Accelerating Innovation:

HARNESSING THE POWER OF TECHNOLOGY FOR THE SUCCESS OF LTPAC ORGANIZATIONS AND THE PEOPLE THEY SERVE

Proceedings of the CAST Commission Meeting
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Washington, DC

REPORT

LeadingAge™ CAST
center for aging services technologies

ACCELERATING INNOVATION:

HARNESSING THE POWER OF TECHNOLOGY FOR THE SUCCESS
OF LTPAC ORGANIZATIONS AND THE PEOPLE THEY SERVE

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LeadingAge Center for Aging Services Technologies:

The LeadingAge Center for Aging Services Technologies (CAST) is focused on accelerating the 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

Table of Contents

Executive Summary

Majd Alwan
Executive Director
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Technology has changed every aspect of our personal lives and it has disrupted many industries over the past few decades. The aging services sector is not immune to this disruption.

We shouldn't fear technology or the disruption it causes. On the contrary, we must learn ways to harness technology's disruptive power for the success of our organizations and the people we serve.

This is our business imperative: to use technology to create new and innovative ways to provide long-term and post-acute care (LTPAC). This imperative is particularly timely, given the dramatic changes taking place in our health care system, the current pressures on our reimbursement systems, and the fact that every provider of aging services in this nation is being asked to do more for less.

Focus on Innovation

Because these trends are so important to LeadingAge members, the CAST Commission decided to focus its Spring meeting on technology-related innovations in the LTPAC field. We explored a variety of innovations affecting our field, including:

- **Innovations in payment reform.** CAST Chair Mark McClellan shared the latest developments in the federal government's effort to implement new payment systems that will revolutionize the way we deliver services and supports to older adults and the way we interact with our health care partners.
- **Innovations in technology development.** The Commission enjoyed hearing about the technology solutions that young innovators created during the LeadingAge HackFest last October. After representatives of four HackFest teams described their innovation, Commissioners asked questions, offered advice, and contemplated how they and CAST could support and accelerate similar innovations.
- **Innovations that are currently being implemented by LeadingAge members.** During a technology pre-conference symposium following the Commission meeting, five CAST members explained how they are incorporating technology into their care delivery systems to make their business models more efficient and cost-effective.

List of Participants

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Part 1
Introductions and Farewells

Introductions: The Innovations We're Most Excited About

What new project are you most excited about? That's the question CAST Commissioners answered at the beginning of their Spring meeting. Following is an overview of their responses:

CAST and LeadingAge Leadership

Kathy Martin, *CAST co-chair:* "My most exciting initiative is not really an initiative. It is getting to work on the LeadingAge Board and with all the leaders and innovators who belong to LeadingAge."

Majd Alwan, *CAST executive director:* "I'm excited about CAST's new workbook on strategic planning and strategic information technology (IT) planning, as well as our new initiative focusing primarily on functional assessment and monitoring of activities and behaviors."

Larry Minnix, *president and chief executive officer (CEO) of LeadingAge:* "I'm excited about Thrive, a LeadingAge initiative to ensure that the nonprofit sector thrives. It's a self-improvement program that helps an organization's board and leaders ask themselves the right questions. Of course, one of those questions is, 'Do you have a technology plan?'"

Technology Vendors

Frances Ayalasomayajula, *healthcare global senior manager at Hewlett-Packard Company:* "The most exciting thing I'm working on right now is remote patient monitoring, which we call 'health care in a box.'"

John DiMaggio, *CEO of Blue Orange Compliance:* "Having spent most of my career as a long-term care chief information officer (CIO), it is exciting to help long-term care organizations, providers, pharmacies and business partners achieve interoperability with acute care, and to ensure the privacy and security of all those initiatives."

Candace LaRochelle, *business support manager at eHealth Data Solutions:* "We are taking data analytics to a whole new level so our long-term care customers can communicate more effectively with hospitals to provide resident-centered care."

John Rydzewski, *general manager of Direct Supply Inc.:* "We just collaborated with the Milwaukee School of Engineering to build a technology and innovations center where we can do some co-development work with providers and suppliers."

Steve Safier, *chief executive officer and president of Health & Wellness Solutions Inc., at Panasonic Corporation of North America:* "We're excited about our new tool for social engagement and communication for seniors in assisted living."

