

Participation in integrated health plans is not mandatory, and the resulting fragmentation of services is difficult to overcome. Existing fragmentation makes it impossible to get to the data that could identify the drivers of acute care costs and contribute to understanding LTSS needs.

Many providers and stakeholders have a stake in preserving the status quo of fee-for-service payment and delivery. Moving to integration and managed LTSS is scary for individuals and providers who have become comfortable in the current fee-for-service system. They often seek carve-outs from managed LTSS in state legislation. Unfortunately, there's no way to achieve integrated care without substantially changing the system.

LTSS providers cannot survive for long as a commodity. Payment rates will always be too low. ACOs are looking for partners who can assume and share risk for the cost of providing the services needed to achieve a particular outcome. If you assume risk, that is a service, not a commodity.





## Panel 3: Measuring Success

*Moderator: Bruce Chernof, President and CEO, The SCAN Foundation*

- *Valerie Bradley, President, Human Services Research Institute*
- *Peter Boling, Professor of Medicine, Virginia Commonwealth University*
- *Gail Hunt, Chair, NQF MAP Person and Family Centered Care Taskforce*
- *Carol Raphael, Chair, NQF Post-Acute/Long-Term Care Work Group*

### The Need for New Measures

LTSS is in need of a new generation of quality measures. The state of LTSS quality measures is essentially in its infancy, and the wrong things are being measured. For example, we do not need to know what the hemoglobin a1c is in a vulnerable older person.

Measures that capture the experience of those receiving supports and services are more important. Although the role of care coordination is critical, because the way in which you bring all these services together and the person responsible govern success, we do not measure it well. For example, we could ask someone receiving services how confident they are that they understand and agree with their plan of care, and how confident they are that if they had a problem they would know what to do. This starts to get at the effectiveness of that plan of care, and how much that care plan is

driven by the individual and their family and caregivers.

We have different Medicare and Medicaid quality reporting requirements, and all segments are in different stages in terms of whether or not they are required to publicly report or use value-based purchasing. Many assessment tools are used in different sectors of the delivery system to capture the same information, but they are not comparable.

The National Quality Forum's PAC/LTC Workgroup tried to establish a baseline for the quality of today's LTSS landscape, but had a difficult time doing it, for all of the reasons previously mentioned. Furthermore, in the LTSS world we really are not yet involved in the information highway, and do not have an easy way to share information in real time.

One particular challenge is that the LTSS population is very heterogeneous. There are many different subtypes of people living in the community with varying needs, for whom different process and outcome measures would be appropriate. It is difficult to find one measure that works for everyone.

The criteria for selecting measures for LTSS were a variety of factors:

- One of the most important selection criteria for measures is that there is an appropriate mix of measures between structure, process and outcome measures. We would all like to have a preponderance of outcome

measures, but it is often difficult to do so for a variety of reasons.

- Cultural competency is also key. You really don't encounter differences in culture quite as much in an acute care setting.
- Our measures need to be accurate and not too burdensome-- parsimony is critical. We have way too many measures right now, and they are a burden on everyone who has to collect them. Because of the overwhelming number of measures, it is difficult for the general public to decipher what quality is.

The PAC/LTC Work-group came up with 13 measures, in the areas of

- Function
- Goal Attainment
- Patient Engagement
- Care Coordination
- Safety
- Cost/Access

We only had 3 safety measures. We knew that falls were much more prevalent in LTSS settings than in PAC settings, but we recommended that there be fall measure in rehab facilities because we want harmonization—the same measures in every setting.

### **Person- and Family-Centered Experience of Care**

NQF is convening a number of activities around the development of LTSS measures, including a person- and family-centered

workgroup and a PAC/LTSS measures work group.

The key theme that emerged from the person- and family-centered work group at NQF was the importance of capturing the patient's and family's experience of care. There have to be collaborative partnerships between the patient, family, and care providers to enable this across the care continuum. Future measurement development should focus on patient-reported outcomes that offer a more holistic view of care.

We also need to redefine the terminology. Is this patient always a patient, or they sometimes just a person? Is their encounter with the health care system part of their personhood? Family is not just people who are related, but should be what the person views as his or her family. Furthermore, our quality measures need to support caregivers. How well does the system support the supports that are around the individual?

