

*A LeadingAge CAST Report*

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## ABUNDANT OPPORTUNITY:

*How Long-Term and Post-Acute Care Providers  
Can Contribute to Reforming the Nation's Health  
Care System*

Proceedings of the CAST Commission Meeting  
October 20, 2012 | Denver, Colorado

# ABUNDANT OPPORTUNITY: How Long-Term and Post-Acute Care Providers Can Contribute to Reforming the Nation's Health Care System



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.

For more information, please visit [LeadingAge.org/CAST](http://LeadingAge.org/CAST)

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## Welcome:

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### AN OPPORTUNITY TO SERVE A BROADER POPULATION

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#### Rear Admiral Kathleen Martin

*CAST International Vice Chair*

*Chief Executive Officer*

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Prior to our gathering today, I participated in a meeting of the LeadingAge Board of Directors. During a discussion about CAST, I asked my fellow board members to identify the critical challenges they face each and every day as providers of long-term services and supports. Then, I asked board members to imagine which of those challenges could be alleviated or reduced through the use of technology.

During the ensuing discussion, I made sure that board members did not limit their visioning process only to the delivery of services to older adults. My challenge to them—and to you today—is that we need to begin looking at technology in a much broader context.

As many of you know, I spent 32 years in the U.S. Navy. Immediately before I retired as a deputy surgeon general of the Navy, I served as commander of the National Naval Medical Center in Washington, DC. My assignment put me in touch with thousands of young men and women who returned from Iraq and Afghanistan carrying the wounds of war.

When I entered the senior housing field after my Navy retirement, I made an important discovery. The older adults we all encounter in our daily work share some of the same challenges facing the

veterans of war I met at the National Naval Medical Center.

Our wounded veterans come home from war to an environment that is not designed to support their disabilities. Their surroundings—including their homes and their communities—once seemed so comfortable and welcoming, but now these settings present daily barriers to their independence and wellbeing. Veterans with disabilities living in these settings face a new battle when they come home from war. Each day they fight just to be mobile and engaged.

Our homes, communities and care settings also present enormous challenges to older adults and to many people of all ages who live with an array of disabilities. As an organization devoted to promoting technology-enabled services and supports, CAST needs to keep this wider audience in mind when we set out to promote the design, adoption and implementation of technology.

We need to keep in mind that CAST's work has the potential to impact a wide variety of individuals who represent many generations. This is a big responsibility. But it also represents a welcome opportunity to serve not only the elderly, but the entire nation.

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## Part I:

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### **PAYMENT REFORM: AN OPPORTUNITY FOR LTPAC/ ACUTE-CARE PARTNERSHIPS**

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**Mark B. McClellan, MD, Ph.D.**

*CAST International Chair*

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There is currently a great deal of activity taking place in the nation's capital. The outcome of that activity will surely help determine the future of our country for the next decade or more.

The U.S. Department of Health and Human Services is quite busy trying to implement a landmark health reform initiative even as opponents of the measure threaten to overturn it. Policy makers struggle to determine the long-term sustainability of programs like Social Security, Medicare and Medicaid even as we race toward a "fiscal cliff" that could mean higher taxes and significant budget cuts if Congress and the President cannot reach agreement on how to reduce our ballooning deficit.

And, of course, as we meet in late October, the national election looms large, raising questions about who will occupy both the Capitol Building and the White House for the next four years.

Taken together, these developments represent real opportunities—but also some challenges—for long-term and post-acute care (LTPAC) providers. Those challenges and opportunities are linked closely with the Patient Protection and Affordable Care Act (ACA), which President Obama signed into law on March 23, 2010 and which is gradually being imple-

mented across the country.

Granted, many of the ACA's reforms are aimed directly at hospitals and physicians, rather than LTPAC providers. But there is no escaping the fact that the work you do has major consequences for hospital care and for the ability of physicians to manage their frail and complex patients. As a result, I firmly believe that the ACA provides significant opportunities to LTPAC providers. In particular, you have the opportunity to take a leading role in the payment reforms that will dramatically change how our health care system works.

Regardless of which candidate becomes our next President, or who controls Congress after Jan. 3, 2013, these reforms will be a fundamental component of health care reimbursement for the foreseeable future.

#### **A Current Opportunity: Hospital Readmission Reduction**

One of the earliest examples of our evolving payment reform system is the Hospital Readmission Reduction Program (HRRP), which began on Oct. 1, 2012. This program applies to the vast majority of acute-care hospitals in the United States and is intended to reduce the avoidable hospital readmissions that cost the health care system so much money and threaten the health and quality of life of so many of our older citizens.

Essentially, HRRP requires the Centers for Medicare & Medicaid Services (CMS) to track whether patients with three specific conditions are readmitted to the hospital with any acute condition within 30 days of their original discharge. The three conditions—acute myocardial infarction (heart attack), congestive heart failure and pneumonia—

were selected because they represent the most common causes of hospitalization in the Medicare population. In addition, a large portion of Medicare beneficiaries with these conditions—about 20 percent—will experience a hospital readmission.

Each year, CMS sets a readmission rate threshold for these conditions based on the distribution of readmissions that it observes across the country. Under HRRP, hospitals that have a readmission rate above that threshold will be subject to penalties over the next three years.

HRRP will have a significant impact on hospital behavior. As such, it holds a number of opportunities for LTPAC providers that have the ability to help hospitals reduce their risk of penalty. Yet, HRRP has its fair share of critics. Some opponents suggest that by directing readmission penalties at hospitals, the program fails to acknowledge that many of the factors influencing readmissions come into play after the patient is no longer in the hospital's care. Other opponents point out that HRRP gives no incentives to LTPAC providers, even though these providers play a central role in keeping patients from returning to the hospital.