Mary Senesac, *director of health systems at HealthMEDX*: "We are most excited right now about the work we're doing in telemedicine with the University of Pittsburgh Medical Center."

Providers of Long-Term Services and Supports

Dusanka Delovska-Trajkova, *CIO of Westminster Ingleside:* "We have received a grant to connect one of our communities to CRISP, the health information exchange of Maryland. As a result, we are now actually exchanging continuity of care documents."

David Finkelstein, *CIO at Hebrew Home at Riverdale:* "Our organization married its IT strategic plan with our strategic plan and then decided to outsource the technology portion of our IT department."

Steve Hopkins, *executive director of LifeChoice Solutions*: "Our most exciting initiatives are around creating sustainable models in home and community-based services, whether that means delivering care-related services or wellness solutions into homes."

Peter Kress, *CIO at ACTS Retirement-Life Communities*: "We are exploring and implementing technology that supports new ways of relating to our prospects and residents."

Amy Powell, *director of continuing services at Westminster Canterbury on Chesapeake Bay:* "Last October, we embarked on a changeover to electronic medical records. We also partnered with three local universities in Virginia Beach to study the impact of bedside touchscreen technology on our nursing home and dementia unit."

CAST University Members

Jeffery Kaye, *director of the Oregon Center for Aging and Technology:* "We are conducting randomized controlled trials in five retirement communities around Portland to determine how a remote monitoring computing platform may actually prevent or delay transitions to higher levels of care."

Jon Sanford, *director of the Center for Assistive Technology and Environmental Access at Georgia Tech:* "Our most interesting projects are related to linking functional assessments of gait, posture and balance to actual activity performance. This allows us to identify the trajectory of decline among older people and then intervene in home environments."

Farewells: Why CAST is Important to LeadingAge

Larry Minnix
President and Chief Executive Officer
LeadingAge
Washington, DC

Larry Minnix announced recently that he would retire as LeadingAge President and CEO at the end of 2015. During the CAST Commission Meeting, Minnix bid farewell and reflected on the role that CAST can play in helping LeadingAge fulfill its mission.

LeadingAge is not a trade association. Our original documents, created 55 years ago, say that we are a membership organization that exists for the purpose of the people we serve. In short, LeadingAge is a public benefit organization.

We are also a quasi think tank, a quasi crucible of innovation. We are pollinators. Part of our objective, as we "expand the world of possibilities for aging," is to identify and showcase creative ideas that are going to make a difference.

The role of LeadingAge is to make our field better, and to do it quickly. We want to be a catalyst for change. We want to be innovators. We want to create new ideas and help get them to the marketplace. CAST can lead the way because it is a thought leader.

Thank you very much for your creativity. It's not necessarily the products you develop that are most impressive. It's what the products represent.

In short, you are helping us think differently about our work.

You know better than anyone what technology can do for older adults. Technology used to be about gadgets and gizmos and fun and games. Now it is about helping people better manage their lives. It's about improving quality and reducing costs. It's about keeping families connected in the most difficult of circumstances.

Technology is changing the world of possibilities for aging, and that's what LeadingAge is all about. By helping us continually explore these possibilities, you keep our organization on course. I hope you will continue doing that important job for many years to come.

Part 2
Payment Innovations: Trends LTPAC Providers Should Watch

Mark B. McClellan, MD, Ph.D.
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CAST Co-Chair Kathy Martin and CAST Executive Director Majd Alwan facilitated a far-reaching discussion between CAST Commissioners and CAST Chair Mark McClellan. The following is a summary of the question-and-answer session.

Value-Based Payment Timelines

The Department of Health and Human Services (HHS) recently announced an accelerated timeline for moving our health care system to value-based payment purchasing. What can you tell us about that timeline? What is your advice for providers of long-term and post-acute care and services?

The announcement and timeline that came from HHS is a reminder that we are in the midst of a long journey toward value-based payment purchasing. But rest assured that value-based purchasing is here and it is going to become a permanent feature of Medicare, Medicaid and other health care financing.
The significant thing about the HHS announcement is that it came directly from Secretary Sylvia Burwell, not just from the staff at the Centers for Medicare and Medicaid Services (CMS). The announcement also highlighted goals and a timetable that go far beyond the end of the Administration in 2017.