It is important to develop measures that really address that experience of care, and we may not be capturing that now. For example, Consumer Reports recently did a survey of primary care practices in Massachusetts, ranking them out of 5 stars. Almost all practices got 1 star out of 5 because of poor patient experience. People reported that the physician never looked at them, didn't really listen, and didn't explain what to do. The outcomes may have been perfect. The physician might have given the person the right diagnosis and the right medication, resulting in the patient getting better, but that's not what the survey was

addressing. How do we get at that experience of care?

### **National Core Indicators (NCI)**

Unlike the more general area of long-term services and supports, there has been a consensus around a set of quality metrics in the Intellectual Disability/Developmental Disability (I/DD) world for some time. The National Core Indicators (NCI) for I/DD were first developed in 1997. There are currently 41 states including the District of Columbia, and many sub-state areas that use the NCI. The HHS Administration on Community Living (ACL), recognizing the value of outcome data, has begun providing funds to expand the number of states in NCI.

The NCI quality metrics are now being modified for use with the aging and physical disability populations. There is a schedule to launch these new indicators in 15 to 18 states beginning next year.

NCI data are comparable across states, and are entirely transparent. NCI addresses:

- Individual characteristics of people receiving services
- Locations where people live
- Activities they engage in during the work day, particularly whether or not they are working
- Nature of experiences with supports
- Context of their lives—friends, community involvement, and safety
- Health and well-being

There is an effort underway to apply these same metrics in managed LTSS settings. NCI is done on a reliable sample of at least 400

people in each state. NCI developers are meeting with people in the aging and disabled communities to help develop sampling strategies for those populations. LTSS providers have shown an interest in developing internal quality processes that align with some of these metrics. NCI developers have done a crosswalk of NCI metrics with new Home- and Community-Based Services (HCBS) requirements around settings, and hope that will lead to incorporating NCI as part of the emerging quality improvement (QI) initiatives across the country.

### **Independence at Home**

Independence at Home is a national demonstration involving 10,000 Medicare beneficiaries at 18 sites. These beneficiaries are home-limited, must have at least two chronic conditions, and have at least two functional limitations, among other criteria. The hypothesis is that if you put the patient in a longitudinal house-calls program with a tied-in network of support services, you can reduce total medical spending. The expectation is that people who are high risk and enrolled in this program will have decreased medical spending, some of which can be recaptured and used to pay for their in-home services, so that their total cost of care can be financed within the existing premium.

How do you measure that? Optimally, you want to define the population, put together a package of social and medical services that meet their needs, align the funding, measure quality, and divide that by cost to

produce value. However, this is very challenging.

The way we measure value is broadly quality over cost. Quality must be measured in a way that is population- and setting-specific, and the direct cost of care must be risk-adjusted, particularly for the sickest individuals. When you are trying to focus on the most expensive 5% of patients, you need to know what that group is going to cost without an intervention so that if you do intervene you can see whether or not you are saving money. In looking at where savings occur, however, it is important to consider indirect costs as well, such as the cost of lost productivity to employers due to having family caregivers miss work.

### **Moving Forward**

The best way to accelerate the use of quality data is for stakeholders and funders to see it being used to actually influence quality improvement.

We tend to overemphasize measures as a means of achieving quality. We certainly want to have simple clear measures, but, in and of itself, this won't produce quality. You need valid, credible, risk-adjusted measures if providers' performance evaluations and incomes are going to be affected by the quality measures. We cannot just define measures, though, and leave it at that. We have to change cultures, practice, and front-line service delivery. We have not spent enough time on that part of the quality equation because we have spent 90 percent of our time trying to define the measures.

We need a different model that would allow us to get out earlier and test measures in the real world. One quality measure development effort required accurately measuring care that took place over 6 to 8 weeks, and finding measures that could differentiate between different types of service providers, establish what they should be paid, and determine whether or not an individual provider would receive a bonus or not. This complexity was necessitated by the silo-ed way in which health care service delivery and payment are handled in this country.

The process would be simpler and less constrained if you could look at a defined population more globally, and develop global measures to capture safety and preferences. However, searching for a holy grail of quality measures that will cross populations is a fool's errand. There will be some core items and outcomes that are valued by all people, but different populations value different outcomes, and require different modes of surveying and language. We need to be flexible as the system becomes more diverse.