Despite the criticisms of HRRP, providers of long-term services and supports do have much to gain by helping hospitals prevent readmissions. Certainly, if LTPAC providers are successful in keeping post-acute patients healthy, they will enjoy potentially lucrative partnerships with hospital systems that see the value of their participation in:

- ***Pre-discharge transition planning.*** In order to avoid CMS penalties, hospitals need to establish more effective transition plans that facilitate better handoffs of patients moving between

hospital and LTPAC settings. These handoffs will require the exchange of patient information, including thorough medication lists, so LTPAC providers have the tools they need to stabilize patients so they can return to their homes.

- ***Post-acute collaboration.*** Under HRRP, a hospital can rely on LTPAC settings to provide the services that the hospital would normally provide during a readmission. As long as the patient receives these services from an LTPAC provider under contract with the hospital, CMS will not count that care as a readmission.

Hospitals will need to invest money, time and effort in making the care transitions process work better. There is little doubt that hospitals will want to work with post-acute providers to carry out that work. But hospitals will choose their post-acute partners very carefully and base their decisions on hard data demonstrating your ability to contribute to successful care transitions.

Before a hospital enters into a partnership with you, it will want to know how likely it is that the patients it entrusts to your care will be readmitted to the hospital. Specifically, it will want to know how often your residents and clients return to acute-care settings. It will be interested in how long those patients and clients remain stable in community settings.

### **Coming Opportunities: Payment Reform Initiatives**

The Hospital Readmission Reduction Program is important because it is happening right now. But

future payment reform initiatives will have an even bigger impact on the relationship between acute-care hospitals and LTPAC providers.

For example, the Center for Medicare & Medicaid Innovation (CMMI) is getting ready to pilot four bundled-payment models in 2013. Two of these models – called Model 2 and Model 3 – could directly involve LTPAC providers during the 30-90 day period following a hospital discharge.

Under Model 2, a care team comprised of a hospital and an LTPAC provider will receive a total bundled payment that is based on what Medicare is now paying for acute and post-acute care during the first 30-90 days after discharge. If the hospital and LTPAC provider team keeps its costs below this baseline, the team can share in those savings as long as it can demonstrate significant levels of quality. Conversely, if care costs are greater than the current baseline payment, the provider team must absorb the overrun. In either case, the hospital and LTPAC provider share the risk.

Model 3 follows the same formula, but it covers only post-acute care that takes place 30-90 days after the hospitalization. Under this model, for example, a skilled nursing facility might partner with an inpatient rehabilitation facility, a long-term care hospital or a home health agency. These providers must agree to be accountable for the entire post-acute service package. They will share in any savings they produce but are also responsible for any cost overruns.

### Preparing for Change

The HRRP and other payment reform initiatives illustrate a trend that will dominate our health care system over the next decades. Public payers will in-

creasingly reward providers delivering high-quality care while lowering costs. The most successful providers will help their patients, residents and clients avoid unnecessary health care utilization. These providers will not only help their residents and clients prevent a hospital readmission. They will keep these individuals out of the hospital all together.

These trends will present great opportunities for LTPAC providers. However, taking advantage of these opportunities will require some investment of time and money. To be successful in developing partnerships with acute-care settings, LTPAC providers will need:

- ***A technology infrastructure that facilitates care coordination.*** This includes electronic health records (EHR). However, keep in mind that not every provider needs a full-blown EHR immediately. LTPAC providers could begin the process of upgrading their technology capacity by creating a simple registry that allows them to track key patient health information with provider partners.
- ***Performance measures that matter.*** With the right systems in place, LTPAC providers can track readmissions—or patients at risk for readmission—as they deliver care. If CMS adopts new quality measures, these providers will already have the data to show how they compare with other providers in the same sector. This will help them measure their capacity to get costs down and log improvements in quality, especially for patients who suffer heart attacks, heart failure and pneumonia. This data can

and should be shared with prospective partners.

- ***The capacity to exchange health information.*** At the very least, LTPAC providers should be able to exchange medication lists and test results with their primary care and acute-care partners. It will also be important to collect and share the real-time patient data that is collected through remote monitoring or telehealth. This data will help post-acute patients manage their chronic conditions. It will also help patients and their professional caregivers make care decisions.

### Reflections on Current News

A number of political developments will likely influence the implementation of the Affordable Care Act. For example:

- ***Supreme Court Decision:*** In June 2012, the Supreme Court upheld the ACA's "individual mandate" requirement that most Americans obtain insurance or pay a penalty. The court also ruled that Congress had exceeded its constitutional authority by forcing states to expand their Medicaid programs. The Supreme Court decision was important to the future of the ACA, but it was not a complete and unabashed victory for health care reform. In particular, the Supreme Court limited the federal government's control over the behavior of states regarding the ACA and the Medicaid program. We still haven't identified all the likely implications of
- ***The Election:*** President Obama's victory on Nov. 3 would make it unlikely that Congress will repeal the ACA, as Republicans promised during the campaign. However, this does not mean that ACA implementation will be easy. Expect to see variations in how states go about expanding Medicaid and creating health insurance exchanges. Fifteen states already have those exchanges in place, but other states are moving more slowly. This means that we will see a gradual implementation of the ACA. In some states, it may be necessary to look for alternatives to the individual mandate in order to keep insurance markets working well.
- ***The Fiscal Cliff:*** We are getting dangerously close to the "fiscal cliff." This refers to the steep cuts in federal spending, mandated by 2011 Budget Control Act, which will take effect on Jan. 2, 2013 unless a deal is reached beforehand. The Budget Control Act calls for \$1.2 trillion in federal cuts over 10 years. Unless Congress and the President can agree on an alternative, we are looking at \$110 billion in cuts during 2013 alone. If you think we've

this decision. But one thing is clear. The balance of power is shifting to the states and away from the federal government. As a result, I expect to see more comprehensive health reform at the state level and would encourage LeadingAge members to become leaders in their states' reform efforts.