I want to encourage you to think about what is really happening here, and what it means for the day-to-day work of your organizations. Secretary Burwell talked about building out what she called "alternative value-based payment models" so they make up 30 percent of all Medicare payments in 2016 and 50 percent of payments by 2018.

These numbers may seem like a really big shift until you understand we are actually not that far from reaching those goals. For example, fee-for-service payment adjustments are already part of payments to physicians, hospitals, skilled nursing and home health providers. If current trends continue, we will soon hit Burwell's 30-percent goal through these two programs:

- **The Bundled Payments for Care Improvement Initiative:** This alternative fee-for-service program doesn't yet represent most of the payments to hospitals and skilled nursing facilities, but many providers are trying it out in clinical service areas.
- **The Medicare Accountable Care Organization (ACO) Program:** Medicare ACOs have been flying a little beneath the radar. But we are getting close to having about 20 percent of fee-for-service Medicare beneficiaries enrolled in an ACO.

The vast majority of ACOs in Medicare have upside-only risk. This means that they still get all their fee-for-service payments but, in addition, they have a second payment track that holds them accountable for some health-related and quality-related measures for the populations they serve.

Our payment system is really changing. Watch for steps to move the weight of Medicare ACO payments away from fee-for-service and into alternative payment models. Watch for more ACOs to move into up-side risk plans that bring significant financial exposure if they don't really get costs down. This includes partial capitation models or models that tie fee-for-service adjustments to clinical outcomes that are truly meaningful for patients.

In addition, keep your eye on new payment models that are already being implemented in Medicare and state Medicaid programs and the private sector. These models are a better indicator of how much our payments will change in the future.

Health Reform and the New Congress

Now that control of the U.S Senate has changed hands, what do you see happening with health reform, payment reform, ACOs and other programs that affect long-term and post-acute care (LTPAC) providers?

Everybody in Washington and many people around the country are paying attention to how the Supreme Court will deal with the latest challenge to the Affordable Care Act (ACA). This is a different challenge than the one that the Supreme Court decided in 2012. It is not constitutional. Instead, it is the result of bad drafting and a lack of clarity.

The Supreme Court case focuses on whether subsidies to buy insurance should be available in all 50 states, or only in states that have taken action to set up their own health care insurance exchanges. There is going to be a Supreme Court decision on this case in June.

ACA supporters are concerned about what will happen if subsidies are overturned in the 34 states that aren't running their own exchanges. I guarantee the Administration is working right now on steps that these states can take to become overseers of a federally administered exchange. In addition, you will see the Administration calling immediately and strongly for legislation that will extend the subsidies to people in these 34 states. Millions of these people already have coverage through the ACA.

This action by the Supreme Court to overturn the subsidies would also force Republicans to come up with an alternative. For example, a bill from Sen. Orrin Hatch (R-UT) proposes a long-term alternative that would work like Medicare Advantage. There would be a subsidy for getting coverage, there would not be a mandate, and you would pay a penalty if you added more coverage after you were first eligible. A short-term path would enable people to transition from the current version of the ACA exchanges to this more competitive approach.

Most close observers put the odds on the Administration to get out of this with a win. Republications may try to put an alternative together, but they will not get support from Democrats in the Senate. That alternative would certainly be vetoed by the President, maybe leading to some short-term patches for the next 6 months while Congress tries to work out an alternative that enables people to continue their coverage at least through the end of 2015. Expect to see another extension until 2017, and then litigation on this issue after the election.

This latest development continues to keep the ACA front and center. The ACA is not going to be a lead issue during the Presidential election, but if Republicans win the White House you can expect significant revisiting of some of its provisions. The Republican alternatives will be something to watch over the next few months.

ACO Results

What can you tell us about the latest evidence from ACOs?

The Medicare ACO program has been around since 2012 and the overall big picture is that the program is doing quite well in terms of higher levels of measured quality.

The results that are subject to criticism are on the cost-savings side. The Medicare ACO program has yielded only about one-percent savings compared to its benchmark targets. But keep in mind that these are first-year results. ACO activities represent longer term investments that take more time to show up.

