A LeadingAge CAST Report

WHAT MATTERS MOST TO LTPAC?

How Payment Reforms, Data and Education Will Transform Business Models for Long-Term and Post-Acute Care Providers

Proceedings of the CAST Commission Meeting
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LeadingAge™ CAST
center for aging services technologies

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How Payment Reforms, Data and Education Will Transform Business Models for Long-Term and Post-Acute Care Providers

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 6,000 not-for-profit organizations dedicated to expanding the world of possibilities for aging.

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Part I:

Conversation with Mark McClellan: Why Payment Reform Matters

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CAST Vice Chair Kathleen Martin kicked off the March 17 CAST Commission Meeting by engaging CAST Chair Mark McClellan in a far-reaching dialogue about payment reform, technology solutions, coordinated care, family caregivers, electronic health records (EHR), Accountable Care Organizations (ACO), and the Center for Medicare and Medicaid Innovation (CMMI). Along the way, McClellan offered his predictions about the future of health care and technology-enabled services and supports.

CAST Commissioners submitted questions for McClellan in advance of the Commission meeting. At the end of the formal conversation session, McClellan responded to additional questions from the floor. What follows is a summary of the interchange. The following is a summary of the question-and-answer session.

Kathleen Martin: *Can you give us an update on payment and delivery reforms, including ACOs? What are some of the new opportunities for CAST and LeadingAge members?*

Mark McClellan: As you know, ACOs are multidisciplinary groups of providers that deliver coordinated care to a specific population of patients. In exchange, they receive bundled payments and share in either the health care savings they achieve or in the cost overruns they incur.

The Brookings Institution and Dartmouth have been working to promote ACOs for more than five years. Together, we developed an ACO Learning Network that tracks ACO implementation around the country and identifies ways of overcoming the current challenges that ACOs face.

Our experience over the past five years illustrates one important fact: the world of health care in this country is changing. When we first formed the ACO Learning Network, there were 10 ACOs operating across the country. Today, implementation of ACOs is really taking off. Last month, the Medicare Shared Savings Program announced support for 130 new ACOs, bringing the total number of ACOs in the Shared Savings Program to well over 200. Approximately 15 percent of all Medicare fee-for-service beneficiaries are now covered by ACO contracts. In addition, Medicare has contracts with 33 Pioneer ACOs. These ACOs have made a commitment to bear substantial financial risk as they manage the health care needs of specific populations of patients.

The number of private-sector ACOs is also growing. Every major insurer now has some kind of ACO-focused program. Retailers like Walgreens are also entering this market. The drug store chain sponsors

several physician-led, community-based ACOs that rely on pharmacists to support patients as a way to reduce their use of high-cost alternatives like the emergency room.

The proliferation of ACOs represents a clear shift in focus within the health care system. The ACO model—and the payment reforms that support it—promise to reduce the financial rewards that physicians, hospitals and other health care providers receive for the volume and intensity of health care interventions. Instead, new payment models reward health care providers that achieve measurably better results and lower costs.

Don't assume that these new payment systems will pay more for technology solutions like EHRs, telemedicine or remote monitoring. Instead, expect these new systems to pay for the *better outcomes* that will result from the targeted and the effective use of these technologies.

To date, new payment reform initiatives have focused on physicians and hospitals because Medicare has traditionally been acute-care focused. This doesn't mean that the success of these initiatives can be achieved without leadership from long-term and post-acute care (LTPAC) providers. Instead, the next round of reforms must focus on ways to include other providers, including LTPAC providers, in new payment systems.

Kathleen Martin: *How can providers of technology solutions help bridge the gap between today's fee-for-service models and tomorrow's capitated and fee-for-performance models? Should we be proposing an intermediary reimbursement program to enable this shift?*

Mark McClellan: The fact that we have many different payment reform initiatives has made the reform landscape a bit disjointed and fragmented. However, I would encourage you not to try to go off in a completely different direction with transitional reimbursement systems.

Instead, start thinking about the incremental steps we can take to improve quality of care and quality of life for patients with complex illnesses, multiple chronic conditions and frailty. We need to take steps to facilitate collaborations among hospitals, physician groups and LTPAC providers. And we need to get measures into ACO and other payment reform systems that will reinforce the aspects of quality that are most important to the older adults you serve.

Kathleen Martin: *Can you give us any examples of organizations that truly have connected care at all levels?*

Mark McClellan: I don't think there are many examples of organizations that are connecting care at all levels. Organizations that are doing this tend to be large health systems that already have in place both integrated payment systems and integrated care delivery systems. Typically, these systems:

- Have EHRs that cover the bulk, if not all, of their patients.
- Have well-established communication systems that connect all the providers delivering care.
- Don't view post-acute and long-term care as an afterthought. Rather, they see partnerships with LTPAC providers as a primary way to guarantee effective management of patients with multiple chronic conditions.

Unfortunately, organizations that are connecting care at all levels are in the minority. But the payment reforms that we have been talking about today are a way to get more organizations to reach this goal. This is a long journey and it will take time.

Kathleen Martin: *How can doctors and providers best integrate patient data into their workflow? From your perspective, are there any preferred ways to receive this information?*

Mark McClellan: There are many potential ways of getting patient information into the data systems that are used to support care delivery. Clinicians can populate EHRs with information reported to them by patients. Patients can send information directly to their EHRs through smart phones and email. And, of course, remote monitoring devices are a very promising way to send patient information to clinicians automatically.

Regardless of how you receive patient data, you need to have a strategy for how you will use that information to achieve improved patient outcomes. You need a clear, specific, well-thought-out strategy that fits your organization's financial and time limitations as well as your organizational capacity for transformation.