seen the last of Medicaid and Medicare reimbursement cuts, think again. Yet, squeezing down payment rates is not an effective way to survive a fall from the fiscal cliff. Instead, we need to continue our efforts to create a payment system that focuses on value by paying for measurably better care and measurably lower costs.

### **The Role of LeadingAge**

How can LeadingAge and CAST help its members address the challenges—and take advantage of the opportunities—that face us? First and foremost, we need to provide leadership in helping our members demonstrate the value that they bring to the health care reform debate. The good news is that many LTPAC providers—including the providers featured in CAST’s 2011 case study collection—are already developing business models that address issues related to access, quality and cost. LeadingAge and CAST are doing their part to disseminate this information widely.

Thank you for your leadership in bringing about needed changes that will help LeadingAge members continue to play an important role in improving quality of care and quality of life for older adults.

### **Part II:**

## **CAST VIDEO: AN OPPORTUNITY TO EDUCATE LTPAC PROVIDERS AND THEIR STRATEGIC PARTNERS**

### **Larry Minnix**

*President and Chief Executive Officer  
LeadingAge, Washington, DC*

Twice each year, the LeadingAge Board of Directors confers with a thought leader in the field of long-term services and supports. We have a multi-hour conversation with this individual to ascertain his or her unique perspectives on and insights into our field. Together, we contemplate important questions. What are the major trends and opportunities for us now and in the future? What do our members need to do to take advantage of these trends and opportunities? What should we be doing as an association to move our field forward?

This year, we conferred with Linda Brock, global director of senior living at Philips Healthcare, which is LeadingAge’s newest partner.

Linda gave us a whole new sense of urgency. She urged LeadingAge to help its members understand that we can’t just sit around waiting for the next best software product to come down the pike. We need to help our members understand that unless they conduct strategic planning that includes technology platforms and systems, they will not be able to compete successfully in the emerging managed care world.

I walked away from our board meeting firmly convinced that our members will create problems for themselves, as well as for their residents and clients,

if they do not embrace technology and use that technology to demonstrate that they are providing quality care at a lower cost.

We still have members who are taking a wait-and-see attitude when it comes to technology-enabled services and supports. LeadingAge is committed to doing everything it can to change that scenario. Two initiatives, which will come to fruition before the end of 2012, will help move us closer to fulfilling this commitment.

### **The CAST Video**

In 2005, CAST released an eight-minute video called “Imagine—the Future of Aging,” which introduced the concept of aging services technologies to a wide audience of consumers, providers and policy makers. Through the use of a fictional storyline and professional actors, the video gave viewers an opportunity to imagine what the future of aging could look like with help from technologies that were “possible, practical and affordable.”

During their meeting in October 2011, the CAST Commissioners began thinking seriously about creating a new video that would highlight the important role that long-term and post-acute care (LTPAC) providers can play in delivering technology-enabled services and supports that foster care coordination across multiple providers and settings. The Commission confirmed its support for this project in April 2012 and CAST embarked on script development and video production soon afterwards. During this process, many of our CAST Commissioners contributed to shaping the concept and the vision for this video project. The project is being implemented in two phases:

- During Phase 1, we will produce a video in which actors tell the story of a fictional character named Alma. The video will follow Alma as she transitions through multiple care settings, including her home, an acute-care setting and a short-term rehabilitation facility. At the end of the video, Alma will transition back to her own home. She will avoid a hospital readmission with the help of long-term and post-acute services enabled by a wide variety of technologies.
- During Phase 2 of the video project, we will film interviews with field experts who will drive home the major points of the Alma video. These interviews will eventually be woven into a “director’s cut” that will serve as a commentary on the story that the actors are telling.

Our new video project will illustrate very clearly how technology that is available right now can help real people achieve better health, receive better quality care, and enjoy enhanced independence at a lower cost. It will also show that technology needs to be part of the business plans of every provider of long-term services and supports, from the smallest housing members serving low-income residents to the largest CCRC serving a middle-income population. No matter what our size or the populations we serve, we have to be in this game. If we are not leaders in this area, we will be forced to take whatever the system sends our way.

## Institute of Medicine Forum

We are currently working with a Baltimore-based production company to shoot the video on the campus of Asbury Methodist Village in Gaithersburg, MD. We expect this video to be a great resource for our members as they educate their boards and their strategic partners about the benefits of technology-enabled services and supports.

In addition, we are excited about the video's potential to spark the imagination of academics and policy experts who are in a position to influence the redesign of our health care system. We will reach out to those audiences when we unveil the video at a Public Workshop on Fostering Independence and Healthy Aging through Technology that the Institute of Medicine's (IOM) Forum on Aging, Disability and Independence is sponsoring. The workshop takes place on Dec. 19 in Washington, DC and will be available, in real-time, through a free webcast.

The IOM is one of the most credible and prestigious research organizations in Washington, DC and it tackles the world's biggest health care problems. The chief operating officer is a geriatrician, named Dr. Judy Salerno, who really understands our world from the inside out. We are fortunate to have someone with her background in such a prominent position.

