A LeadingAge CAST Report

FINDING OPPORTUNITY IN A CHALLENGING TIME:

The Role of Aging Services Providers in Driving Health Care Reform

Proceedings of the CAST Commission Meeting
October 15, 2011 | Washington, D.C.

LeadingAge™ CAST
center for aging services technologies

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The Role of Aging Services Providers in Driving Health Care Reform

A program of LeadingAge

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LeadingAge Center for Aging Services Technologies:

The LeadingAge Center for Aging Services Technologies (CAST) is focused on development, evaluation and adoption of emerging technologies that will transform the aging experience. As an international coalition of more than 400 technology companies, aging-services organizations, businesses, research universities and government representatives, CAST works under the auspices of LeadingAge, an association of 5,400 not-for-profit organizations dedicated to expanding the world of possibilities for aging.

For more information, please visit LeadingAge.org/CAST

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Introduction

One day before the Commissioners of the Center for Aging Services Technologies (CAST) gathered in Washington, DC for their fall 2001 meeting, the Department of Health and Human Services (HHS) suspended CLASS, a national, voluntary insurance program for long-term services and supports that was authorized by the Affordable Care Act. The suspension came just two weeks after a planned "recalibration" of the RUGS-IV payment system reduced FY 2012 Medicare payments to skilled nursing facilities by a significant 11 percent. Adding to the gloom, CAST Commissioners arrived in Washington fully expecting the Joint Select Committee on Deficit Reduction to fail in its efforts to cut $1.2 trillion from the federal budget, thus triggering an additional two-percent, across-the-board cut in Medicare payments by 2013.

Commissioners had good reason to feel discouraged when they began their meeting at noon on Oct. 15, 2011. But by the time the meeting adjourned five hours later, there was a decidedly optimistic tone in the room.

Early in the day, CAST Chair Mark McClellan, MD, Ph.D., assured the Commissioners that meaningful health reform would succeed as long as it achieved needed cost savings by delivering care more efficiently, not by squeezing provider payments. As summarized in Part I of this document, Dr. McClellan outlined concrete approaches, already being tested around the nation, that would make meaningful and sustainable reform possible. He maintained, however, that the full participation of aging services providers will be required if these reforms are to succeed.

LeadingAge and CAST members added to the optimism in the room by sharing with Commissioners nine case studies of the work they are already doing to improve quality of care, reduce costs and deliver the person-centered services and supports that consumers are demanding. These case studies, which are summarized in Part III of this document, are part of a larger case study collection entitled *Preparing for the Future: Developing Technology-Enabled Long-Term Services and Supports for a New Population of Older Adults*. A synthesis of the major themes of this case study collection, which was developed by CAST during 2011, was presented by CAST Vice President Majd Alwan and appears in Part II of this report.

Following the case study presentations, the CAST Commissioners engaged in a lively discussion about steps that CAST should consider taking in order to help more LeadingAge and CAST members prepare for the future by adopting technology-enabled, consumer-centered business models. A summary of that discussion appears in Part IV of this document.

Part I:

Finding Opportunity in a Challenging Time: The Role of Aging Services Providers in Driving Health Care Reform

Mark McClellan, MD, Ph.D.
CAST Chair
Director, Engelberg Center for Health Care Reform
Leonard D. Schaeffer Chair in Health Policy Studies
Brookings Institution, Washington, D.C.

The growing deficit and the cost-cutting climate in Washington may cause providers of long-term services and supports to be downcast as 2011 draws to a close. However, the work of CAST is more relevant and its leadership in driving health care reform is more necessary than ever. Specifically, CAST has an unprecedented opportunity to promote technology as an essential tool that can help aging services organizations deliver higher quality care while reducing the cost of providing aging services to a growing number of at-risk older Americans.

Challenging Policy Environment

The October 2011 meeting of the CAST Commission took place just one day after the Department of Health and Human Services (HHS) suspended CLASS, a national, voluntary insurance program for long-term services and supports. Even though HHS maintained that it based its suspension decision on actuarial analyses and adverse selection rather than budget constraints, the suspension reminded us that providers of long-term services and supports face very real challenges as they seek to develop innovative financial models to sustain their work.

News about CLASS was sandwiched in between equally disturbing news about provider payment rates. Two weeks before the CAST Commission meeting, a planned "recalibration" of the RUGS-IV payment system reduced FY 2012 payments to Medicare skilled nursing facilities by 11 percent. A month after the meeting, the Joint Select Committee on Deficit Reduction announced that it had failed in its task to cut $1.2 trillion from the federal budget, raising the very real possibility that providers of long-term services and supports would be forced to absorb an additional two-percent, across-the-board Medicare cut by 2013.

This won't be the last time that provider payments are squeezed in an attempt to save Medicare dollars. In fact, the payment squeezes will get even worse in the future unless we can find new ways to reduce health care spending, which is the largest contributor to our deficit problems. Rather than penalizing providers, however, cost reduction strategies need to focus on making care delivery more efficient and implementing financing models that support that efficiency.

Innovative Alternatives

Several programs authorized by the Affordable Care Act (ACA) promise to introduce more efficiency into the health care system. These include initiatives designed to:

- Reduce hospital utilization by penalizing hospitals for preventable rehospitalizations that occur within 30 days of discharge.

- Increase care coordination by creating Accountable Care Organizations (ACOs) through which multidisciplinary groups of providers receive bundled payments and a share in the Medicare dollars they save while caring for a specific patient population.
- Reform the Medicare payment system by creating the Center for Medicare and Medicaid Innovation and giving it very broad authority to explore and implement promising payment reforms.

LeadingAge and CAST members have an important role to play in testing these new approaches and identifying additional ways to help move us away from the current fee-for-service payment system, which discourages care coordination. In order to become full partners in reform efforts, providers of long-term services and supports must demonstrate their willingness to:

- ***Embrace innovative care delivery systems.*** Shifting to innovative systems that deliver more efficient and higher value care won't be easy and it will require several kinds of investment from providers of long-term services and supports. First and foremost, aging services organizations will need to invest in information technology (IT) and other technology-enabled services as a way to support their new care delivery models. They will also need to invest in their own managers and frontline staff members, who must learn to work differently with one another, with payers, and with stakeholders in other parts of the health care system.
- A number of new care and service delivery models are being tested around the country by health care organizations. Among these innovators are a number of CAST and LeadingAge members who saw the need to change their business models in order to achieve better outcomes for current and future residents and long-term sustainability for their organizations. More LeadingAge and CAST members need to participate in these reform efforts, since meaningful health care savings cannot be sustained, especially for high-risk patients, without the full participation of long-term services and supports providers.
- ***Collect data that support meaningful quality measures.*** It will be impossible to achieve changes in reimbursement and other policies that support innovative care delivery options without hard data documenting that those approaches are meeting performance measures that consumers care most about. There are many gaps in performance measurement in our health care system, and those gaps are especially wide for patients receiving long-term services and supports. Fortunately, the Long-Term Quality Alliance (LTQA), an organization that LeadingAge has been instrumental in launching, has begun to close that measurement gap. One early indicator of its progress is the recent endorsement of LTQA-developed quality measures by the National Quality Forum, a nonprofit organization that is building consensus on national priorities and

goals for performance improvement. These new measures have the potential to play an important role in forthcoming health-reform initiatives. Still, the work to develop quality measures that are relevant to the long-term services and supports sector is just beginning and needs the support of aging services organizations.