Kathleen Martin: *Some of our health information technology initiatives leave out one central provider of care and that is the family caregiver. How do some of the leading ACOs engage family caregivers?*

The most promising examples of family engagement come from palliative care programs. These programs work with individual patients and family members to identify the patient's needs, give the patient and family caregivers a better understanding of the patient's condition, and then focus on meeting patient's most important needs. Those needs may revolve around pain management, nutrition support, assistance with activities of daily living, or long-term and post-acute care. Meeting any of these needs can lead to better outcomes and lower costs for patients and their families.

The ACO Learning Network will soon be working with LeadingAge and the Long-Term Quality Alliance to identify best practices around family engagement in care. We'll also be looking at organizations that do a good job of supporting patients with chronic illnesses.

Kathleen Martin: *How do ACOs justify technology investment? What budget processes are being used?*

Mark McClellan: Some ACOs are using initiatives like the Medicare Shared Savings Program to dip their toes in the payment reform waters. But more mature ACOs are moving beyond just thinking about shared savings. They are adopting an actual sustainable financial model that facilitates lower costs and better outcomes.

These ACOs are not just seeking a better awareness of the status of their patients vis-à-vis care utilization, gaps in quality of care, and opportunities for cost reduction. They are also devising specific strategies and timelines for interventions that will *change* utilization rates, *improve* quality of care and *reduce* costs.

There are many ways to improve care. But most organizations only have so much investment capacity. Some of the most effective ACOs have identified a manageable number of projects that are geared to making measurable impacts on overall system performance. These ACOs aren't just implementing payment reforms and hoping for the best. They are

taking specific steps on a definitive timeline with a well-thought-out investment of both money and staff time. Technology investments are part of that overall strategy.

Kathleen Martin: *What is happening with the Center for Medicare and Medicaid Innovations (CMMI)? Can we expect it to release more funding for pilots? What's happening with the rest of the initially allocated $7 billion?*

Mark McClellan: As everybody has noticed, funding is getting kind of tight at the federal level. CMMI has already launched many pilot initiatives that have touched nearly every area of the health care system. Clearly, the center has its hands full. And now we are facing some tighter funding, which has cut back on the center's ability to award grants.

For all of these reasons, I expect to see a slowdown in new kinds of initiatives coming out of CMMI. Instead, I expect CMMI will be paying more attention to evaluating the large number of pilot programs that are currently operating. The emphasis will be on getting these programs right and on learning from them.

Charlie Hillman: *Other countries—particularly the United Kingdom and Australia—are already implementing telehealth. In the United States, we are still talking about whether telehealth works. Who is resisting the shift to home-based technology?*

Mark McClellan: The real issue is how fast we can move to new systems that are focused on results rather than volume intensity. These new systems will lead to a greater use of telehealth and other care-enabling technologies.

I wouldn't get discouraged about this. Real changes are happening. Perhaps they are not happening as fast as we would like. But one important theme is emerging: *Don't think just about the technology. Think about payment alignment along with it.*

This means that you should not expect to get a new fee-for-service payment for telehealth. Instead, advocate for payments that are tied to results at the person-level. That will be the best path to more widespread adoption of technology in health care.

Peter Kress: *What kind of changes do you think we can expect in the next three-to-five years?*

Mark McClellan: In three-to-five years, a lot more health care organizations are going to be getting better results at the patient-level because they will have found much more effective ways to work with LTPAC providers. I do not think that will be universal, however.

I wish I had a more precise crystal ball about the timing for all of these reform implementations. However, I can tell you that these reforms are accelerating, especially in states that understand these efforts and in markets where ACOs or managed care plans are being held accountable for costs and results, particularly for chronically ill and frail populations.

The immediate challenge for LPTAC organizations is to determine if you are well-positioned to be part of the first wave of reforms that will take place in the next two-to-three years. Otherwise you will be forced to stick with current payment systems and wait for things to develop over a somewhat longer timeframe. You will be in a better position if you are already participating in some of these Medicare reforms, including ACOs and other payment reform systems.

Lewis Mattison: *If you can't look into the crystal ball, what about the rearview mirror? What are some of the initiatives that looked like they were going to work but didn't show value?*

Some of the initiatives that Medicare has tried over the past five years, including programs that have paid for telehealth implementation, have been a mixed bag at best. It's not that these technologies aren't effective. The problem is that they are being grafted onto old systems of payment and care delivery. These systems make it difficult to apply innovative technologies to the right patients at the right time and in a way that really lowers costs and improves outcomes.

Fortunately, we are learning how to do a better job at applying these technologies more appropriately. I don't know of any ACO that has not invested significantly in better information systems, for example. The difference is that the technology implemented by these ACOs is part of an organizational strategy that systematically targets technology solutions to the patients who can really benefit from them.

Part II:

Population Health Management: Why Data Outside the Hospital Matter

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Payers worldwide are pushing clinical and financial risk onto health care providers. As a result, providers are now focusing their attention on finding better ways to manage patient populations. This means that providers must take care of patients across the entire continuum of care. In order to do so, they need tools, resources and know-how.

Between Oct. 2011 and July 2012, Philips held 60-minute interviews with 30 executives from Accountable Care Organizations (ACO) and integrated delivery networks. We also conducted an online bulletin board where an additional 18 executives provided comments, answered questions and participated in an online dialogue. In addition, we conducted focus groups with 29 administrators from home health agencies, skilled nursing facilities and hospitals.

We learned a number of things through this market research:

1. ***Health care reform is clearly on the minds of health care leaders and their organizations.*** A number of those organizations are already focusing their resources on patients with the greatest needs. These organizations are stratifying

their patient populations according to risk and they are managing patients by their risk level.

2. ***Health care leaders are beginning to recognize their limitations.*** These leaders understand that they cannot effectively manage their patient populations without the help of community-based settings. They simply do not have the resources. Partnerships between ACOs and skilled nursing facilities, and between ACOs and home health agencies, are being viewed as a solution to this lack of resources.