LeadingAge is thrilled that our video will open the upcoming IOM workshop. We look forward to working with this well-respected organization to shine a spotlight on the great potential of aging services technologies to improve the quality of care and quality of life of our older citizens.

## Part III:

### IOM FORUM ON AGING, DISABILITY AND INDEPENDENCE: AN OPPORTUNITY TO REACH NEW AUDIENCES

#### Dr. Tracy Lustig

*Senior Program Officer*

*Institute of Medicine, Washington, DC*

When the Institute of Medicine (IOM) was established in 1970, it joined three other organizations that make up what is commonly referred to as the National Academies. The oldest organization in our group is the National Academy of Sciences, which President Abraham Lincoln chartered in 1863 to serve as an independent, nonpartisan nonprofit organization that would advise Congress on any subject within the fields of science or art. The National Research Council and the National Academy of Engineering were added in 1916.

The IOM, the youngest of the National Academies, is known mainly for its studies, which bring together experts from around the country to consider a specific health-related question. The expert committee for each study looks at all the evidence that exists on a selected topic, conducts a rigorous peer-review process, and then issues evidence-based recommendations. In recent years, we have released several groundbreaking studies, including [\*To Err is Human: Building a Safer Health System\*](#), which examined the important issue of medical errors; and [\*Crossing the Quality Chasm: A New Health System for the 21st Century\*](#), which called for fundamental changes to close the quality gap in the American health care system. These reports have changed the conversation about medical errors and patient care.

In addition to our studies, the IOM also holds forums that bring together stakeholders in academia, philanthropy, government and the private sector, as well as consumers, to talk with one another about a particular topic. These forums are less formal than our studies.

The forums are assigned a general agenda, but they are essentially self-governing. Members decide what topics they want to address, what workshops they will hold, and what papers they will commission. The forums do not issue recommendations. Instead, their primary goal is an intangible one: to help stakeholders around a particular issue work together to understand and overcome barriers to progress.

The Forum on Aging, Disability and Independence is striving to bring together stakeholders in the aging and disability worlds who don't often talk to one another even though they have much in common. So far, we have agreed that our primary focus will be on independence. We want to examine the challenges facing adults who are impaired in their ability to be as independent as possible. We want to pay attention to the special factors that have accelerated the negative impact that families, communities and society experience as these individuals grow older.

Technology is the first topic that the forum will explore. Our first workshop will focus on how current technology can make a difference in the lives of people with disabilities. We will also explore why people with disabilities are not using technology and why, in some cases, they are abandoning technology. During future workshops, we hope to explore the intersection of the formal and informal workforces, the prevention of secondary disabilities, and a variety of financing issues. But I expect that the topic of technology will keep coming up in our discussions.

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## Part IV:

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### AST STUDY: AN OPPORTUNITY TO PUT RESEARCH INTO PRACTICE

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#### Majd Alwan

*Senior Vice President of Technology*

*CAST Executive Director*

*LeadingAge, Washington, DC*

One of CAST's most important accomplishments this year has been the [Aging Services Technologies Study](#), which we co-led and co-authored with the National Opinion Research Center (NORC) at the University of Chicago. The study was funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services (HHS). The study report was reviewed in collaboration with a number of HHS agencies, including the Office of the National Coordinator for Health Information Technology (ONC).

The American Recovery and Reinvestment Act of 2009 (ARRA) mandated the Aging Services Technologies (AST) study. The legislation explicitly called for a study "of matters relating to the potential use of new aging services technology to assist seniors, individuals with disabilities, and their caregivers throughout the aging process." Our final report, which ASPE has submitted to Congress, provides:

- A detailed discussion of ASTs related to eight care issues: falls, medication management, chronic disease management, cognitive impairment, sensory impairment, depression, mobility impairments, and functional decline and loss of independence.

- A discussion of the interplay between ASTs and health information technology (HIT).
- An exploration of barriers to the development and adoption of ASTs, including a discussion of potential strategies that can be implemented to address these barriers.
- A systematic framework for considering the existing evidence supporting the effectiveness of a diverse array of ASTs.
- Information pertaining to ASTs that are under development and those that are available outside of the U.S.

During the study, CAST and NORC reviewed the existing literature and evaluated the existing evidence of efficacy and cost-effectiveness for a variety of technologies. Each chapter of our report begins with the definition and prevalence of a care issue, and then goes on to describe the cost burdens associated with the issue, and the technologies available to address prevention, detection and treatment. Each chapter also explores the benefits of technologies for the specific care issue, identifies technologies under development, and describes the experience of other countries in developing, deploying and using these technologies.

The AST study yielded a number of general findings:

- **Many technologies:** A large variety of technologies are available to address the common health and functional challenges faced by older adults and persons with disabilities. Many of the aging services technologies we examined had multiple applications to different care issues, while some were specific to particular care issues.
- **Challenges integrating ASTs with HIT:** In order to maximize the benefits of ASTs, we must integrate those technologies with other health information technology. The majority of ASTs we studied can collect and transmit very useful data about an older person's sleep patterns, gait, balance or other measures of health and wellbeing. However, we found that health care professionals rarely collect or analyze this data. Our biggest challenge will be to get this data on clinicians' "radar screens." That can best be accomplished by integrating the real-time data that we can collect through telehealth devices and embedded sensor technology into standard HIT tools like electronic health records.
- **Lack of clinician training:** Enhanced clinician training represents an important strategy for integrating ASTs and HIT. Clinicians and other health care professionals are not used to thinking about the data that remote monitoring and telehealth systems can collect and transmit. Our ability to maximize the benefits of ASTs depends on our ability to train clinicians to recognize the benefit of AST data, use that data effectively, and integrate that data into electronic health records (EHR) and clinical decision support systems.