- ***Engage in strategic partnerships with other health providers.*** Health and long-term care providers have the best chance of saving health care dollars, sustaining new care models and increasing revenues if they work together to reduce medical complications that land patients in the emergency room or result in more costly inpatient admissions. These goals cannot be reached without a host of support services to help at-risk patients avoid expensive medical crises. Primary care and acute-care providers are already experimenting with new care models that make more effective use of support services. They are likely to implement these services with or without the help of aging services providers. Finding ways to work with these providers, through strategic partnerships, would be in the best interest of LeadingAge and CAST members and would speed up efforts to promote coordinated care.

- ***Participate in the development and testing of new payment models.*** A variety of payment models are already being implemented, some on a pilot basis, to provide financial support for coordinated care models. These new models are gradually moving us away from fee-for-service models that reward care providers for the quantity, rather than the quality, of medical interventions. There is compelling evidence, beginning with the 2005 Physician Group Practice Demonstration, indicating that quality will increase and costs will decrease when health care providers share in the savings they create through efficient and coordinated care. That demonstraton program led to similar programs that facilitate the creation of Accountable Care Organizations (ACOs). In addition, the bundled payments made to health care partners under the Center for Medicare Medicaid Innovation's Bundled Payment Pilots will give physicians, hospitals and post-acute partners the flexibility they need to design more efficient care models that cost less and achieve better outcomes for patients.

- ***Adopt technology to improve care and accountability.*** Aging services providers will find it difficult to participate in health care reform without deploying technologies that support clinical decision making, facilitate person-centered care, and enhance coordination and communication among multiple providers. As providers of long-term services and supports explore technology implementation, they also need to be thinking about how IT systems can help them publicly report performance measures that reflect the care that they

are actually delivering and that hold them accountable for that care.

Impressive Progress

Over the past several years, CAST and its members have been highly engaged in addressing an important question that is at the core of health care reform: namely, how do we create sustainable care models that meet the needs and preferences of consumers and offer the highest quality care at the lowest cost? The simplest answer to this question is that we must be willing to embark on a journey of transformative change, both within our organizations and in the overall health care system. This kind of transformative change involves hard work, but it is the key to our survival.

CAST and LeadingAge are clearly demonstrating that they can help lead efforts to reform the health care system. The progress that we have made in a relatively short time has been impressive and gives us reason to be proud of our organization – and to be hopeful about the future.

Part II:

Preparing CAST and LeadingAge Members for the Future

Majd Alwan, Ph.D.
Vice President
LeadingAge Center for Aging Services Technologies (CAST), Washington, DC

The CAST work plan for 2011 aimed to prepare LeadingAge members for the adoption of new and innovation business and operational models that will allow us to measure quality, share information and coordinate care across the continuum. As part of that effort, CAST published a scenario planning document entitled *A Look into the Future: Evaluating Business Models for Technology-Enabled Long-Term Services and Supports* in the Spring of 2011. The planning document identified potential characteristics of the future operating environment, delineated categories of potential business models that could represent viable options for LeadingAge members, and evaluated how changes in the characteristics of the operating environment would affect these potential business models.

During 2011, CAST conducted 19 interviews with pioneering organizations that are implementing or exploring such future-ready models. These providers graciously agreed to participate in an exploration of the business models identified through the scenario planning process. Based on these interviews, CAST produced 18 case studies, which are included in a new publication called *Preparing for the Future: Developing Technology-Enabled Long-Term Services and Supports for a New Population of Older Adults*.

Case Study Themes and Drivers

Nine CAST and LeadingAge members briefly presented case studies about their organizations at the fall 2011 meeting of the CAST Commissioners. These case studies, together with nine additional studies that also appear in CAST's case-study collection, share a number of common themes:

A health reform context: Many of the organizations featured in *Preparing for the Future* are working hard to position themselves as effective strategic partners in a number of initiatives that are encouraged by health reform, including Accountable Care Organizations (ACOs), bundling of provider payments, managed care initiatives, programs aiming to reduce hospital readmissions and special programs for consumers who are eligible for both Medicare and Medicaid.

Focus on consumers: Case study participants bring a strong sense of consumer-centeredness to their technology-enabled services and supports. A number of organizations changed their business models after conducting a formal process to understand better the needs and preferences of older consumers living on their campuses and in the wider community.

Appreciation for frontline staff: Organizations are emphasizing the role that frontline staff can play in making technology initiatives a success. They are engaging these staff members in the early planning for technology initiatives by involving them in the selection and deployment of appropriate technology tools and depending on key staff to serve as champions for particular technology initiatives. The organizations also make sure that key IT staff

work hand-in-hand with clinical staff to plan major technology initiatives such as the implementation of electronic health records (EHRs).

Emphasis on evidence: Organizations recognize the importance of having an evidence base that demonstrates the efficiency and cost effectiveness of technology-enabled services. Several organizations represented in our case study collection are actually investing in research and participating in pilot programs that are helping to create that evidence base.

A variety of technology platforms: Organizations are deploying a variety of aging services technologies, including EHRs, remote monitoring, and computer applications that enhance social connectedness. Of note is the growing use of tele-coaching and telehealth by providers of aging services. In addition to deploying individual telehealth units in a client's apartment, several organizations are breaking new ground by deploying telehealth kiosks in the common areas of sub-acute care units, independent housing and retirement communities.

Elusive ROI: Questions about return on investment (ROI) are at the heart of discussions when organizations make decisions about changing business models. However ROI is not easy to calculate because, especially in the case of infrastructure technologies, it often intertwined with many other aspects of an organization's operations. Many organizations recognize that ROI must sometimes be deferred. These organizations typically view technology investments as a market differentiator that will eventually attract new customers or position the organization as a strategic partner with other health care organizations like hospitals seeking to reduce readmissions. A number of organizations maintain that technology-enabled services offer them an indirect ROI that manifests itself through improvements in quality of care, the efficiency of business operations, and the organization's enhanced ability to fulfill its mission by helping older adults remain healthy and independent.