3. ***Health care organizations are enlisting the help of new partners.*** For example, some organizations are expanding the role of pharmacists to improve medication management. Hospitals and primary care practices are turning to nurse navigators to help patients steer through the health care system, and avoid a readmission, after a hospital discharge.

4. ***Organizations worry about their ability to provide adequate care in community-based settings.*** They are concerned that there is no tool that can follow patients home from the hospital and ensure their long-term recovery from an acute episode.

5. ***Lack of appropriate technology poses challenges to both providers and patients.*** Within the health care system, processes are not always clearly defined or efficient. As a result, staff members feel that their capacity to manage many patients is being increasingly challenged. Communication among staff members is not optimal, especially across the care continuum. Changes to workflow are often met with internal resistance.

Clearly, health care organizations need help and support as they try to manage the care of their patients. At Philips, we believe that Population Health Management, which combines technology and services, could provide such help. This approach involves efficiently managing an entire patient population through ongoing quality improvement. Population Health Management has five distinct steps:

1. Segment Your Patient Population.

As you know, CAST just released a new video called *High-Tech Aging: Improving Lives Today*. The video features an 83-year-old woman named Alma, who suffers a stroke and then takes advantage of a variety of technology solutions while she recovers at home.

The story of Population Health Management starts a few steps before Alma enters the health care system. It begins with the top leaders of Alma's health care organization. These leaders work together to create a strategy for how the organization will help patients like Alma. Essentially, they try to identify the characteristics of their patient population by dividing patients into subgroups based on their disease, disease severity, costs and other factors.

Organizational leaders will ask themselves questions like, "What do our stroke patients look like?" and "How many of our patients share the same profile?"

How will leaders go about answering these questions? The process could be as simple as making a database query, if the organization is already collecting information about patients. It could be as complex as developing a sophisticated mathematical model that determines risk for each segment of the patient population. At the end of this exercise, the organization should have a good idea of what its patient population looks like and how many people belong to each subgroup of patients.

Different organizations will stratify their patient populations in different ways. For example, a senior living organization might partner with a health care organization to educate patients with chronic obstructive pulmonary disease (COPD) who experience high readmission rates. The partners might stratify the patient population according to specific behaviors. One subgroup might consist of patients who are having a hard time with smoking cessation. Members of another subgroup may not understand how to use home-based therapies. Patients might be assigned to a third subgroup because they lack the motivation to self-manage their conditions.

2. Determine the Optimal Interventions.

Once the patient population is identified and stratified, the next step is to devise interventions for each of the patient subgroups. At the population level, the leaders of the organization will use a tool to determine or predict the potential return on investment (ROI) of these interventions. This tool takes into account the proportion of patients in a particular subgroup, the cost of the recommended interventions and, most importantly, the clinical efficacy and cost-effectiveness of those interventions.

At Philips, we have developed a prototype of this ROI tool for patients with heart failure. The tool uses the medical literature to help an organization determine the best strategy for working with each patient subgroup, given the organization's resources and the number of patients in the subgroup. For example, let's assume that 30 percent of an organization's patients fit Alma's profile and that the organization has a portfolio of technology solutions and care paths to help these patients. Taking its resources and patient characteristics into account, the organization crafts different bundles of interventions for different patient subgroups.

In the case of the COPD patients described above, interventions might include educational materials that are customized to particular behavioral profiles. But interventions could also involve asking a nurse to make telephone calls to follow up with patients after a COPD exacerbation. There will be a variety of interventions and these interventions will have different levels of intensity and different costs.

3. Implement the Care Plan.

After Alma suffers a stroke, she is admitted to the hospital. When she is about to be discharged, Alma meets with a nurse who crafts a package of interventions that make up Alma's care plan.

Philips has developed a tool that would help Alma's nurse carry out this task. To use the tool, the nurse solicits a variety of clinical and non-clinical information from Alma and enters that information into the tool. Some of the information will be automatically fed into the tool from Alma's electronic health record. The tool crunches the numbers and then comes up with an optimal strategy for Alma's post-discharge care. That strategy could involve technol-

ogy interventions like remote patient monitoring. It could also involve implementing standardized care paths.

The success of this care plan will depend on getting buy-in from a variety of key stakeholders. Those stakeholders will include the patient and his or her family. Community-based organizations that provide needed interventions in the home setting will also be important members of the stakeholder group.

4. Collect the Data.

Alma goes home with a variety of technology solutions, including a personal emergency response system, a telehealth unit and a medication dispenser. As soon as Alma uses any of these devices, data are generated. This includes clinical data like blood pressure and heart rate. But it also includes operational data.

Alma's caregivers can learn a great deal about her from this data. For example, they will know when Alma interacts with her devices. Does she measure her vital signs every day as recommended by the care plan? Is Alma taking all her medications on the proper schedule?

As more data are collected, the caregiving team also gains many insights into Alma's health status. In addition, the team is collecting outcomes data that will help it determine not only the impact of specific interventions on Alma's care, but also Alma's satisfaction with her care.

5. Analyze the Data.

All of the data collected from all of Alma's devices will be brought together in a data warehouse where they can be aggregated and analyzed. Armed with this critical mass of data, the heath care team can start answering certain questions.

For example, Alma's health care team may use her data to create a computational model that assesses Alma's risk of being re-hospitalized. This tool could then be deployed into the workflow and physicians could change Alma's care plan well in advance if a red flag appeared.

Data analysis can also take place at the population level. Let's assume, for example, that Alma has diabetes. When Alma's health care organization analyzes the glucose measurements of all its diabetic patients, it notices that Alma and her group of patients have glucose measurements that vary considerably throughout the week, even though they are receiving diabetes treatment. That would be a red flag that should spur clinicians to ask themselves why these fluctuations are occurring. It could be that patients don't understand fully their own treatments. It could be that certain care paths are not being followed. Or it could be genetic predisposition. The data lets health care providers search for the causal relationship and design appropriate interventions to address the issue.