- ***Efficacy and cost-effectiveness:*** The evidence is mixed when it comes to demonstrating the efficacy and cost-effectiveness of ASTs. The strength of that evidence often depends on the care issue, the technology itself, and whether we are using that technology for prevention, detection or treatment. Telehealth and remote patient monitoring show the strongest evidence of efficacy and cost-effectiveness, especially for patients with congestive heart failure, chronic obstructive pulmonary disease, and hypertension. Cost-effectiveness is generally linked to providers' operational and business models.
- ***Barriers:*** The major barriers to technology adoption appear to be lack of awareness of technology among older adults, their family caregivers, and the professional caregivers who should be the trusted referral channels for this technology. In addition, our report notes that there are stigmas associated with some ASTs. Education campaigns, like the CAST case study project, could help increase awareness. Applying a user-centered approach to the design process could also ensure that we are developing technologies that consumers will adopt because they look aesthetically pleasing and are not stigmatizing. Other barriers include lack of interoperability and data entry standards, as well as concerns about privacy, security and liability.
- ***International experience:*** Most of the technologies being developed outside the U.S. are also available in this country. However, adoption rates are higher in Europe because public funding of ASTs encourages utilization.

### **The Impact of Reimbursement**

A significant barrier to technology adoption is the lack of provider incentives to review the data collected through telehealth and remote monitoring technology. The fact that public and private payers do not cover the cost of ASTs or the services delivered or enabled by these types of technologies is also a barrier. These financing barriers cannot be ignored because they slow market growth, which impedes private-sector investment in developing new ASTs and evaluating the effectiveness of existing technologies. Private-sector investment is critical to widespread adoption and implementation simply because the upfront costs for researching, developing and bringing technologies to market is so significant.

Reimbursement and payment issues were outside the scope of the AST study. However, other opportunities to explore these issues in more depth could soon be available. Specifically, we are urging the Center for Medicare & Medicaid Innovation to support a large-scale demonstration, conducted collaboratively by acute- and long-term care providers, to evaluate the cost-effectiveness of technologies that have been proven efficacious. In addition, we believe that our AST study contains the information we need to design a demonstration that could evaluate new innovative business models that reduce costs while, at the same time, redistributing incentives more equitably among different parties.

The AST study helped us collect the evidence that technology can improve the quality and reduce the cost of care for individuals receiving long-term services and supports. We know which technologies work and which technologies don't work. Now we need to find a way to turn this academic research product into practice.

How can CAST meet this goal?

## Part V

### COMMISSION DISCUSSION: TAKING ADVANTAGES OF CURRENT OPPORTUNITIES

The Oct. 2012 meeting of the CAST Commissioners ended with a discussion of how CAST might use the Aging Services Technology (AST) Study to move research about ASTs into practice. During the discussion, Commissioners identified a variety of strategies that CAST might pursue in its efforts to raise awareness about technology-enabled services and supports while increasing support for technology adoption among older consumers and their families; Long-term and post-acute care (LTPAC) providers and their strategic partners; and public and private payers. Those strategies fell into a number of general topic areas.

#### Return on Investment

LTPAC providers vary in their approach to technology and in their need to see an immediate return on their investment in technology-enabled services and supports. Some providers expect their technology systems to last for 10 or more years while others are anxious to grab hold of every new innovation that hits the marketplace. CAST,

LeadingAge, pioneering providers and technology vendors should work together to educate providers so they make wise choices and have realistic expectations about technology and the return on investment (ROI) they can expect after adopting technology-enabled services and supports.

Specifically, CAST needs to encourage providers to take a broader view of ROI and to recognize that not all ROI is financial. Rather than focusing on a financial return on their technology investment, providers need to invest in technology-enabled business models because these models support positive health outcomes.

Providers must recognize that they will soon be called upon to keep older adults healthy and independent in their homes rather than simply moving them through the continuum from independent living to assisted living and eventually to skilled nursing. In order to be successful, providers must measure health outcomes and invest in business models that emphasize independence. These business models will eventually pay off financially.

#### Need for Broad Partnerships

Providers in many health care sectors are seeking to increase care quality while reducing care costs. These common goals create a good opportunity for LTPAC providers to join with other partners in reforming current care and payment systems. Meaningful health reform requires broad partnerships that cut across a variety of settings and include home health care providers. Providers of long-term services and supports must also move beyond bricks-and-mortar settings to embrace new concepts like the "medical home."

If CAST members intend to participate in new models of care, we need to bring a consortium of providers to the table that includes home care providers as well as university researchers and federal agencies like the Department of Veterans Affairs. This consortium could advocate for a package of payment reforms that (1) reward the use of technology to deliver more efficient and effective care, and (2) allow providers to share in the savings that technology-enabled services and supports generate for public and private payers.

Multiple consortia of providers and their partners might operate at the state and regional level. To begin this state-based conversation, CAST should consider working through the National Governors Association to stimulate discussion about ASTs and enlist support for technology-enabled care models that reduce State Medicaid spending. Any successful initiatives at the state or regional level could be replicated on the national level once their effectiveness was demonstrated.