Case Study Participants

CAST extends its gratitude to the 19 organizations that graciously agreed to participate in our case study initiative. Those organizations are listed below. Organizations marked with an asterisk presented their case studies at the Fall 2011 Commission Meeting.

- ACTS Retirement-Life Communities, West Point, PA
- Billings Clinic, Billings, MT
- *Cathedral Square Corporation; South Burlington, VT
- Dahl Memorial Healthcare Association, Ekalaka, MT
- Ecumen, Shoreview, MN
- Eskaton, Carmichael, CA
- *Evangelical Homes of Michigan, Saline, MI
- *The Evangelical Lutheran Good Samaritan Society, Sioux Falls, SD
- Front Porch, Burbank, CA
- *Jewish Home Lifecare, New York, NY
- *Lutheran Homes of Michigan, Frankenmuth, MI
- *Lutheran Homes of South Carolina, Irmo, SC

- *Mather LifeWays, Evanston, IL
- MJHS, New York, NY
- *MorseLife, West Palm Beach, FL
- Presbyterian SeniorCare, Verona, PA
- Providence Life Services, Tinley Park, IL
- Selfhelp Community Services, New York, NY
- *Volunteers of America, Eden Prairie, MN

Part III:

Case Study Presentations

Cathedral Square Corporation
Burlington, VT

Nancy Eldridge
Executive Director

The Organization: Cathedral Square Corporation (CSC) owns and manages 24 affordable housing communities for seniors and individuals with special needs. For 30 years, the organization has worked to ensure that its residents can stay in their homes even if they require a nursing home level of care. To accomplish this goal, CSC developed Support And Services at Home (SASH).

The Approach: Through SASH, an interdisciplinary team of health professionals and service providers works at a housing site to help residents remain independent. The team is comprised of a full-time SASH coordinator and a wellness nurse, as well as nurses, caseworkers, mental health professionals and service providers from community-based organizations. When residents join the SASH program, they receive various assessments to gauge their cognition, mental health status and ability to live independently. The SASH team uses assessment results to help each resident establish health and wellness goals and develop an Individual Healthy Aging Plan for meeting those goals. The team also develops a Community Healthy Aging Plan that addresses health issues affecting the entire congregate setting.

Business Case: Using funds from the Vermont legislature, the Vermont Health Foundation and the MacArthur Foundation—as well as its own funds—Cathedral Square Corporation developed and piloted SASH at one of its apartment buildings from August 2009 to August 2010. SASH has since been integrated into the Blueprint for Health, Vermont's new health reform initiative. A Medicare-funded SASH program will expand the capacity of the Blueprint's community health teams to serve older adults living in 112 housing developments throughout the state.

Technology: To improve coordination of care for SASH participants, the State of Vermont has made a formal commitment to connect each SASH site to the state's health information exchange (HIE). While SASH waits to be fully integrated into the HIE, it is creating a database of its health assessment data that is modeled on the database that will be used by community health teams participating in the Blueprint for Health initiative. When those community health teams and the SASH sites are connected to the state's HIE, the databases created by SASH and the teams should be interoperable.

Outcomes: During its one-year testing stage, SASH interventions helped reduce hospital admissions by 19 percent among housing residents at the test site. No SASH participant who was discharged from a nursing home during the test period experienced a readmission. In addition, falls among SASH participants at the test site have been reduced by 22 percent, the number of residents at moderate nutritional risk fell by 19 percent, and the percentage of physically inactive residents was reduced by 10 percent.

Evangelical Homes of Michigan Southeast Michigan

Steve Hopkins

Vice President, Wellness and Home Based Solutions

The Organization: Evangelical Homes of Michigan (EHM) offers an array of products and services for older adults in Southeast Michigan, including independent housing and housing with services, skilled nursing and short-term rehabilitation, hospice care, memory support services, adult day programming, respite care, home-delivered meals, home care and geriatric care management.

The Approach: EHM has gone through significant changes in the past five years after making a number of strategic decisions based on extensive research about its current customer and the customer of the future. These decisions resulted in the launch of an organization-wide health and wellness initiative and the purchase of two home care agencies. In addition, EHM launched two subsidiaries:

- **LifeChoices**™, a continuing care at home program, provides members who pay a one-time fee and a monthly service fee with an inclusive package of services and supports designed to keep them independent and cared for over a lifetime, all in the comfort of their own home.
- **LifeChoice Solutions**™ provides an a la carte menu of support products that promote wellness, safety and independence through the use of the latest technologies and lifestyle coaches.

Technology: Lifestyle coaches in the LifeChoice programs get to know their customer well and follow the consumer's lead in deploying whatever solutions will help that consumer remain healthy, enriched and independent. This may involve managing a home modification like a bathroom renovation; hiring a handyman to take care of burdensome maintenance chores; delivering daily meals or catering dinner parties; or introducing a variety of technology solutions that can keep track of vital signs, send an alert to caregivers when a problem arises, or allow a person with a hearing impairment to know when visitors arrive. Currently EHM utilizes over 20 technology solutions tested through a road-mapping process.

Business Case: As of Oct. 2011, an executive director and a team of lifestyle coaches served 140 customers in the LifeChoices™ and LifeChoice Solutions™ subsidiaries. The LifeChoices™ one-time membership fee is based on the customer's age and ranges from $35,000 to $50,000. Monthly fees average $400. According to the LifeChoices™ model, the program will break even if it can count 25 customers among its members. EHM projects that the typical LifeChoices™ member will participate in the program about nine years before requiring ongoing health care and 12 years before they require skilled nursing care. EHM is at risk for the payment of that care in this model. Currently, the sales cycle for LifeChoices™ is about six-to-eight months.

The Evangelical Lutheran Good Samaritan Society Sioux Falls, SD

Rusty Williams

Vice President, Information Services/Technology Systems and Chief Information Officer

The Organization: The Evangelical Lutheran Good Samaritan Society is the nation's largest not-for-profit provider of senior care and services, serving more than 27,000 people in 240 locations nationwide. While it initially focused solely on offering traditional skilled nursing care, the organization now provides senior living apartments, home health, assisted living, hospice care, inpatient and outpatient therapy and specialized units for people with Alzheimer's disease and related dementias.