On the operational side, let's assume that the health care organization treating Alma implements an educational program for patients recovering from a stroke. The program offers all discharged patients access to electronic educational materials designed to help them manage their conditions. Because these materials are electronic, the health care organization can track when patients view the materials and how many materials they view. It may be that a group of patients does not complete the educational modules. That red flag should prompt educators to explore the reason behind this behavior and make

appropriate adjustments.

Data analysis can also help organizations better understand how they are performing compared to other health care providers. For example, the health care organization treating Alma might report aggregated data about its stroke patients to a national registry. The registry then provides benchmarking data that shows the organization how well it meets certain standards and how it compares with other providers.

In step 2 of the Population Health Management program, Alma's health care organization used an ROI prediction tool to forecast the potential benefit of intervention bundles for different patient groups. A few months into the program, an organization no longer has to predict ROI. It can use the data it has collected to determine the true success of its interventions. In addition, the organization can recalibrate the tool so it is uses the organization's own collected data, rather than the medical literature, to determine ROI. This makes the tool much more accurate.

Conclusion

Heath care organizations are being asked to bear the risk of treating patients who live outside of the hospital most of the time. Data collected outside of the hospital matter because such data allow clinicians to assess whether they are providing the right level of care through the most appropriate interventions and care paths.

Philips is sharing its approach to Population Health Management with hospital clients. We are encouraging these clients to collaborate with LeadingAge members to implement this approach. That's because we believe that community-based settings like LeadingAge members have a critical role to play in Population Health Management, given their history and experience. For example:

- You know how to effectively utilize community caregivers. The tools described could enhance the effectiveness of your caregivers even further.
- You are adept at working with family members. Family involvement is critical to quality care.
- You take a holistic view of your residents and clients. You address their psychological and cultural life, in addition to their clinical status. In addition, you offer services along the entire continuum of care.

You can read more about Population Health Management in two whitepapers that are posted on the LeadingAge website:

- *A Population Health Management Approach in the Home and Community-based Settings.*
- *The Importance of Home and Community-based Settings in Population Health Management*.

I hope these papers, the Alma video and my presentation will give you a clear and exciting vision of how aging services can evolve over the next few decades. This vision won't happen overnight. And we don't have all the answers. But we are willing to learn along the way. We hope you will join us on the journey.

Part III:

Expanding on Alma's Message: Why Education Matters to LeadingAge Members and Their Partners

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One year ago at the Spring 2012 meeting of the CAST Commissioners, we laid out the vision for a new CAST video called *High-Tech Aging: Improving Lives Today.* The video, released in Dec. 2012, has become known in CAST circles as "the Alma video." We are pleased to report that, to date, the Alma video has received 11,000 views on YouTube. And we are just getting started.

Now that the video is released and enjoying a growing audience of viewers, we need your help as we spread Alma's story to audiences that will connect with its primary message. That message is:

Coordinated care facilitated by technology could be happening right now.

Survey of CAST Commissioners

We recently asked CAST Commissioners to give us their feedback on a proposed plan to create educational modules that will build on the Alma video. We're particularly interested in educating executive teams and board members of LeadingAge provider organizations about the business, care and payment models that can facilitate technology-enabled services and supports.

We solicited your feedback through an online survey that 24 Commissioners completed. The survey results provided us with important information about:

- ***The usefulness of the Alma video.*** On a scale of 1-10, the Alma video received an average score of 7.8 for its helpfulness in facilitating board education. The video received an average score of 7.9 for its helpfulness in educating strategic partners like hospitals, physician practices, health information exchanges, and others. Twenty-five percent of responding Commissioners gave the video a perfect score of 10 in both categories.
- ***The video's audiences.*** Respondents reported showing the Alma video to a variety of audiences. They screened it for employees (11) and senior staff (9), used it in presentations (7), embedded it on their websites (5), showed it at board meetings (4) and shared it with strategic partners (3).
- ***Preferred educational modules.*** Commissioners who completed the

survey generally agreed with CAST's proposed plan to offer additional education about technology-enabled services and supports to LeadingAge members through a multifaceted, multipronged program. Respondents felt that board members could benefit from modules that: (a) offered an expanded explanation of how specific technology works and delivers on its value; (b) outlined the steps involved in technology implementation; and (c) shared real-life stories from other providers that have implemented specific types of technologies.

Respondents did not believe that board members would find testimonials from residents or families to be helpful. In addition, the dissemination of interviews with high-level experts received mixed reviews. While these interviews can be effective in outlining the value of technology at a very high level, respondents felt that they often do not address care, business and payment models and do not offer board members or executive teams enough detailed guidance about technology implementation.

- ***Preferred educational formats.*** Articles, case studies and animated PowerPoint presentations were the preferred formats for CAST's planned educational materials. PowerPoint presentations have the advantage of being low-cost, easy to edit and expand, and easily shared. One Commissioner suggested that CAST develop a 2-D matrix that maps the needs of individuals on one axis and applicable technology solutions on the other.

CAST's Educational Strategy

Based on the survey findings, CAST and LeadingAge believe that we should focus our efforts on developing educational modules that:

- Explore the return on investment (ROI) that could be achieved from implementing technology solutions.
- Offer guidance on how to implement technology-enabled services and supports.
- Share case studies focusing on technology-related care and business models.

We have already launched a series of articles examining 12 categories of technologies that are featured in the Alma video. These articles explain the value of a particular technology, review evidence illustrating that technology's efficacy and cost effectiveness, and offer advice for selection and implementation. A new article is published each month in CAST's *Tech Time* newsletter. Articles also appear on the video's webpage.