ACOs in the private sector show a bit of savings in the first year, more in the second, more in the third, and more in the fourth. As ACOs get a better handle on what's going on with their patients, they have a greater capacity to see savings and improvements in outcomes.

It's interesting to note that most of the first-year savings in the Medicare ACO Program came from about 20 percent of the ACOs. These ACO have some interesting distinguishing characteristics:

- They tend to be located in areas where Medicare costs are high to begin with. In those areas, it may be easier to take some pretty easy steps to get costs down.
- They tend to be smaller. Smaller, physician-led ACOs tend to do better in terms of getting more saving on average, because they do not carry out complicated interventions.
- They take simple steps to reduce costs. These ACOs work hard to manage their patients and their post-acute care provider partnerships. More of these ACOs are recognizing the importance of post-acute care, not just in preventing hospital readmissions, but in preventing hospitalizations in the first place.
- They focus on the 10-20 percent of patients who have the highest expected cost and the highest risk. It's important to manage patients with diabetes and high blood pressure, but it's hard to get measurable and significant savings over the short-term by preventing complications from these conditions. That's because those complications tend to appear two or three years down the road. On the other hand, an ACO that can keep high-risk patients out of the hospital for the next six months could see a real payoff. ACOs that took this approach found ways to address problems without sending patients to the hospital. This experience could provide an incentive for ACOs to work more closely with post-acute and long-term service providers in the future.

ACOs and Telehealth

We know that CMS recently solicited public comments on proposed rules for Shared Savings ACOs. One of those rules focused on waiving some current restrictions on telehealth reimbursement. Is this an indication that CMS and the Center for Medicare and Medicaid Innovation (CMMI) are starting to see the value of telehealth?

CMS has received a good amount of feedback from ACOs about why they aren't able to do more to transform care. Some of the feedback is related to the fact that if you are a Medicare ACO, you can't use tools like telehealth to do remote monitoring for your high-risk patients.

Similarly, ACOs don't like the Medicare's policy that covers a post-acute care stay only after a patient has been in an acute-care hospital for three days. That restriction is a barrier to connecting patients with services that could keep them out of the hospital in the first place.

ACOs are asking for more flexibility so they can really change the way they deliver care. And CMS has really listened. It is sending signals that it is going to incorporate more flexibility into the next version of the ACO program. In addition, CMMI has announced the "Next Generation ACO" program. ACOs in this program will be able to waive the three-day hospital stay requirement for telehealth, among other things.

There is a catch, of course. In order to be in this program, an ACO has to move away from fee-for-service payments toward something like partial capitation and real financial accountability. The idea behind this new program is that the farther you are from fee-for-service, the less you need the kinds of restrictions that are imposed on fee-for-service coverage to prevent overspending and inappropriate care.

The IMPACT Act

Can you give us your read on the progress of IMPACT Act planning and implementation?

I know that CMS is moving ahead on developing the IMPACT program. The question is how long it will take and how hard is it going to be to get it right. My main worry relates to the compatibility of this program's timeline with everything else that is going on in payment reform.

The IMPACT process is projected to be ready in 2022 or 2023. But there are signs that we could see more fundamental reform well before then. We may find ourselves in a situation where the real driving force for change in post-acute care will not be IMPACT. We may see more significant change coming when physicians, hospitals and other health care providers move in a more serious way into fundamentally different payment models.

Don't wait on the current IMPACT timeline. Instead, look at some of the things that are happening around the next version of the Medicare ACOs, around Medicaid, and around CMS support for payment models that are quite different from fee-for-service. These initiatives may bring about larger changes, way ahead of the IMPACT schedule.

ONC and the Benefits of Health IT

We're seeing, at least in theory, emphasis from the Office of the National Coordinator for Health Information Technology (ONC) on LTPAC and long-term services and supports settings. This was particularly obvious in ONC's latest strategic plan. However, we're not seeing ONC taking many concrete steps to address issues in LTPAC settings. In your opinion, what is the future of ONC and its health IT programs in 2016 and beyond, especially after Medicare's Electronic Health Record (EHR) Incentive program ends in 2016?