Technology: The Good Samaritan Society expects technology-enabled services to help it meet its goal to engage with a broader population of consumers. The organization is currently working on several projects to make this possible.

- **The LivingWell@Home program**, established in June 2010, provides health-monitoring technology to older adults living in the place they call home. One month after the program began, the Good Samaritan Society received an $8.1 million grant, which it matched with $3 million of its own funds, to test the ability of the WellAWARE remote monitoring system, the Philips Lifeline personal emergency response system and the Honeywell HomMed telehealth system to facilitate healthy aging in place.
- **Electronic Medical Records**: In preparation for implementation of an electronic medical record (EMR) program, Good Samaritan Society staff members spent months streamlining the organization's business and clinical processes and standardizing the forms it uses to document those processes. Before the streamlining effort began, the Good Samaritan Society used 460 such forms; today it has less than 100.
- **Center for Innovation:** A new Center for Innovation, opened in late 2011, will focus exclusively on helping the Good Samaritan Society work with its own employees and a variety of industry and academic partners to design innovative processes, products and services that will help older adults maintain their health, wellbeing, independence, and quality of life.

Business Case: The LivingWell@Home research is designed to provide critical evidence that technology-enabled services can help older adults optimize their health and independence. Armed with this evidence, the Good Samaritan Society and other aging services providers will be able to make a strong case that public and private third-party payers should support these technologies as a way to improve health care quality and reduce costs. In addition, evidence from the LivingWell@Home research will allow the Good Samaritan Society to promote itself as a valuable partner that can help Accountable Care Organizations (ACOs) and medical homes use technology-enabled services to reduce rehospitalization rates and increase care coordination and efficiency.

Jewish Home Lifecare
New York, New York

Bridget Gallagher
Senior Vice President, Community Services

The Organization: Jewish Home Lifecare (JHL) operates nursing homes, independent housing communities in Manhattan, the Bronx and Westchester County, NY. Its Community Service Division is comprised of two home care agencies, three medical day centers and one social day center program. The organization also has partnerships with four Naturally Occurring Retirement Communities (NORCs) in Manhattan and the Bronx, where a part-time registered nurse from JHL offers tenants health education and screening.

Technology: At least three days a week, clients of Jewish Home Lifecare's Community Service Division use a telehealth device called HealthMonitor to send their vital signs, and their answers to a daily dialogue, to a telehealth nurse at the organization's Manhattan headquarters. When data and client feedback indicate that the individual has a health concern requiring action, the telehealth nurse sends an alert to the client's home care clinician. The clinician then follows up to help resolve the health issue before the client requires hospitalization. Clients who attend JHL's medical day center programs, and residents of JHL-affiliated NORCs, participate in the HealthMonitor program by using telehealth kiosks.

Outcomes: During pilot testing, Jewish Home Lifecare's telehealth program was shown to reduce hospitalization rates among home care clients with congestive heart failure (CHF) from 16 percent to five percent. The organization has been able to maintain these low rehospitalization rates over time. The telehealth units also help home care nurses maximize their home visit time with clients. The telehealth kiosks help day center nurses to reach out to clients who need assistance and are expanding JHL's presence in its NORC-based programs.

Business Case: JHL installed teleheath kiosks in its sub-acute units as a way to help patients learn how to control their conditions and avoid a readmission. When CHF patients are discharged from the sub-acute unit to their own homes, JHL is hoping they will take a private-pay telehealth unit with them and continue to actively manage their condition. JHL also believes that the presence of these kiosks gives its sub-acute units a competitive edge in the marketplace, especially among hospitals that are interested in helping newly discharged patients avoid a rehospitalization. The organization is confident that hospitals will be more willing to pay for the cost of its telehealth service than to pay the cost of a hospital readmission. This will be particularly true after Oct. 2012 when the government begins to penalize hospitals for unnecessary readmissions that occur within 30 days of discharge.

Lutheran Homes of Michigan
Frankenmuth, Michigan

David Gehm
CEO and President

The Organization: Lutheran Homes of Michigan (LHM) is one of the largest nonprofit providers of residential senior services in Michigan. The organization offers a variety of housing options as well as assisted living, skilled care, memory care, hospice, and home care programs. In 2009, LHM received 80 percent of its revenues from on-campus services provided to its residents; 20 percent of its revenues came from home and community-based services (HCBS). By 2016, the organization hopes to receive half of its revenues from campus-based services and half from HCBS.

Technology: To increase its offering of home and community-based services, Lutheran Homes of Michigan established the Aging Enriched Network, a one-stop information and referral service for seniors, their caregivers and their families. The network provides more than 20 categories of services that LHM has determined older adults need to stay independent. LHM provides some of these services, including home health care, transportation, in-home safety devices and telehealth technologies. A pre-screened group of affiliated businesses, volunteer organizations and individuals provides other complementary services, including transportation, home repair and modification, light housekeeping, meals, financial and legal services, housing, mental health services, social activities and medical equipment.

Aging Enriched Resource Centers, where consumers can meet face-to-face with a nurse or other health care professional, are located on LHM campuses and in some local churches. In addition, technology powers a call-in center that family caregivers can use to access the Aging Enriched Network. The software analyzes caregiver requests and provides relevant information and referrals that callers need to keep their loved ones safe, healthy and independent at home.

Business Case: In seeking to rebalance its revenue streams, Lutheran Homes of Michigan decided that its home care model needed a complete makeover. As part of that makeover, LHM's private duty home care agency became the Personal Services Division and no longer offers a standard menu of services that it will deliver to home-based clients. Instead, staff members are trained and encouraged to find ways to provide whatever service a client requests or needs.

Establishing the Aging Enriched Network required a modest investment from LHM to develop the program's software. However, because the network represents a service delivery model that is new to consumers, LHM has made a significant investment in marketing the network. Consumers, who can join the network for free, use either their own funds or private long-term care insurance to pay for the services they receive. LHM found that an appreciable proportion of the users of this service have long-term care insurance.

Lutheran Homes of South Carolina
Irmo, South Carolina

Thomas E. Brown, Jr.
President and CEO

The Organization: Lutheran Homes of South Carolina (LHSC) provides independent living, assisted living, skilled nursing care, memory support and hospice care in five continuing care retirement communities that employ 1,100 staff members. LHSC has earned a reputation for taking innovative steps to improve quality of care in its communities. In partnership with Lutheran Services for the Aging of North Carolina, the organization received a grant from the Duke Endowment in 2004 to adapt the Wellspring Model to its nursing facilities. Through the model, interdisciplinary staff teams create and implement interventions to improve the quality of care for nursing home residents. LHSC also received grant support to implement a comprehensive wellness program called BeWell Home Services, which provides a host of non-medical services to older people living in their own homes.