CAST is also considering the possibility of producing a set of tools that would help providers think about, plan for and implement technology-enabled services and supports. The tools would include a fresh set of case studies. Individual educational modules would:

- Describe the overall technology implementation process at a very high level.
- Focus on the importance of conducting information technology (IT) strategic planning as part of the organization's overall strategic planning process.
- Explain how to build an IT infrastructure that would serve as a foundation upon which organizations could deploy different technology applications.
- Provide high-level guidance on technology planning and selection.
- Offer access to detailed tools and case studies that provide guidance on specific technology solutions, including electronic health records (EHR) and telehealth. Each tool would point to additional and more detailed sets of tools and resources.

CAST continues to update and expand its tool for selecting and implementing EHRs, and we are currently developing similar tools for selecting and implementing telehealth solutions. New materials in our EHR toolkit will focus on the impact of EHR implementation on outcomes like hospital readmissions. We also plan to explore in more detail the advanced features of EHRs, interoperability, and the exchange of health information with partners. Our telehealth whitepaper will focus on available business models, care models and ROI to payers and providers.

Formats for the Educational Modules

The CAST educational program would include the development of a CAST Story Bank. The CAST Story Bank would provide a platform for member organizations and providers of technology solutions to tell their stories about technology-enabled services and supports. LeadingAge members would access the Story Bank through the CAST website.

As we make plans for the CAST Story Bank, we welcome your feedback about which story-sharing formats would have the most appeal for LeadingAge members. There are several options, including:

- ***Animated PowerPoint presentations.*** These presentations could be posted on the CAST website. In addition, LeadingAge members or CAST-trained "technology ambassadors" could use these presentations to offer in-person education to boards of directors and potential strategic partners.
- ***Member-generated videos.*** LeadingAge members could submit raw footage that CAST would then edit and post on its website.
- ***Screencasts.*** Many LeadingAge members already have presentations about their technology programs. These presentations could be included in the CAST Story Bank with an accompanying narrative provided by the member. Screencasts would give CAST the opportunity to disseminate existing member presentations beyond the audiences for which they were prepared.

- ***White Boards.*** This format, used by Kahn Academy and other online educators, involves telling a story through attention-grabbing, on-screen illustrations.

Commissioners Respond

During a discussion about educational modules and story-telling formats, CAST Commissioners made the following recommendations:

1. ***Sponsor a video contest.*** CAST could sponsor a contest to encourage LeadingAge and CAST members to submit videos to the CAST Story Bank. Such contests can yield high-quality products, according to Commissioners who have sponsored similar challenges. Staff members who interact with a particular technology solution, and have first-hand knowledge of its implementation and impacts, could produce and submit videos. The contest could offer a financial reward to the staff person and national visibility to the organization.

2. ***Recognize innovators.*** CAST could sponsor a LeadingAge Award that recognized innovative, technology-enabled business, care or payment models. This award could be presented at the LeadingAge Annual Meeting during a well-publicized recognition event.

3. ***Engage college students.*** CAST could sponsor a program through which it engages college students in projects that promote aging services technologies. For example, students might be challenged to develop smart phone apps that promote the health and independence of older adults. CAST could invite technology vendors to support the students financially. In addition, LeadingAge members could serve as mentors who could provide the students with valuable insights into the needs and preferences of older adults. Tools developed by the students would provide a benefit to LeadingAge members. In addition, the program could encourage college students to pursue careers related to aging services and technology. Graduate students in health care management and long-term care might be good candidates for this type of project.

4. ***Promote video communications.*** Video may be the preferred option for the CAST Story Bank. Videos could be produced in varying lengths and could easily be featured on member websites.

5. ***Address key decision points.*** CAST should target its educational modules to key decision points that specific audiences are currently facing. One decision point might be a board's initial decision to explore technology solutions. Another decision point might involve a chief financial officer's challenge to develop financial models that support technology adoption. A third decision point might involve whether to participate in an accountable care structure. Educational materials that are tied to decision points will help members

answer real questions. This will make the educational products extremely relevant.

6. ***Explore the "how" of technology implementation.*** Case studies should not just describe what an organization accomplished. They should also explore *how* the organization arrived at its goals. The case studies should focus on a variety of strategies for incorporating technology into the organization's business models.

7. ***Target board members.*** Board members should be a primary audience for CAST's initial set of educational modules. To make these materials as relevant as possible, CAST may want to target its materials to a subgroup of boards that are at a common decision point, and provide those boards with educational materials that are targeted to that decision point. The most effective materials will address either an opportunity that the organization wants to seize or a problem that it wants to solve. All materials should provide a consistent vision so they are applicable to a wide range of organizations. CAST may want to use this same approach to target its educational materials to audiences other than board members.

Part IV:

Closing Remarks

Rear Admiral Kathleen Martin

CAST Vice Chair
Chief Executive Officer, Vinson Hall Corporation
McLean, Virginia

A recent meeting of the LeadingAge Board convinced me that CAST must take very seriously its mission to help LeadingAge members to be as successful as possible. Our members are navigating a challenging operating environment right now. We're witnessing increased needs for services and supports among a rapidly growing older population. At the same time, we are buffeted by financial challenges brought on by rising costs and shrinking reimbursements.

The LeadingAge Board is exploring new ways to reach out to our members and position them for success. I believe that these initiatives will have a positive impact on our members and on the people they serve. As we reach out and support our members, we enhance their ability to reach out and support the individuals they serve.

CAST can offer LeadingAge members important benefits. We can raise their awareness of technology-enabled services and supports. We can educate members about new business and care models that can ensure their success over the long-term. We can offer technical assistance to help members bring the benefits of technology to their organizations, their residents and clients, and their strategic partners.