In LTSS, as evaluated in the National Core Indicators (NCI) approach, the goal is to determine whether the services and supports provided are contributing to the life that the individual wants to live, whether it is going out, having friends, or whatever it is.

Ultimately, measuring quality is only one part of the task of ensuring quality. There are other critical tasks, including making changes the delivery system so that it can

deliver value. How do you fund a team-based, integrated approach, and how do we begin to measure the benefits that LTSS provides so that we can contract with health plans and ACOs?



## Panel Four: Scaling Up Success

*Moderator: Terrence O'Malley,  
Internist/Geriatrician, Partners HealthCare*

- *Mary Kennedy, Vice President for Medicare and Managed Long-Term Care, Association for Community-Affiliated Plans*
- *Sue Kvendru, Coordinator for Seniors' Managed Care Programs, Minnesota Department of Human Services*
- *Sarah Barth, Director of Integrated Health and Long-Term Services at the Center for Health Care Strategies*

How do you take all the lessons that have come from successful LTSS integration and apply them on a much larger scale? How do you make success more prevalent? The three initiatives represented on this panel have scaled up success. Each of these organizations uses collaboration, shared learning, and dissemination of key lessons learned to convey elements of successful LTSS integration projects to a broader community of actors.

The Association for Community-Affiliated Plans (ACAP) is an organization that provides a platform for sharing learnings among its membership of small, non-profit, community health plans that integrate LTSS and medical care. Minnesota has integrated LTSS across the State's Medicaid managed LTSS program that is implemented in each of 87 county-run systems of care. The State government has played a major role in helping the counties learn from each

other and jointly solve common problems. Sarah Barth will describe the PRIDE project at the Center for Health Care Strategies which is testing and defining, with its seven participating integrated plans, the attributes of a high-performing, integrated health plan for dually-eligible beneficiaries, and disseminating this learning to other plans across the country.

### **Making Integration Work for the Small Community Health Plans**

The Association for Community-Affiliated Plans (ACAP) is an organization of 58 relatively small, non-profit, community health plans – primarily Medicaid-focused plans - that integrate LTSS and medical care and serve Medicare-Medicaid “Dual” beneficiaries as part of their mission. Half of these plans operate Medicare Advantage Special Needs Plans for Dual beneficiaries. Seventeen of the plans are participating in CMS's Duals Demonstration. Some plans, like VNS Choice in New York, integrated long-term services and supports (LTSS) from the beginning or because their states included managed LTSS in Medicaid.

The organization provides a platform for sharing learnings among member plans. This mechanism has enabled member organizations to learn from each other's mistakes and build on each other's successes in implementing person-centered, integrated care.

Most of these plans began as Federally-Qualified Health Centers (FQHCs), academic medical centers or government-based plans and have had to ramp up their size to handle the Dual's population. The strength

of the community-affiliated plans is that they really know their communities and beneficiaries.

The challenge in moving from a Medicaid acute care focus to being able to fully serve a Duals population is learning things like Medicare Part D compliance, or how to manage “downstream” community-based service providers. As the plans have taken on newer populations and learned to integrate long-term care, they have had to make internal changes – integrating operations and changing the way the plan operates. As they have changed populations they have also had to change the metrics they are using to measure performance.

No matter whether you start working on integration as a Medicare plan adding LTSS or you start as a Medicaid plan bringing in the Medicare-covered services, the health plans are challenged to reach into a different culture, set of rules, and networks. Medicare has a much more rigorous level of compliance and also requires greater transparency. The hardest skill to learn, however, is person-centeredness: understanding the person being served and how to get away from the medical model and serve that person’s interest. The good Medicaid plans have learned some of that over the years and have more experience with the LTSS world.

In the end, though, it is hard, no matter where you start, to get beyond simply sticking the different programs together, and achieve true integration. The challenge is for the plan to make the connections seamless to the beneficiary.

## **State Leadership to Build Integrated Managed Care Networks**

Minnesota’s Senior Health Options (MNSHO) program has been around since 1997. Over the intervening years it has had to redefine itself several times in relation to different state or federal initiatives. It is an integrated program built on the platform of the state’s Medicaid Managed Care program – Minnesota was an early Medicaid managed care adopter. Now it is a Duals Demonstration program for CMS -- using a unique “alternative alignment” approach.