Across the clinical spectrum, people are asking the same question: When are we going to start seeing some of the real clinical benefits of health IT?

Unquestionably the Meaningful Use payments that are part of the EHR incentive program, as well as ONC's policies on interoperability, have had an impact. Most hospitals now have EHR systems. A growing number of physicians also have them. In addition, some areas of care, including ePrescribing, are clearly making a difference.

But there is a lot of frustration out there.

I know LTPAC providers are frustrated that they weren't even part of the Meaningful Use program. But some of your colleagues in physician practices feel equally frustrated because they have spent a lot of money on IT

systems that aren't effectively communicating with one another and haven't helped them reduce their day-to-day data-entry burdens.

We need to strive for more direct emphasis on achieving these outcomes. ONC needs to make the roadmap much more practical. We need to do more than just create standards. We need to actually demonstrate that data are becoming liquid and moving among providers to achieve a clear and meaningful clinical benefit.

Conclusion

I want to thank all of you who are part of CAST. With help from Majd and the rest of the staff here at CAST, and with the support coming from all of you, CAST has produced many very useful outlays. I know this is hard work, but it is a real pleasure to have the opportunity to do it with you. It is going to make a big difference.

Part 3
HackFest: Shining a Spotlight on Young Innovators

For the second year in a row, LeadingAge sponsored a HackFest during its October 2014 Annual Meeting and EXPO in Nashville, TN. HackFest encouraged teams of young inventors to define a challenge facing older adult; brainstorm a solution to address that challenge; build a tool through storyboarding, designing and coding; and create a 15-minute presentation describing their tool's feasibility, marketing and potential revenue. A Council of Elders, and coaches from the aging service field, were on hand to advise each HackFest Team.

HackFest was co-sponsored by LeadingAge Gold Partner Ziegler and The Asbury Group, a LeadingAge Business Associate. A team of judges selected the winning technology based on its originality, usability and feasibility.

Representatives of each winning HackFest team presented their technology solution during the Spring meeting of the CAST Commission. Following is a summary of those presentations.

Grand Prize Winner

Team Excite: Gaitmaster

Bob Burke
Lauren Sims

Falls are a major symptom of decline among older adults. One in three older adults fall each year. About 20-30 percent of people who fall will suffer moderate-to-severe injuries, including lacerations, hip fractures and head traumas. A fall can often result in loss of self-confidence, fear of falling and loss of independence.

The most common risk factors for falling include gait deficits, a history of falling, muscle weakness and poor balance. Team Excite wanted to change some of those markers by creating a technology solution aimed at predicting increased fall risk early enough to allow clinicians to implement strategies to improve gait and prevent falls.

Gaitmaster

GaitMaster is designed to use the Xbox Kinect to measure an older person's gait, walking velocity, and movement of the hips, knees and ankles. This information can help physicians, physical therapists and discharge planners assess an individual's risk for falling and measure that person's progress during physical therapy. The tool's ultimate goal is to reduce hospital readmissions among older adults and provide them with a higher quality of life.

After the Xbox Kinect is connected to a computer, the individual walks an L-shape path within a 10-foot by 10-foot area. The Kinect creates an avatar of the person, which serves as a baseline. Subsequent tests add to a clinician's understanding of how the person's gait has changed over time.

Advantages of the Gaitmaster

The Gaitmaster assessment is quick and easy to perform. The solution's low cost makes it possible to repeat the gait assessment as frequently as necessary. As a result, the tool can continue to be used to assess the individual throughout the physical therapy program, and can help therapists assess whether their interventions are working and how they might be improved.

Costs

An organization would pay approximately $4,750 for the Gaitmaster technology. This price would include the cost of the Xbox Kinect, the software developed by the HackFest team, and training for employees. Licensing and maintenance fees would probably start at $1,000 a month and decrease over time.

Runner-Up

Team Adage: Promoting Activity Safety and Security (PASS)

Amanda Horne
Liberty Pertiwi
Jonathan McCottry

Research suggests that walking speed decreases with age and is associated with fall risk, mortality, disability cognitive impairment and institutionalization.

A person who walks at less than one meter per second is 28-percent more likely to experience a fall. Individuals who walk at a rate that is less than .7 meters per second are 54-percent more likely to fall. For every .1 meter per second decrease in walking speed, there is a seven percent increase in the likelihood of experiencing a fall.