### **Research into Practice**

Many providers of long-term services and supports are passionate about addressing the challenges of delivering quality care at a lower cost. The new CAST video will stir those passions. But passions require a business model if they have any hope of being turned into sustainable practices.

Providers need to develop business models that support technology. They also need to collaborate with technology vendors and university researchers to advance innovation. These collaborations must include the end-users of technology, who can con-

tribute to the design, implementation and evaluation of new technology systems.

### **Data Sharing among LeadingAge Members**

Larger continuing care retirement communities (CCRC) may dabble in experimental technology projects. But the real challenge comes when those CCRCs attempt to bring their experimental initiatives to scale over a relatively short period of time. As a first step in this process, providers must come together to share data about outcomes, aggregate that data, and translate it into meaningful benchmarks.

Encouraging this kind of data sharing could be challenging since providers operate in competitive environments. But it will be difficult to solve big problems unless we come together, think collectively about our business processes, and share our evidence while honoring the fact that each of us is taking a unique approach to the delivery of long-term services and supports.

Aggregating the data from multiple providers will help us tell a larger story about technology-enabled business models. A story that communicates our common goals, our business models, and our positive outcomes will make us more effective at the federal and state levels. It will also help us engage consumers through media coverage that connects with the consumer experience and sparks our collective imaginations.

## Appendix A:

### MAJOR CAST ACCOMPLISHMENTS FOR MAY – SEPT. 2012

- CAST co-directed and contributed to the “Aging Services Technology Study” which led to a report to Congress. The report provides a systematic framework for considering the existing evidence supporting the effectiveness of a diverse array of Aging Services Technologies (ASTs), information about ASTs that are under development, and those that are available outside of the U.S., thereby fulfilling the legislative mandates stipulated in the American Recovery and Reinvestment Act (ARRA). CAST had originally advocated for the study.  
<http://aspe.hhs.gov/daltcp/reports/2012/ASTSRptCong.pdf>
- Published “The Future is Now: Creating a Compelling Vision of Technology-Enabled Care Models for Today and Tomorrow” report of the Proceedings of the CAST Commission Meeting and held April 15, 2011, in Washington, DC.  
[http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/Future\\_is\\_%20Now.pdf](http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/Future_is_%20Now.pdf)
- CAST produced and released a portfolio of products to help members plan for, select and implement Electronic Health Records (EHRs). The portfolio includes:
  - An online tool for identifying products that meet an organization’s requirements.
  - An accompanying whitepaper that guides organizations through an interdisciplinary planning for EHRs process and defining the needed specifications.
  - A set of 13 case studies of providers’ implementations of EHRs.  
[http://www.leadingage.org/CAST\\_Releases/Online\\_EHR\\_Tool.aspx](http://www.leadingage.org/CAST_Releases/Online_EHR_Tool.aspx)
- CAST partnered with Ziegler, a LeadingAge Partner, on conducting the first Ziegler-CAST Technology Spending Survey. CAST published the results which show that high-speed connectivity ranks high on the list of technology priorities for long-term and post-acute care (LTPAC) providers. The survey ranks top technology categories Chief Financial Officers (CFOs) have invested in over the past 12 months, as well as technologies they plan to invest in, or increase investment in, over the coming 12 months.  
[http://leadingage.org/uploadedFiles/Content/About/CAST/Resources/Tech\\_Survey\\_Results\\_2012.pdf](http://leadingage.org/uploadedFiles/Content/About/CAST/Resources/Tech_Survey_Results_2012.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

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:

- **The Aging Services Technology Study** – The National Opinion Research Center and CAST completed this study, which was mandated in the HITECH act and funded

by the Department of Health and Human Services (HHS). The purpose of this study is to provide education on the potential value of aging services technologies, technologies under development and the barriers to their development and adoption, and to share the experiences of other countries with aging services technologies to learn from their lessons. The study concluded with a report to HHS, which submitted a report to Congress. The report is available at:

<http://aspe.hhs.gov/daltcp/reports/2012/ASTSRptCong.pdf>

- **EHR portfolio** – The EHR portfolio project was completed. CAST released a portfolio of products to help members plan for, select and implement Electronic Health Records (EHRs). The portfolio includes:
  - An online tool for identifying products that meet an organization's requirements.
  - An accompanying whitepaper that guides organizations through an interdisciplinary planning for EHRs process and defining the needed specifications.
  - A set of 13 case studies of providers' implementations of EHRs.

The portfolio has been very well received.

[http://www.leadingage.org/CAST\\_Releases\\_Online\\_EHR\\_Tool.aspx](http://www.leadingage.org/CAST_Releases_Online_EHR_Tool.aspx)

- **iKOP project with the University of Utrecht** – CAST continues to participate in this project

and CAST Executive Director serves on the steering committee.

- **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 was held in December to discuss next steps, where CAST Executive Director emphasized the importance of demonstration projects to evaluate existing technologies in partnership with aging services providers, in addition to the focus on discovery and technology development, as well as the importance of incorporating example projects into the overall proposal to establish the research infrastructure.

## CAST FEDERAL POLICY UPDATE – 2012

Election-year mania is in full force and effect in the country, but election-year inertia is in full force and effect in Congress! As we noted in our April update, during a Presidential election year very little that is not vital usually gets done, and that pattern has persisted.

For our purposes, the major must-do legislation is the budget for FY 2013, which affects discretionary spending – HUD housing, Older Americans Act, nutrition and meals and transportation programs and the like, as well as avoiding cuts to Medicare and Medicaid.