The MNSHO project was designed to integrate LTSS from the beginning, including nursing home stays. It also serves as Minnesota’s elderly Home and Community-Based Services waiver program. Most Medicaid eligible seniors are in the MNSHO program -- 36,000 seniors are enrolled and all statewide senior care programs participate.

Unlike a number of other states, Minnesota was not motivated to pursue a managed care approach to LTSS to achieve cost containment targets, although the program did have to be cost neutral. Rather, the state was trying to create a program that would make sense for beneficiaries. It was not called “person-centered” at the time, but it was.

LTSS integration improved the beneficiary experience. It made sense to use a single integrated assessment tool rather than distinct tools for medical and for LTSS – the



---

health plans asked for a single assessment tool – and that tool was developed building on the LTSS assessment tool and incorporating the health risk assessment into it.

Minnesota’s care coordination and delivery model was built around partnerships with the organizations that already existed – learning to do integration. Collaboration with the health plans and engagement of a broad cross-section of stakeholders and providers was essential. The health plans and other stakeholders were not approached separately but have all been part of one big stakeholder group that all meets together.

Counties have played a major role: Minnesota’s LTSS waivers were county-based – there are 87 counties in MN, each with its own way of doing the waiver. Minnesota is largely a rural state, and so the state encouraged health plans to look to the counties to provide care management of the waived services, and a large portion of the plans contract with the counties for those services. The county service providers embraced the integrated model because they can at last address the whole person and their needs whether they are social or medical. In about 12 of Minnesota’s 87 counties that were “frontier counties”, lacking a well-developed network of services, the state had to build a system. The State explicitly made the health plans serve areas they would not have gone to before and absorb the costs of building the networks – to ensure access to both the acute and LTSS services.

Different health systems and health plans approached integration differently. Minnesota relies heavily on large care systems (now ACOs). Many years ago these large medical systems had to develop the ability to coordinate and learn about LTSS services. Some of the larger integrated health plans saw the need to develop their own care system within the plan to provide their own care coordination to small model clinics not big enough to provide that coordination on their own. Much of Minnesota’s large ethnic population is served by community care systems. The state reached out to some of these community organizations to provide the care coordination for their own populations.

The MNSHO project has been successful as measured in a variety of ways. Consumer satisfaction is high – the CAHPS rating of the MNSHO program is consistently the highest of any Medicaid program in MN – with less than a 2 percent disenrollment rate from the integrated plans. Also, Minnesota has substantially rebalanced the options for long-term care. MNSHO incentives to health plans to help beneficiaries move to the community were a factor and the managed care plans were great partners in helping achieve that goal. It helped that the Republican governor in office at the program’s beginning had set out to control long-term care spending by shutting down institutional beds. Over time, the state has seen a complete reversal from primarily institutional care to now primarily home- and community-based care for seniors in need of LTSS.

The biggest challenge that remains is the inability to measure and demonstrate quality and outcomes. It has been hard to quantify the value of MNSHO and to clearly separate out its impact. MNSHO is part of a larger successful plan of action in Minnesota –it is difficult to assess what part of that success can be attributed to MNSHO and what part results from the larger plan. MNSHO has been a component of the effort to rebalance, but it has not been the only contributor.

### **Promoting Integrated Care for Dual Eligibles (PRIDE)**

The Center for Health Care Strategies (CHCS) has three projects focused on integrating care for dual eligible beneficiaries.

- Implementing New Systems of Integration for Dual Eligibles (INSIDE), supported by The SCAN Foundation, brings together 16 states – 6 integrated platforms and 10 financial alignment demonstrations – to share information as a learning collaborative.
- Promoting Integrated Care for Dual Eligibles (PRIDE) is the brainchild of the Visiting Nurses Services of New York, supported by the Commonwealth Fund. PRIDE is a learning collaborative of 7 high-performing integrated plans across

the country that test different approaches and share learnings broadly - a framework paper from this project is in the folder.

- The Integrated Care Resource Center (ICRC) is a project CHCS staffs with Mathematica to support the CMS Medicare-Medicaid Coordination Office as they move forward with the demonstrations. ICRC is a different type of environment - more focused on technical assistance to the demonstrations, where INSIDE is a shared learning environment for the states.