An older person who walks at a rate of one meter per second or greater can be completely independent. However, once that person's walking speed declines to .6 meters per second and lower, the ability to remain independent decreases.

The PASS System

The PASS system developed by Team Adage measures how quickly an individual walks from point A to point B. The basic PASS setup would involve two iPads, one located at point A and the other at point B. The tester would press "start" at point A and "stop" at Point B. Walking speed between those points would be recorded by and stored in the software application.

An automatic PASS system would use a fob and sensors to measure walking speed. Individuals would carry the fob as they walked through particular areas of an assisted living community, for example. Sensors in those areas would locate the fob and assess how long it took each fob carrier to move from one sensor (Point A) to another (Point B).

A "premium" version of the system called "PASS Plus" would include a web application that allowed the individual and his or her family members to monitor gait speed. The PASS Plus would also allow clinicians to calculate a "Vitality Index" for the individual. PASS Plus systems equipped with a floor scale, a dynamometer, and an algorithm would be able to use measurements of walking speed, energy level, weight, level of exhaustion, and grip strength to calculate the Vitality Index. A score on the index would predict the individual's risk for falls and cognitive decline.

The fob could also track a resident's location to determine when and where a fall took place. PASS might eventually be programmed to monitor vital signs like blood pressure and heart rate, track activity goals and rewards, and facilitate audiovisual communication with a therapist. Physical activity data from other wearable devices, including Fitbits and smart watches, might also be incorporated into the PASS System.

Cost Structure

Team Adage estimate that an assisted living community might purchase the PASS system for $2,999. The program would carry a monthly subscription fee of $299.

Runner-Up

Team Primed: You Are Here

Nikhal Baviskar

Team Primed recognized that Alzheimer's disease affects not only the people who have the disease. It also affects people who live with and care for people who have the disease. This realization inspired the team to develop a website called "You are Here," which would:

- Keep family, friends and paid caregivers involved in the care of the person with dementia.
- Ensure that the person with dementia would not forget who they were and still are.

The team's website would feature a Community of Memories, which would provide an online repository of memories for people with Alzheimer's disease or a related dementia. The website would provide these individuals and their families with the ability to record video and audio, and to post anecdotes about the individual.

The information posted in the Community of Memories would also be very useful to nurses and other professionals who cared for the individual in an assisted living, nursing home, or other memory care setting. These caregivers could visit the website to gain a better understanding of the individual and his or her past. This knowledge could help strengthen the relationship between the individual and his or her caregivers, and help improve quality of care.

Family caregivers would use the You Are Here website to access their own online community. The website would also provide information and support to help caregivers carry out their responsibilities.

People's Choice Award

Team CarreFours: Living Well Together

Jacy Smith

A website called "Living Well Together," developed by Team CarreFours, would attempt to solve the housing shortage facing aging baby boomers by encouraging older adults to live with one another through co-housing arrangements. There are more 100 co-housing communities across the nation and that number is rapidly increasing.

Living Well Together

Living Well Together would provide:

- Education about co-housing and how it can benefit the baby boomer generation.
- Assessment and evaluation tools to help individuals determine if cooperative living was appropriate for them. The website would include exercises to help people understand what it takes to live with other people. Recognizing that it is not easy to give up your personal space, the exercises would encourage individuals to adopt a different way of thinking about their housing.
- A searchable database that would match potential residents with co-housing communities.

Features of the Database

Individuals would register on the "Living Well Together" website after they had successfully completed a "human verification process." Once accepted, the potential co-housing resident would enter information about himself or herself into the database.

A search of the database by a co-housing community would generate a profile of a potential resident, including information that would give potential roommates a general understanding of the person's personality and living requirements. Only registered members of the site would have access to these profiles.

Descriptions of the co-housing community, also posted on the site, would feature an interactive map that would show potential residents where the home was located.

Visitors would be warned to use the website and database at their own risk. They would also be encouraged to research the housing setting thoroughly, and to set up an in-person meeting, to ensure that the co-housing arrangement would be a good fit for the resident and the co-housing community.

Part 4
How Can CAST Promote Innovation?