Technology: Technology initiatives at Lutheran Homes of South Carolina are grounded in the organization's strategic goals and priorities related to improving the quality of care and services for residents. Current technology initiatives include:

- **Vitals** helps LHSC assess active lifestyle, independent and assisted living residents and plan wellness initiatives. It also facilitates lead management, marketing and referral management.
- **Cerner HomeWorks** and **RoadNotes** support clinical, billing, financial and administrative functions in the LHSC hospice program.
- **MyInnerView** measures a set of key performance measures, including clinical indicators; workforce performance metrics; and employee, resident and family satisfaction.
- **CareTracker** is used in LHSC's skilled nursing facilities to help caregivers perform required resident documentation on touch-screen devices placed in strategic locations.
- **Volgistics** helps LHSC staff recruit, track and coordinate volunteers.
- **Keane MDS** and **MDS Director** assist with documenting care plans and service delivery, and billing for services provided to skilled nursing residents.
- **AV Powell's Fast** helps the organization track amortization of entrance fees.
- **Procura** supports the operation of BeWell Home Services.

Business Case: Development and maintenance of a state-of-the-art information technology (IT) system in support of all of the organization's product lines is an expensive proposition. Although LHSC will occasionally receive grants to fund its technology projects, most of these initiatives are part of the organization's capital budget. This means that Lutheran Homes of South Carolina must weigh each technology purchase against other organizational priorities.

Mather LifeWays
Evanston, Illinois

Kathryn Brod
Vice President of Senior Living Strategic Initiatives

The Organization: Mather LifeWays operates three continuing care retirement communities in Illinois and Arizona. In addition, its Community Initiatives programs allow Mather LifeWays to act as a point of contact for older adults who seek access to community resources. Mather Institute on Aging plays a leading role in enhancing the lives of older adults through numerous collaborative and applied research and education projects targeting healthy aging, workforce development, caregiver support and senior living trends.

Technology: The Mather LifeWays Institute on Aging developed a measure, called "Observing Quality of Life in Dementia" or OQOLD, which enables professional caregivers in a variety of settings to assess the quality of life of persons with dementia based on their observations of those individuals during a variety of activities. Quality-of-life scores, which range from a low of -3 to a high of +3, are based on the person's level of engagement and/or emotional reaction during the activity.

Through a partnership with Benten Technologies, and thanks to a grant from the National Institute on Aging, Mather LifeWays staff members currently record their OQOLD scores on an iPod Touch. Data are wirelessly transferred from the iPod Touch to a website where the scores are organized into a variety of reports that staff can download and use to maximize both the quality of care provided and the quality of life of participants with dementia.

Outcomes: Using the OQOLD measure, staff members in various settings have been able to identify the impact that specific activities have on individuals with dementia. This enables staff to match individuals with activities that yield high quality-of-life scores for them, test out the effectiveness of new activities, and match participants with new activities as their dementia symptoms change over time. The technology-enabled OQOLD measure also helps organizations to keep families better informed about the engagement level of their relatives and to better match the skills of staff members to the requirements of specific activities.

Business Case: Initial discussions with Benten Technologies have focused on the feasibility of offering a mOQOLD service that would be available on mobile devices like the iPod, iPhone or Android smartphone. After purchasing a mOQOLD subscription, a mobile device owner would receive access to the OQOLD assessment method developed by Mather LifeWays, as well as future software modules that Benten might add to its mOQOLD platform. Mather and Benten will be discussing how they might share revenues from the sale of the mOQOLD subscription service.

MorseLife
West Palm Beach, Florida

Alan Sadowsky, Ph.D.
Senior Vice President for Home and Community-Based Services

The Organization: MorseLife is a non-sectarian, charitable organization that cares for seniors in various settings, including its long-term care facility, short-term rehabilitation center, independent and assisted living residence, and through home and community-based services (HCBS) that enable seniors to age in place. The organization also conducts research designed to develop best practices in the care of current and future seniors. The programs conducted on MorseLife's 37-acre campus serve between 400 and 500 individuals on any given day. Thanks to an expanding HCBS program, MorseLife serves four times as many people in the community surrounding the campus.

Technology: MorseLife employs a variety of technologies in its provision of services and supports:

- Remote monitoring technology, including Cybernet Medical's MedStar.
- Therapeutic recreation technologies, including "It's Never 2 Late."
- Cognitive rehabilitation technology such as Dakim Brain Fitness software.

MorseLife also uses a paperless employment application process, has installed wireless networking technology throughout the MorseLife campus in preparation for the deployment of an electronic health record (EHR) system; and uses care documentation software, including CareTracker and Casamba.

Approach: When the Affordable Care Act (ACA) became law in 2009, MorseLife immediately understood that the historic health reform legislation would have an impact on providers of long-term services and supports. The organization worked with Artower Associates, a group of advisors formerly associated with Dixon Hughes, to improve its understanding of the law's components. This education process led to a summer retreat in 2010, during which the MorseLife's 45-member management council recommended a collection of strategic initiatives that the organization should pursue in order to participate fully in health reform initiatives. As part of these efforts, MorseLife has worked hard to develop relationships with hospitals and physician groups and to position itself as a useful partner that can help reduce local hospital readmission rates. To complement this effort, the organization developed new clinical pathways for patients with chronic obstructive pulmonary disease, congestive heart failure, hip and knee replacements, and stroke. MorseLife is also taking steps to track critical outcomes and readmission data that can help the organization promote itself as a potential collaborator in any ACO that is established as part of health reform.

Business Case: MorseLife spent over $350,000 on information technology in 2010, a figure that represents one third of its capital budget. This included wiring the campus for Internet, purchasing CareTracker and Casamba, and providing smart phones for management staff.

Volunteers of America
Eden Prairie, Minnesota

Wayne Olson
Senior Vice President of Operations

The Organization: The 115-year-old Volunteers of America is a major provider of professional long-term nursing care for seniors and others coping with illness or injury. The organization's 25 facilities offer a continuum of services for older people and people with disabilities that includes skilled nursing, assisted living, home health, rehabilitation and memory care. VOA manages seven senior housing communities in three states and sponsors an Aging with Options initiative that helps older people maintain independence and self-sufficiency while living at home.