### Budget FY 2013

While the appropriations committees in both House and Senate have been working on appropriations for FY 2013, only the House HUD/Labor bill

has passed the House, and no bills will come to the floor in the Senate. Since a budget has to be passed by Sept. 30 to avoid a government showdown, and given the negative reaction to the cliff-hanger last summer and fall, both parties and houses have agreed to a six-month Continuing Resolution, based on budget figures established last year in the Budget Control Act of 2011. The House passed a CR on September 13, which essentially sets the federal budget at FY 2011 figures through March 13, 2013. The CR is now before the Senate. Congress's goal is adjourn by the 23rd of September through the election, so that leaves 3 days as of this writing to accomplish this goal.

### Medicare

Congress has not addressed the Medicare (or Medicaid) programs this year; we don't expect any major, substantive debate to hold until the new Congress and Administration. However, Congress does have to address Medicare payments to physicians (the ever-popular "doc fix") before the close of the calendar year. Each year Congress must decide whether to implement the spending formula enacted in 1997, which would result in steep cuts in Medicare payments to physicians, or not, which costs billions of dollars. Assuming, realistically, that Congress is not going to reduce rates to physicians, the question is how to pay for the "fix". Historically, payment comes from some other part of the Medicare system, and each year LeadingAge works to prevent payments from coming from skilled nursing and home health. In addition, caps to payments for therapy for Medicare beneficiaries, also ordered in 1997 and never implemented, come into effect at the end of the year unless the current process that allows for exceptions to the cap is extended. This is another key advocacy agenda item.

## Lame Duck

The “doc fix”, therapy caps and other expiring provisions (Bush-era tax cuts, for example) all have to be resolved by Dec. 31, during the “lame duck” period (that period in Congress after the election, when the old Congress is about to be replaced with a new Congress). Another key issue that will have to be addressed is whether the budget for discretionary programs like HUD housing, OlderAmericans Act, transportation, meals, etc. will be reduced pursuant to the Budget Control Act provision known as “sequestration”. Sequestration is the process that goes into effect at the beginning of 2013 because Congress could not come to agreement on cuts in programs and/or increases in revenues last year. Under sequestration, defense and non-defense programs each take about an 8% “hit”, and Medicare programs are reduced by 2%. Poverty programs like Medicaid are protected, but not affordable senior housing. There is extensive lobbying going on to eliminate, ameliorate, modify or otherwise avoid sequestration, particularly because of the impact on defense. LeadingAge supports a balanced approach to avoiding sequestration, and strongly opposes efforts to preserve the defense budget at the expense of domestic programs.

The only other legislation of interest to LeadingAge that appears to have a snowball’s chance of being considered in the lame duck session is HR 1543/S 818, the Improving Access to Medicare Coverage Act of 2011. This bi-partisan, bi-cameral legislation addresses a long-standing problem for Medicare beneficiaries. A beneficiary must be admitted to a hospital for 3 full days to be eligible for post-acute care SNF benefits. For a number of years, hospitals have characterized some beneficiaries as “under observation” instead of as “admitted,” so beneficia-

ries who need SNF care and are otherwise eligible have been denied Medicare payment. The legislation does not eliminate the 3-day rule but states that as long as a beneficiary has been in the hospital for 3 full days, regardless of how the hospital bills Medicare, the beneficiary would be eligible for SNF benefits post-discharge. We have been told that there is a slim chance that this legislation could come up during the lame duck, and we are vigorously advocating for it.

Other legislation that we have reported on in the past, in particular the FITT Act (Fostering Independence Through Technology) and reauthorization of the Older Americans Act, have little to no chance of moving. There are a number of bills in the Senate to reauthorize the OAA, but no movement in the House. We would note that there is interest in including funding for technology in at least one of the OAA Senate bills (various members of the Senate introduce bills with provisions that interest that member, and then the bills would be merged and become amendments to the OAA). However, no action is going to happen, and these bills will likely be reintroduced next year.

So for the balance of the year: Congress will adopt a Continuing Resolution to keep the government running through March of 2013 (or so the rumor goes); address the “doc fix” at least for another year; presumably include extension of the therapy caps exceptions process for another year; maybe fix the “observation day problem”; decide whether sequestration will go through on January 2, 2013 and if not, why or how not; and address expiration of the Bush-era tax cuts. What and how these issues will turn out will depend in large part on the results of the Presidential election, and to a lesser extent, on the results of the Congressional and Senate races.

## CAST STATE POLICY UPDATE – SEPTEMBER 2012

### State-level Technology Activities

In its continuing effort to track technology activities in the states, CAST facilitated two webinars through the CAST State Technology Policy Workgroup over the past few months. The first provided information about the Colorado Regional Health Information Organization (CORHIO) and its LTPAC challenge grant, and the second reported on the results of a survey on the adoption and use of HIT in nursing homes in Minnesota.

#### Webinar by Pamela A. Russell

*Development and Outreach Manager LTC,  
Colorado Regional Health Information  
Organization (CORHIO)*

The webinar provided definition of Health Information Exchange (HIE) as the ability to electronically exchange patient health information including lab/pathology results, imaging/radiology reports, scheduled orders, transcribed notes, and continuity of care documents (CCDs) when needed for patient care.

The goal of CORHIO is sharing health information for all individuals in every Colorado community and promoting a community-based HIE. CORHIO serves 29 hospitals under agreement (20 are already connected to the HIE), 767 office-based physicians/providers being connected and has 902,485 unique patients with clinical info in the HIE.