By doing what we do best, CAST will become an important partner in LeadingAge's efforts to pro-

mote meaningful engagement with our members. In the process, we can play a critical role in ensuring quality of life and quality of care for older adults around the country.

Appendix A:

Major CAST Accomplishments for Oct. 2012– April. 2013

- LeadingAge and CAST are co-sponsoring and participating in the Institute of Medicine's Forum on Aging, Disability and Independence. CAST participated in the Forum's second public workshop, "Fostering Independence and Healthy Aging through Technology," where the CAST video, "High-Tech Aging: Improving Lives Today," was revealed. CAST Executive Director, Majd Alwan, participated in the workshop and presented on aging services technologies and on the highlights of the Aging Services Technologies Study that CAST co-directed, including evidence, adoption barriers, and suggested strategies. Majd's presentation emphasized the role of technology in connecting aging services providers with strategic acute-care partners to coordinate care, improve outcomes, avoid hospital readmissions and reduce the cost of care.
  http://www.iom.edu/Activities/Aging/AgingDisabilityForum/2012-DEC-19.aspx
- CAST produced and released a new vision video, "High-Tech Aging: Improving Lives Today," that shows how affordable technology currently available can facilitate coordinated care and aging in place. The video demonstrates the possibilities through the story of Alma, an 83-year-old woman whose journey from home to hospital, rehabilitation and back home is assisted by technology.
  http://www.leadingage.org/high-tech/
- Published "ABUNDANT OPPORTUNITY: How Long-Term and Post-Acute Care Providers Can Contribute to Reforming the Nation's Health Care System," report of the Proceedings of the CAST Commission Meeting held on Oct. 20, 2012, in Washington, DC.
  http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/Abundant_Opportunity_Final.pdf
- Continued to advocate 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 aimed at gauging technology adoption, and other technology-related activities, including technology policy and advocacy efforts.
- 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 March 2013:

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:

- **EHR portfolio:** Last year, CAST released a portfolio of products to help members plan for, select, and implement Electronic Health Records (EHRs). The portfolio includes:
  - An online tool
  - An accompanying whitepaper that guides organizations through an interdisciplinary planning for EHRs process and defining the needed specifications.
  - 13 case studies of providers' implementations of EHRs.

  CAST is currently updating the EHR portfolio as follows:
  - Adding clearer information about interoperability and Health Information Exchange, including new interoperability standards and detailed information on types of exchange supported.
  - Providing details about Clinical Decision Support Systems (DCSS) relevant to long-term and post-acute providers that the vendors support.
  - Adding 15 new EHR vendors; we currently have 37 vendors participating.
- **Telehealth portfolio:** We are applying the approach we followed with the EHR portfolio to help members plan for, select, and implement Telehealth Solutions. The portfolio will include:
  - An online tool for identifying products that meet an organization's requirements
  - An accompanying whitepaper that guides organizations through an interdisciplinary process of planning for Telehealth Solutions and defining the needed specifications.
  - A set of case studies of providers' implementations of Telehealth Solutions.
- **Technology Adoption and Technology Spending Surveys:** Last year, CAST had developed two questionnaires: one on the adoption of technology and another on technology spending. The technology spending survey was developed in partnership with

Ziegler, who administered the survey to the CFOs who participated in the CFO hotline. Results were published last year. Ziegler has incorporated our technology adoption survey questions into the research process they use to build the L-Z 100 Study. They've sent the survey out to the top LeadingAge providers and we hope to see the results of that survey sometime in June. We will be working with Ziegler on updating and administering the Technology Spending Survey to CFOs who will participate in Ziegler's CFO hotline later this year.

CAST Federal Policy Update March 2013:

Financial issues, specifically the risk of implementing sequestration (budget cuts imposed by the Budget Control Act of 2011) and the expiration of the so-called Bush-era tax cuts, dominated Congress after the November election. The Administration's view was that the election supported the President's position – that individuals with earnings over a certain amount should have their tax rates restored to pre-2001 levels; the opposition pushed for continued cuts in spending. With the clock ticking away, the outcome wasn't clear as the New Year's ball dropped on Times Square.

However, after negotiations lasting into the night, on Jan. 1, Congress passed the American Taxpayer Relief Act of 2012 (H.R. 8), which avoided the so-called fiscal cliff by:

- Permanently eliminating an increase in the tax rate for most Americans.
- Temporarily avoiding steep cuts to domestic and defense spending scheduled to take effect on January 1 (known as sequestration).
- Preventing a 27% cut in payments to Medicare physicians and implementation of caps on out-patient therapy.

In addition, however, the legislation also repealed the Community Living Assistance Services and Support (CLASS) Act, creating a Long-Term Care Commission to address the broad question of how to best provide long-term services and supports.

Here is a top-line review of major provisions in the bill that affects LeadingAge members and the people we serve.

Impact on employees:

- Current tax rates for individuals earning under $400,000 and married couples earning under $450,000 are made permanent; rates for individuals and couples above those income limits raised to 39.6%.
- Child Tax Credit and Earned Income Tax Credit expanded.
- Alternative Minimum Tax (AMT) fixed to avoid applying to middle and lower-income workers.
- Payroll tax cut not extended (this relates to payments into Social Security fund; no changes to Social Security program enacted).

Impact on Medicare beneficiaries:

- No change in eligibility (eligibility age not raised to 67; no increase in premiums).
- Docs fixed, temporarily: payments for doctors kept at 2012 rates through 2013, no 27% reduction under Sustainable Growth Rate (SGR) formula which was scheduled for January 1, 2013.
- Therapy cap exceptions process extended through 2013 for both non-hospital and hospital settings.
- Extended the authority of specialized Medicare Advantage plans for special needs individuals, also known as special needs plans (SNP), through 2015.