Technology: Volunteers of America began exploring technology-enabled services in 2004 when researchers at the University of Virginia (UVA) approached the organization seeking feedback on the design of a remote monitoring system that they were developing. Using funds from an outside investor, the UVA researchers implemented two pilot studies to test their monitoring system at facilities managed by VOA in Minnesota and the Evangelical Lutheran Good Samaritan Society in South Dakota. Pleased with the results of those pilots, both VOA and the Good Samaritan Society decided to invest in what has become known as WellAWARE. Each organization now owns 25 percent of the company.

Outcomes: Within the first week of a 90-day pilot for WellAWARE, nurses at the VOA test site reported that they were successfully using the remote monitoring system to identify urinary tract infections before they caused serious illness or triggered a medical crisis. Follow-up studies showed a significant reduction in health care use by residents monitored by WellAWARE. VOA also has anecdotal evidence that remote monitoring has helped care staff reduce by 40 percent the number of telephone calls they make to doctors' offices.

Business Case: Remote monitoring with WellAWARE is becoming the new standard of care at Volunteers of America. The organization is implementing the technology throughout its Senior Care Division. In 2011, VOA began deploying WellAWARE in skilled care settings and expects that the technology will be fully deployed in all of its 14 nursing homes by the end of 2012.

Volunteers of America raised the rent for assisted living apartments by $70 per month to cover the cost of the WellAWARE units. The rent increase did not yield a profit for the organization. Instead, VOA ties its return on investment to the fact that monitored residents have been able to remain in assisted living for longer because early intervention kept them from developing more serious health conditions that might have prompted a move for them and a vacancy for the organization.

Part IV:

Next Steps

David Gehm
President and CEO, Lutheran Homes of Michigan
CAST Vice Chair

Case Study Dissemination

CAST and its commissioners are energized by the progress that some providers of long-term services and supports have made in using technology to help transform the way they do business. But we also recognize the need to increase technology awareness among LeadingAge members who are still unfamiliar either with the breadth and potential of cutting-edge technology solutions, or with plausible operational models that are enabled by these technologies. We understand how some members could be overwhelmed by the challenges involved in deploying technology solutions.

To promote member awareness of technology-enabled services and supports, and to provide guidance for meeting deployment challenges, CAST plans a three-pronged approach to disseminating its case study collection and the lessons it holds. It will:

- Provide opportunities for pioneering LeadingAge members to offer coaching and encouragement to other members seeking to start or expand their technology-enabled services.
- Foster collaborative efforts between CAST and LeadingAge-affiliated state associations to disseminate information about technology-enabled services to their members as well as state policy makers, and to help individual members adopt new technology-enabled business models.
- Help case study participants tweak their own business models by conferring with one another to discuss common challenges and strategies for overcoming those challenges, or by meeting with experts in the field to gain additional insights and ideas.

A Video for Providers

In 2006, CAST released an eight-minute video called "Imagine – the Future of Aging," which introduced viewers to an affable older gentleman named Ernesto. In spite of increased frailty and declining health, Ernesto maintained his independence and dignity by using a collection of home-based technologies, many of which were in the very early stages of development when the video was released. Taken together, those "dream" technologies allowed Ernesto to communicate with and be supported by a network of family members, caregivers, doctors, nurses and providers; increased his ability for self-care through devices like medication dispensing systems; and gave him access to coordinated care that was facilitated by remote monitoring and his electronic health record.

Five year later, many of the technologies that CAST imagined in 2006 have now come to market and are having a very real impact on quality of care and quality of life among older adults. Clearly, the state of aging services technologies is no longer something we have to "imagine." CAST believes that it

is now time to change our discussion about these solutions from one that focuses on "possibilities" to one that documents the real-life impact of technology-enabled services and supports.

To spotlight this switch in focus, CAST will explore the possibility of producing a new video that views the potential of aging services technologies from the perspective of providers of long-term services and supports. The video would highlight the achievements of pioneering organizations that have succeeded in incorporating technology into new service delivery models in order to improve their care and services, lower their costs, broaden their customer base and improve the viability and sustainability of their organizations. Just as Ernesto inspired consumers to imagine the future of aging, the new video would strive to inspire providers to see the bright and exciting future of aging services —and take steps to participate fully in creating that future.

Appendix A

Major CAST Accomplishments for April – Sept. 2011

- Published "Leading By Example: CAST's Role in Helping LeadingAge Members Turn Core Competencies into Sustainable Business Models" report of the Proceedings of the CAST Commission Meeting held Apr. 10, 2011, in Washington, DC. The meeting focused on the CAST work plan and the report captured the tenor of the discussion while outlining both the challenges and the opportunities that face CAST and LeadingAge members as the national movement to reform our health care system moves forward. Specific discussions, which are summarized in this report, include: payment reform, future delivery models, and future challenges and opportunities.
- Published the results of the CAST Scenario Planning in a report entitled: "A Look into the Future: Evaluating Business Models for Technology-Enabled Long-Term Services and Supports". The report builds on previous CAST and LeadingAge initiatives. The report set out to paint a picture of the desired future, and then identified key trends, drivers and uncertainties that will shape the future of technology-enabled care, and then described 3 categories of future models (Health Care, Community-Based Support, and Real-Estate Models), key enabling technologies for each and how these models will be affected by uncertainties identified.
- Published two journal paper, and a government report summarizing the findings of the AHRQ-funded Hypertension Study.
- Advocating for Senate Bill S. 501, known as the Fostering Independence Through Technology Act of 2011 (FITT), introduced by Sen. John Thune (SD) and Sen. Amy Klobuchar (MN). The bi-partisan FITT Act creates a pilot program under Medicare to provide incentives for home health agencies to use home monitoring and communications technologies to improve access to care and help beneficiaries remain in their own homes.
- Continued to advocate for including long-term and post-acute care providers as active participants in Health Information Exchange activities and potentially other ARRA funded activities including state-designated Health Information Exchanges entities and Beacon Communities.
- Continued to provide guidance and successfully influence LeadingAge state-affiliates and members in different states to become actively engaged in state HITECH Act initiatives.
- Continued to support LeadingAge state-affiliates on technology education, technology surveys and other technology-related activities.
- Kept CAST and its members mentioned in main media outlets including newspapers, magazines, trade and industry publications, both in print and electronic media.