CORHIO received supplemental funding from ONC under the Challenge Grant program to:

1. Encourage LTPAC provider participation in community-based HIE
2. Define and implement community goals, processes and protocols for LTPAC transitions; integrate with Clinical Advisory Committees
3. Develop a statewide template and standards for improving LTPAC transitions, using HIE as an integral tool

CORHIO's ONC grant targets communities in Boulder County, Colorado Springs, Pueblo/Canon City and San Luis Valley. Its goal is to pilot HIE with 160 LTPAC providers in the 4 communities.

More information on the LTPAC program is available on CORHIO's website [www.corhio.org](http://www.corhio.org).

#### Webinar by Dr. Darrell Shreve

*VP of Health Policy for Aging Services  
of Minnesota*

Dr. Shreve discussed the results of their survey on the adoption and use of HIT in nursing homes in Minnesota. The survey was proposed by Aging Services of Minnesota to update a 2007 Study by Stratis Health (Minnesota's QIO) and was conducted by the Minnesota Department of Health.

382 certified facilities were surveyed in November and December 2011. The response rate was 83% (316 of 382).

Survey questions covered status of EHR adoption, workforce needs, barriers to electronic exchange, clinical uses of EHRs, interoperable uses, types of information needed/wanted via HIE, and current exchange capability and need.

The survey revealed that 69% of facilities who responded had an EHR (78% among Aging Services of Minnesota members), up from 32% in 2007. EHR adoption was slightly lower among stand-alone facilities that were not part of a chain, at 59% (66% among Aging Services of Minnesota members).

The largest challenges for EHR adoption included costs to acquire/update EHRs, staff education/training, internal technical resources, product appropriateness, and effects on workflow.

In response to the question on the barriers to electronic exchange, 62% cited the unknown capabilities of others to send/receive, 44% cited the system's inability to generate/send/receive data in a standardized format and 33% cited the capabilities of others being limited or nonexistent. Only 5% felt there was unclear value on ROI.

The top three current clinical uses of EHR are for MDS, demographics, census (97%), document diagnoses, care plan, allergies (95%), and clinical notes, vitals (87%).

The top three current uses for alerts are medication reminders (62%), advance directives (60%) documentation and resident or condition specific activities, such as foot exam, (48%).

For interoperable uses, the survey found the top two uses were CPOE for nursing orders and eMAR at 36% and CPOE for physicians and med orders at 24%. Rounding out the top three was viewing lab results with 18%.

According to the survey, the types of info needed/wanted via HIE are history & physical (97%), clinical summary of care record (97%), lab results (96%), current/active medication list (96%), im-

munization history (95%), radiology reports (94%), and resident demographics (90%).

The webinar discussed the impact of the fact that LTC is excluded from federal incentive payments on adoption. It also emphasized that interoperability is minimal: CCHIT has certified only two EHR products (at the time of the survey) under its LTPAC standard, and while HL7 includes LTC items, those are not widely adopted by vendors. The study shows that the market for interoperability is not very developed.

## **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 and 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-plan-

ning software (41%). “Therapeutainment” technology mixing therapeutic or social interactions with entertainment—including gaming systems such as the Nintendo Wii—is used by 38%.

### State Updates

**LeadingAge Florida** – The Agency for Health Care Administration whose in the governance of Florida HIE has a HIE coordinating committee that met to reaffirm their position on continuing the governance of Florida’s HIE. They felt that it keeps stability in the HIE arena as it grows in the state of Florida. Through the 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 education of all the stakeholders including the patients. The patients need to know how the system works and its benefits. One of the concerns was the actual security of the different systems. They looked at the different regions of Florida and where their plans were in implementing their programs and the obstacles they’ve faced. The stages of development in implementation are immature and a lot of work 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.

## CAST HIT STANDARDS UPDATE

### Key Standards Initiatives and updates

- The LTPAC HIT Collaborative Roadmap was published in June, 2012. The Roadmap prioritizes action around care coordination, quality, business imperative, consumer-centered and workforce acceleration.  
  
<http://www.ltpachealthit.org/content/2012-2014-roadmap-hit-ltpac>
- Standards work in the area of care coordination continues through ONC Standards & Interoperability Framework (S&I) Longitudinal Coordination of Care Workgroup (LCC WG). This work builds on MDS based CDA work led by AHIMA and Geisinger HIE, and continuing development of CDA implementation of Plan of Care originating out of VNSNY. The committee currently expects to take its work through HL7 standardization later this year.
- Mixed messages continue to proliferate around certification. CCHIT certification for LTPAC organizations is available and several organizations have achieved the necessary credentials. Regulatory language is explicitly declining to consider such certification as satisfaction of meaningful use “certified EHR” requirements. While LTPAC are not direct recipients of HITECH funds this language introduces uncertainty into partnership discussions and is delaying vendor pursuit of certification. Effort is needed to close the gaps between current certification and regulatory

goals and to promote adoption and use of existing certification as a first-step.

- There is growing understanding of the need to incorporate LTPAC concerns in the quality initiatives being developed for meaningful use stage # criteria under HITECH. The collaborative is working hard to build awareness and cooperation between LTPAC and other health care quality stakeholders.
- Direct (Health ISP) deployments are increasingly opening up opportunities for LTPAC participation.
- Marketplace driven partnerships including Health Information Exchange, pProvider to provider initiatives and Accountable Care Initiatives are all driving formal and informal exchange activities enhancing standards development and adoption.
- It is important to note that Meaningful Use #2 guidelines have adopted “consolidated CDA” as the basic standard for health information exchange. This is in place of CCD and CCR.
- **Action Areas:** Coordination of Care, Transition of Care, Care Plan, and Quality Standards.





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