Impact on provider communities:

- Medicare: Approximately 10% reduction in payment for multiple same-day Medicare Part B therapy procedures, but no additional cuts to skilled nursing facilities, home health or hospice providers. The bill focused on hospitals for payment reductions to pay for the "doc fix." However, the bill's pay-fors focus on areas that could in the future apply to long-term care providers, especially recoupment for up-coding. A 2% across-the-board spending reduction mandated by the Budget Control Act of 2011 was suspended for 2 months.
- Medicaid: 1-year extension of Qualifying Individual (QI) program that allows Medicaid to pay Medicare Part B premiums for some low-income beneficiaries.
- AoA programs: Funding outreach and assistance for Area Agencies on Aging (AAA) and Aging Disability Resource Centers (ADRC) extended for 1 year.
- Tax exempt impact: Sliding scale reduction of itemized deductions and phase out of personal exemptions for couples with income over $300,000 and individuals with incomes over $250,000. Charitable deductions are not otherwise affected. The Independent Sector has more information.
- Housing and Older Americans Act programs: Current funding continued for 2 months, at which time Congress will have to address the funding cuts to domestic and defense programs included in sequestration along with the debt limit and other deficit reduction and budget issues.

CLASS Act repealed and Long-Term Care Commission established:

- The bill repealed the CLASS Act and replaced it with the establishment of a commission to develop a plan for better financing and delivery of long-term care services. The creation of the commission is in line with our advocacy agenda around financing long-term services and supports.

Agenda Looking Forward

With the exception of the repeal of CLASS, this legislation avoided significant reductions in our programs, but left significant questions about reforming the tax code, entitlement "reform," long-term care, and funding for housing for the rest of 2013.

LTC Commission: LeadingAge, both on our own and as part of AdvanceCLASS, is actively pursued a seat on the Commission for our Board Chair, Audrey Weiner, along with other key players, including Larry Minnix. In addition, we will be working to provide research and information to the Commission as it proceeds. The Commission has a very short time frame (appointments by end of January; report and proposed legislation 6 months later) to look anew at issues that have been studied for over 30 years.

Fiscal Conundrum: Congress has three deadlines in the next 3 months that pose significant risk to our programs: raising the debt ceiling; re-imposition of sequestration; and expiration of Continuing Resolution that finances FY 2014. It is expected that "entitlement reform" (i.e., Medicare, Medicaid and Social Security) and tax reform will be the biggest substantive discussions as well, either part of or in addition to or after the fiscal issues are resolved. The same risks that our programs faced last year will confront us this year.

Our goals in the first 6 months of the new Congress include:

- Introduce LeadingAge and its members, including CAST, to new members of Congress and new leaders of key committees.
- Support funding for housing programs and housing with services
- Provide responsible recommendations regarding Medicare and Medicaid payment and delivery systems, advance the work of the ACA
- Inform the work of the LTC Commission
- Protect tax exempt status and charitable giving
- Advance support for technology

CAST State Technology Update March 2013:

State-level Technology Activities

In its continuing effort to track technology activities in the states, CAST facilitated three presentations through the CAST State Technology Policy Workgroup over the past few months. The first was on the results of a survey done by AgeTech California, next CAST facilitated a webinar on Keystone Health Information Exchange in Pennsylvania and last CAST facilitated a webinar on Stratis Health's one year Health Information for Post-Acute Care grant-funded project in Minnesota.

Presentation by Scott Peifer, Executive Director, AgeTech California

AgeTech California surveyed the members of Aging Services of California and the California Association for Health Services at Home to determine a baseline of current eCare technology use by home care, senior housing, and service providers.

AgeTech received a 14% response rate (114 providers responded out of 850). The survey asked questions regarding fall detection, medication optimization, home Telehealth, remote ADL monitoring, cognitive fitness, "therapeutainment," community connection, wandering detection, care planning, and electronic medical health records.

Overall the survey demonstrated a relatively low level of current technology utilization, with a wide spectrum of use by type of technology, but indicates significant provider interest and plans for leveraging technology if certain barriers can be overcome.

Almost half of the respondents indicated that they use wandering-detection technology (43%) and fall-detection technology (48%). More than a third use electronic health records (34%) and care-planning software (41%). "Therapeutainment" technology mixing therapeutic or social interactions with entertainment -- including gaming systems such as the Nintendo Wii -- is used by 38%.

Presentation by Jim Younkin, Director of the Keystone Health Information Exchange and Administrator for the Keystone Beacon Community

Background provided for the Keystone Health Information Exchange (HIE) Initiative and Keystone Beacon Community.

Solution implemented to take MDS and Oasis assessment data and turn it into a Standard Continuity of Care Document (CCD) that can be shared through HIE. An exciting product is being developed to allow all nursing homes and home health agencies the ability to do the same within their organizations.

Scope of the Beacon Communities Program: This was an initiative enabled through ARRA funding and the Office of the National Coordinator for Health IT. Seventeen Beacon Communities were funded across the US. The 3 aims of the Beacon Communities are to build and strengthen Health IT infrastructure, reduce cost while improving quality and population health, and test innovative approaches. Keystone Beacon Community is made up of 5 counties in central PA. They each have a care component with care managers that were hired and placed into hospitals and ambulatory practice settings. There is a call center that helps with transitions of care and follows up with patients for 30 days. The overall goal is to reduce hospital admissions and readmissions to patients with heart failure and lung disease. A number of practices, home health agencies, nursing homes, and hospitals participated in this project.

The Gobbler: Nursing homes wanted to share functional status data with other care providers through the HIE. To help meet that challenge, they took the data out of the nursing homes structured documents and turned them into another structured document using the continuity of care document (CCD) as the model. The Gobbler was created. The Gobbler a piece of software that looks for an MDS file to be created, and when generated, it will access and transform the file into CCD format and push it through the HIE.