CAST Research Update

CAST continues its efforts to encourage and actively engage in outcome oriented evaluation of aging-services technologies as an essential element to more informed decision-making and wider adoption. Here is an overview of the new opportunities and on-going research initiatives:

- Hypertension Study - The hypertension study was closed. A manuscript of technical lessons learned has been published in the Journal of Telemedicine and E-Health. The final report is available on-line on AHRQ's web site.
- AHRQ's Active Aging Research Center – Unfortunately the award was made to the University of Wisconsin. Representatives from the research team have reached out to LeadingAge and CAST and we will engage them in CAST and are exploring collaboration potentials with their new AARC.
- Aging Services Technology Study – The Task Order Officer and the Department of Health and Human Services (HHS) team reviewed the chapters and provided feedback and comments. The comments have been addressed and are resubmitted to HHS.
- HIT Incentives to other providers – We completed our role on the study.
- iKOP project with the University of Utrecht - CAST continues to participate in this project and CAST VP serves on the steering committee. Their goal is to make students projects accessible over the web. As soon as they become available CAST members will have access and will benefit from the students' work.
- Intel's 10,000 household vision - CAST continues to work with Intel on this project, now called Scaling Independent LiVing Research (SILVR). A meeting facilitated by the NIH Foundation is scheduled in December to discuss next steps.

CAST Federal Legislative Update

Federal advocacy over non-budget issues ground to a halt over the past few months, as Congress and the President fought over extending the debt ceiling and enacting deficit reduction. And with passage of the Budget Control Act of 2011 the fall legislative agenda likewise is expected to be dominated by budget issues.

Technology Legislation – The most significant piece of technology legislation that affects aging services is S. 501, the Fostering Independence Through Technology Act of 2011 (FITT), introduced by Sen. John Thune (SD) and Sen. Amy Klobuchar (MN). The bi-partisan FITT Act creates a pilot program under Medicare to provide incentives for home health agencies to use home monitoring and communications technologies to improve access to care and help beneficiaries remain in their own homes. The FITT Act is budget neutral (and is designed to reduce Medicare) since the incentive payment to the home health agency is based on a percentage of the Medicare savings achieved as a result of telehealth services.

The LeadingAge advocacy team has been meeting with Senate offices to obtain sponsors. Current co-sponsors are: Susan Collins (ME), Kent Conrad (ND), Bob Corker (TN), Mike Crapo (ID), Tim Johnson (SD), and Bill Nelson (FL). There is a small chance that FITT could be included in a larger deficit reduction package or in other Medicare legislation.

Impact of the Budget Control Act (BCA) of 2011 – The Budget Control Act (Public Law 112-025) became law on August 2, 2011. This bill will dictate Congress's agenda through the close of 2011 (and probably well into 2012 as well). The legislation had a dual purpose: (1) provide a mechanism to raise the debt ceiling (the amount of money the federal government is authorized to expend on current debt) through 2012 and (2) reduce federal expenditures by $2.5T over a ten-year period (the deficit reduction piece). In addition, the legislation has a process in place to have Congress vote on an amendment to the Constitution requiring a balanced budget.

There are three major phases or tranches embedded in the Act:

1. Immediate reduction in discretionary spending of approximately $1T. The appropriations committees in both House and Senate are charged with finding approximately $1T in savings over the next ten year period (2012-2021). We assume that the committees will report out their recommendations and that they will be incorporated into a Continuing Resolution for FY 2012, sometime before Oct. 1, 2011 (or a series of smaller CRs). This tranche affects our senior housing programs and programs funded by the Older Americans Act, but not Medicare or Medicaid. Our advocacy will focus on preserving rental subsidies for low income housing, such as Sec. 8, and preserving funds for additional construction under the Sec. 202 program. Our advocacy for Older Americans Act programs like "Meals on Wheels" and transportation programs will focus on preserving the current status and preventing reduction in funding.
2. Second reduction in all spending of approximately $1.5T, also for FY 2012-2021. This is ultimately the charge to the Joint Committee, but the Act gives authorizing committees

in the House (Energy and Commerce, Ways and Means, Financial Services) and Senate (Finance, HELP, Banking) a shot at proposing changes to the programs they control. Medicare, Medicaid and discretionary programs are all in play. The authorizing committees have until Oct. 15 to report recommendations to the Joint Committee, which then is required to report out legislation to the House and Senate by Nov. 23. Both houses of Congress are required to vote on the Joint Committee legislation as written by Dec. 23. If the President signs the legislation, it will go into effect January 2012. If there is a glitch in the process – the Joint Committee fails to report out legislation or Congress fails to approve the Joint Committee's legislation or the President vetoes or the final legislation contains less than $1.5T in deficit reduction – then…

3. Sequestration occurs, effective January 2012. This means an automatic cut across the board for all government programs up to $1.5T. However, the cut to Medicare can only be 2% of the program's cost, so the reduction to other programs will have to be higher to make up for the Medicare limit. Medicaid and certain other low income programs are excluded from sequestration, but low income housing and Older Americans Act programs are not. The defense department isn't spared either, so the expectation is that the prospect of deep cuts to defense by sequestration will spur development of consensus in the Joint Committee, Congress and the White House.

Advocacy Agenda:

Medicare – We are concerned that the skilled nursing sector may be targeted for cuts in addition to the recent rule promulgated by CMS, which effectively reduced rates for skilled nursing facilities by about 20% through changes to the payment process for therapy and across the board cut of 11.3%. Our goal is to avoid additional reductions/cuts to our members, and to support implementation of the delivery system changes embedded in the Affordable Care Act. We call this the "Enough is Enough Campaign".

Medicare Therapy Caps – In addition to the SNF cuts, we are also going to be advocating continuing the "exceptions process" to caps on therapy payments for beneficiaries. This is a perennial issue; it is usually attached to legislation that addresses Medicare payments to physicians (the "doc fix"). We know that there will be a "doc fix" at some point this year, but it is not clear if that will be part of the BCA legislation or separate.

Medicaid – We have consistently opposed efforts to balance the budget by reducing federal expenditures to the states or by changing Medicaid eligibility. The states have been cutting Medicaid reimbursement and services virtually across the country, and we will be advocating against further cuts or reduction in federal payments to the states. We are part of national coalitions advocating in support of Medicaid (this campaign is loosely called, "don't balance the budget on the backs of beneficiaries and the states").

Housing – As noted above, we, along with other national housing advocacy organizations, are asking that payments through the rental programs for low income residents and seniors not be reduced, and

that new construction funds for Sec. 202 housing be retained.

Older Americans Act programs – We are reviewing all the OAA programs that are at risk, but our basic approach is, again, to urge Congress not to cut programs that help seniors remain in the community. FITT: As noted above, we are supporting the FITT act, and will try to have it included in either the BCA legislation or other Medicare legislation.

CLASS Act – CLASS continues to be at risk and our advocacy continues to allow the program to be implemented.

Questions?

Feel free to contact Marsha R. Greenfield, VP for Legislative Advocacy, LeadingAge, mgreenfield@leadingage.org; 202-508-9488.