The PRIDE project is focused on identifying and disseminating replicable attributes of high performing integrated health plans. VNS NY worked with a national advisory group to identify domains of plan activity and attributes, with input from progressive states looking to integrate care and plans that had the attributes. The Framework paper from the project describes the attributes in the following domains:

- Strong leadership and organizational structure– support for integrated care at the frontline and the leadership level for person-centered care;
- The infrastructure to scale up and stretch out while maintaining quality and value;
- Financial and non-financial incentives to help align plan,

- 
- provider, and member interests (pay for performance, sharing information, strong IT);
  - Coordinated care provided through comprehensive accessible networks in a person- and family-centered care planning and coordination structure;
  - Interdisciplinary teams with strong representation from all types of providers;
  - Capacity to attract and retain members, expand enrollment and increase retention;
  - Strong stakeholder communication about why integrated care is important to them, identifying stakeholder goals and communicating how the plan can help stakeholders reach those goals.
- Healthplan of San Mateo – Providing housing supports for people and then wrapping around care.
  - U-Care – Making assessments more person-centered and culturally sensitive – looking through MNChoices tool to identify further questions that would get at cultural and religious personal goals and supports that the plan could put in place.
  - Together for Health – Addressing determinants of health from the beginning –assessing for social determinants of health during the assessment process.
  - VNS Choice NY – Making care planning more person-centered – implementing an online or electronic care management system. Note: 4 out of the 7 plans are currently developing or implementing electronic care coordination systems.
  - *i* Care – Building independence for members through a personal care attendant program – how during planning process do you get supports in place to make individuals more independent.
  - Care Source – Implementation of their online care coordination system to get a 360 degree view of individual’s care needs.

Each of the participating PRIDE plans chose a best practice/innovation project they would take on during the funding period. All wanted to focus on person-centered care. Most supported the assessment and care planning process and focused on how to make that person-centered; and one chose to focus on quality. Plans have monthly video conferences during which they discuss practical issues with their demonstrations. The plans and their projects are:

- Commonwealth Care Alliance -- How do you capture or document that you are providing person-centered care?

## Success and How to Spread It

Minnesota and Massachusetts are not typical of the rest of the United States. Successes in these States may not be directly translatable to successful integration in other States. But even these States had to start somewhere. Minnesota did not always have services available to everyone. It started from an over-institutionalized, over-bedded system, and did not have a good community-based model. It took concerted effort over the years to develop home and community-based services.

Leadership has been a critical element. There is a policy moment – you need the right leadership at the right levels at the right time to make it happen. There are strengths and opportunities in every place, and you see strengths in places you might not have predicted. Ohio did not have the right leadership in place to get a CMS planning grant for the Duals Demo, but when leadership subsequently emerged was able to implement a Duals Demo and will be able to sustain it. Texas and Arizona have excellent rate setting and managed care management. It is not easy to make it work – California is struggling with this -- but big progress is being made there. You do see momentum forward and you have to be positive that it can be done. The alternative is to accept the kinds of things care managers find: people in dangerous living conditions without care in the home – lacking adequate food or taking too many medications.

Sharing learnings and tools can be a valuable exercise. Plans from different

states come together in the PRIDE project. Plans in states like Massachusetts, Wisconsin, or Minnesota that are often held out as examples are looking at plans in other states to see how they deal with unique populations and issues, like the under-65 behavioral health population. Each plan must build on the State infrastructure and its monitoring and oversight capabilities, and then on the plan level, learn about different subpopulations, and about getting tools in place –like the IT infrastructure to support integrated care and a holistic view of the person. Coming together, the plans are discussing information about hospitalizations and getting transition plans in place. Everyone cross-pollinates with lessons learned and experiences with different populations – they can all learn from each other and they can replicate what others are doing.

This kind of exercise is really productive – and this can happen within the Long-Term Quality Alliance (LTQA) -- to bring people together and identify the kernels that are working around the country to inform each other and identify gaps and barriers, learn from each other, and disseminate these learnings nationally. There are opportunities through the LTQA to engage in these learning-sharing interactions and to stay engaged throughout the year.





1825 K St. NW, Suite 411  
Washington, DC 20006  
[www.ltqa.org](http://www.ltqa.org)