KeyHIE Transform: They thought of the best way to get all of the information out to home health, long-term care vendors, and organizations across the country. KeyHIE opened a source program that anyone could use, but this is only useful for those who procure and install the software. Through discussions with CAST and others, they found that

it would be of greater value to create a transformer service that could be accessed by any organization that wants to transform their documents. They are in an RFP process with a number of vendors to have this build for them and have it hosted on a website that would enable an organization to log in and sign up to participate in this service or on a case by case basis.

Presentation by Candy Hanson, BSN, PHN, Health Information Technology for Post Acute Care (HITPAC), Stratis Health Special Innovation Project

Stratis Health is currently partaking in a one year Health Information Technology for Post-Acute Care grant-funded project (September 28, 2012-September 27, 2013) sponsored by the Centers for Medicare and Medicare Services (CMS). The purpose of this initiative is to further the advancement and the adoption of electronic health records (EHR) in Minnesota (MN) in the hopes of reducing medical error during transitional care through medication management, technical assistance, workflow, and a standardized, structured, common language for health information exchange.

Over the course of this project, Stratis Health will be working with 2-3 communities in MN, each consisting of one hospital, and 5 of its referring nursing facilities. They will also be collaborating with various local organizations, such as the Department of Health and Aging Services of MN, and will be organizing monthly educational webinars. Organizations in both Colorado and Pennsylvania were also recipients for this grant.

CAST Alma Video: CAST shared the CAST Alma Video with the State Policy Workgroup and encouraged participants to disseminate the video through their web sites, communications newsletters, conferences and presentations. We also encouraged members to share it with their partner hospitals and physician groups, and payers. Finally, we encouraged the workgroup participants to share the video with state hospital associations and state Health Information Exchange entities.

State Updates

LeadingAge Florida - The Agency for Health Care Administration (AHCA), which governs the Florida HIE, has created a HIE coordinating committee that met to reaffirm their position on continuing to govern Florida's HIE. They felt that doing so would maintain stability in the HIE arena as it grows in the state of Florida. Through their governance, they are able to keep costs low and maintain a simple structure that's a good fit for a network of networks. The committee identified a problem with educating stakeholders, including the patients. The patients need to know how the system works and its benefits. One of their concerns was the actual security of the different systems. They looked at the different regions of Florida, where these regions were in terms of implementing their programs, and the obstacles they've faced. The implementation stage of development is pre-mature, and a lot of work still has to go into it so they've conducted surveys on early adoption. CAST Commissioner Peter Kress sits on this committee and LeadingAge Florida is part of the governance.

LeadingAge Washington - Washington's Technology and Innovative committee will be doing another survey. The committee is trying to create a database of all of their providers on where they are in regards to technology. LeadingAge Washington will share

that data as it becomes available in the upcoming year.

For LeadingAge Washington, Lynette Ladenburg just returned from Newcastle, England where she spoke at New Active Age Summit. Before the Summit took place, she spoke with government officials, university officials, and business representatives on what's going in Newcastle with regards to global aging and technology. The University of Newcastle has a Campus for Ageing and Vitality. Her understanding is that the campus is one of the top 5 in the world and that the work that they are doing around global aging and technology is absolutely amazing. The way in which they have managed to get universities, government, and businesses to connect, collaborate, and work together on global aging is absolutely phenomenal. She showed them the video of her innovation home at **Tacoma Lutheran Home and Retirement Community** and they have shown interest in collaborating and building an innovation home on the university campus. They are currently working together on that.

AgeTech West - AgeTech West survey of Technology Adoption is out in the field. The three west coast LeadingAge states involved are California, Oregon, and Washington. The results will be compiled within the next couple of months and shared with providers so they know what their peers are using and to encourage information exchange.

CAST EHR Standards and Interoperability Update March 2013:

1. Formal Meaningful Use criteria are increasingly acknowledging long-term and post-acute care (LTPAC) as a part of the continuum and our unique interests in functional status, advanced directives, transfer of care, coordination of care and quality. But, these references come without force or funding and are expected to lack such in the foreseeable future. Still, driving Meaningful Use incorporation of LTPAC related requirements may serve as an instigator of local initiatives.

2. Health Information Exchange (HIE) programs at local, state and federal levels are increasingly acknowledging LTPAC as necessary partners, but without systematic funding or policy drivers, advance will be uneven. Individual HIE/partnered initiatives such as the ASPE-funded Keystone HIE MDS to CCD initiative, the ONC-funded Massachusetts work on transfers (IMPACT), Plan of Care initiatives out of NY HIEs and other similar projects, are continuing to expand standards development. Deliverables from these and similar initiatives may serve as building blocks and enablers for local initiatives.

3. Accountable Care Communities will increasingly need credible LTPAC partners. HIE capabilities are essential to these partnerships and Health IT standards will enable these partnerships, but they will often be implemented in proprietary ways.

4. LTPAC EHR Vendors are increasingly providing basic support for standards that support tactical priorities and have high visibility including CCD, Consolidated-CDA, HL7, NCPDP. These may serve as building blocks for integration, exchange and coordination efforts, but will still often require "customized" or "one-off" implementations. There seems to be greater openness among vendors to work with providers to support participation in local initiatives.

5. Emerging Technology Services and Solutions (mobile web, cloud services, consumer devices, analytics) are all changing the conversation in interesting ways. Many point to solutions that are sometimes being creatively integrated into interesting initiatives.

6. LTPAC providers must look for high business/clinical impact opportunities that can be funded out of their own missions and returns.

7. Sharing of innovative practices will be an accelerator of change and adoption.

8. Collaborative industry advocacy will continue to be necessary and useful to continue to create and support contexts within which innovation can flourish. CAST continues to support this effort directly as well as in partnership with the LTPAC HIT Collaborative.

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