CAST State Policy Update

ONC Challenge Grants

Four state Health Information Exchanges (HIE) were awarded about $1.7M dollars to engage long term and post acute care providers in HIE Activities. The awardees were Oklahoma, Colorado, Maryland, and Massachusetts.

Providers and affiliates that partnered with the state HIE on grant applications have fostered good relationships and elevated the importance of participation from providers around HIE activities. For example, RI HIE is now working to enroll 100% of nursing homes in the state's HIE.

CAST continues to encourage affiliates and members to share information about the partnership with HIE on the application with the workgroup and to continue engaging in dialogue with their HIEs to get more LTPAC providers participate in the health exchange without a significant financial investment.

State-level technology activities

California: Aging Tech California held its inaugural conference and expo February 16th in Pasadena, CA. This was a one day event with general sessions, break outs and an exposition.

AgeTech California did a survey of members from both Aging Services of California and the California Home Care Association. The final number compilation has not been completed but after 1 week they had an 11% response rate. The hope is to have a 50-60% response rate. They would like to use the findings to develop provider resources. They would like to have shared information between providers allowing them to know what providers are doing in certain areas of technology. They plan to produce a resource guide and host tours.

AgeTech California is planning an informational hearing in their state legislature reforming around the use of home telehealth technology.

AgeTech California is finalizing the Tech-Enabled Care Management at Home Future Imperative which will be held November 15th. This is an annual event and is in its second year. The focus will be on giving the nuts and bolts of creating technology-enabled care models at home and on campus settings. A technology expo will be incorporated into the conference and will feature technology company vendors; the general sessions will be held in the in same room as the expo providing more opportunities for interaction.

Florida: Completed its initial phase of the Direct project. Direct is an encrypted email that allows secure health information exchange between certified participating providers. Florida in particular has defined long term-care and post acute care entities as eligible to participate in this project. Direct project represents one avenue forward for a low bar participation in HIE on because it is a form of basic provider to provider communication.

New York: Between April and July there were five regional technology forums throughout the state for their members. The goal was to bring together different service lines as well as a representative from the State Department of Health to talk about state and regional issues. Regional health information organizations (RHIO) attended these meetings to discuss how long-term care could be more actively involved in health information exchange

(HIE). There were round tables and other forms of communication. They goal was to engage people in NY who have done some cutting edge technology efforts.

NYASHA sent out an electronic member survey in December 2010 with the purpose of gaining a better understanding of the priorities, challenges, and level of technology adoption amongst NYAHSA members. Out of 287 recipients they received 168 surveys back that were then analyzed. CEOs and Administrators provided the highest number of responses in addition to Directors of Information Technology. NYAHSA has members with multiple service lines and all were represented in the responses.

Oregon: OASHS is doing a member survey as well and will share the results when completed.

Updates from the States on Aging Services Technology Policy

California: California is working on a few state level policy priorities. The focus is transforming Medi-Cal with home telehealth and technology-enabled chronic care management models. Medi-Cal reform will shift a proportion of the Medi-Cal population into managed care models. The planning process for this shift is actively underway. Aging Services of California (ASC) and AgeTech CA would like to see home telehealth technology as one of the tools used.

The 5 year acute home and community-based services waiver is up for renewal and ASC would like California to follow the lead of other states that are reimbursing for aging services technologies.

CA is expecting to get a planning grant for the health homes option model through the Center for Medicare and Medicaid Innovations (CMMI); ASC is encouraging the state to consider factoring the use of home telehealth coupled with care management services in their cost benefit analysis, as this model would be cost-neutral or could yield savings.

AgeTech California has been engaged in an initiative that was passed through the budget bill in the California legislature as a means to save the state's Medicaid program (Medi-Cal) 140 million dollars by dispensing 40 thousand medication dispensing machines to frail older adults and others at risk for placement in skilled nursing and avoid re-hospitalization. It's the largest initiative that has been done using home care technology in the Medicaid/Medi-Cal program.

AgeTech California is engaged in the California dual eligible integration pilot project funded by CMS and has submitted two proposed models for use by the state's four pilot projects.

Pennsylvania: A few years back the governor's office launched the Pennsylvania Health Information Exchange (PHIX). When governors were switched from Rendell to Corbet that initiative was disbanded. Governor Corbet has emphasized the need for HIE and signed an executive order on July 27th creating the Pennsylvania e-Health collaborative. Invitations have been sent to stakeholders where 3 meetings have been held with state representatives (doctors' offices, optometrists, dentists, hospital, and one LTC representative, Presbyterian Senior Living).

Committee meetings are now underway and the committees are supposed to submit their findings to the advisory board of the e-Health collaborative no later than Oct. 31st. Following those submissions

the collaborative will send RFP's out to potential vendors for whatever is decided upon by the first of next year.

HIT Standards and Interoperability Update

LTPAC Health IT Summit and LTPAC Interoperability Showcase: The 7th annual summit was held in June and it was well received. The interoperability showcase is still not a live showcase where vendors can demonstrate exchanging information with other vendors participating in the showcase. However, we are seeing increasing acknowledgment by the industry and examples of supporting standards. Interoperability will integrate more tightly onto the show floor over the next few years as opposed to being stand-alone showcases.

Opportunities Created by ONC's Challenge Grants: This year's LTPAC Health IT Summit featured a gathering of the ONC Challenge Grantees as well as other state HIEs that were engaging LTPAC providers. The Summit is now being treated as the annual gathering place for the state HIEs.

We are seeing the state grantees interacting with each other and converging goals. We are seeing other states operate around the edges and participate in individual projects. There are 15-20 states with some kind of initiative to incorporate LTPAC.

There are a few of drivers to note:

- There is a concern around streamlining the kinds of electronic documentation that supports transition.
- There is a national effort focused on transfers of care and people are realizing that they cannot all reinvent their own systems so they are converging with others.
- The Direct Program, which ONC is requiring most of the states to implement this year, is inviting LTPAC providers to participate. Direct project allows point-to-point exchange of health information between providers through simple exchange mechanisms like as a secure encrypted email with a certified participant list for example. This program has a low bar of entry and is being watched with the hope that there will be a convergence around transition documentation.
- HIE's are starting to look at sustainability models and are realizing that they have in place all the infrastructure they need to serve not just at a regional level but without geographical constraints and are starting to think as entrepreneurs. This offers a route towards rapid competitive adoption.

Finally, the LTPAC Health IT Collaborative will begin its 2012 roadmap efforts next month and should be able to have a roadmap in place and adopted in the early part of 2012.

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