After the HackFest presentations, the CAST Commissioners discussed how the Commission and CAST could support the development of innovative technologies in the field of aging services. Following are the comments of two CAST Commissioners: Peter Kress, chief information officer (CIO) at ACTS Retirement-Life Communities, and Stephen Hopkins, executive director of LifeChoice Solutions.

Peter Kress: Will Federal Regulation Limit Innovation?

ACTS Retirement-Life Communities is starting to look much more seriously at wellness. As the organization's CIO, I've been looking at how we might link technology to our wellness initiatives. This process has raised questions about how our field can reduce current barriers to implementation of wellness-related technologies.

The main barrier to this innovation seems to be the process that the Food and Drug Administration (FDA) uses to evaluate and approve technologies that provide users with anything that could be construed as a diagnosis. Developing technologies with that diagnostic ability, while extremely useful to those of us who want to assess cognition or gait, could require FDA approval. This would certainly add years of delay and added expense to the development process.

This is an interesting challenge for providers of long-term services and supports. Can we be satisfied with technology solutions that offer generic fitness and health insights—and, therefore don't require FDA approval? At what point do we decide that generic insights aren't enough and that we need greater levels of diagnostic ability so we can design programs based on those diagnoses?

I'm interested in whether there is a role for organizations like CAST to provide guidance on how we should be thinking about the evidence base of our work and how we can use technology to strengthen our ability to apply that evidence base.

Stephen Hopkins: Making the Business Case for Wellness

The innovative ideas that came to light during HackFest should serve as an important reminder that our job as aging services professionals is to create a business case for innovation within our organizations.

Preventing falls is an important goal that we should pursue with passion. But passion won't be enough to bring these technologies into everyday use. We also need to think about how fall prevention fits into our business models.

Why? Because at some time in the future, we will have to go to our chief executive officer (CEO) and convince her or him to spend $5,000 a year for a subscription to a fall-prevention assessment program like the ones that have just been described by our HackFest teams. Making that argument could be an uphill battle. Frankly, programs that promote healthy living don't yield immediate financial rewards for our organizations. Remember that we get our reimbursement for fixing things that are broken, not for preventing problems.

That doesn't mean that HackFest teams and other technology developers should stop trying to build a better fall-prevention tool. But these innovators need some guidance from us. They need to know how to make their technology innovations relevant to our business models and the reimbursement systems with which we work.

CAST can play a role in starting a critical conversation about how innovators make the assessment of gait velocity something that a CEO knows is a valuable part of the organization's business story.

Part 5
Preparing for the Future: Case Studies of Five Innovative LeadingAge Members

The March meeting of the CAST Commission took place the day before LeadingAge opened its 2015 PEAK Leadership Summit. Following the Commission meeting, CAST sponsored a pre-conference symposium that offered attendees a firsthand look at the latest technology-enabled initiatives being implemented by pioneering LeadingAge members.

The case studies presented during the PEAK symposium will be included in a case study collection that CAST will release in May 2015. The collection is an update of CAST's 2011 case study collection, entitled PREPARING FOR THE FUTURE: Developing Technology-Enabled Long-Term Services and Supports for a New Population of Older Adults.

Following is a summary of the symposium presentations.

Tracking Rehab Clients After Discharge

David Gehm
Chief Executive Officer
Wellspring Lutheran Services
Flint, Michigan

After the Affordable Care Act (ACA) became law, my board at Wellspring Lutheran Services asked itself an important question. We were eager to help hospital partners avoid paying penalties when their patients were readmitted to the hospital within 30 days of discharge. Our best strategy for being a good partner was to ensure that patients who came to our rehabilitation center from the hospital would not be readmitted to the hospital after leaving our center.

But we wondered: How can we find out how our rehab clients are doing post-discharge? And can we find out that information *before* we hear about it from an angry hospital readmissions director?

Prior to the ACA, we tended to cut ties with our rehab clients after we discharged them to home. But now, thanks to the ACA—and, frankly, for good care reasons—we need to care about how these clients are doing.

Data is king in the world in which we now live. We need to know if our client's are continuing to progress as we hope and expect after they return home. Most of us have no way of knowing that until something bad happens.

Wellspring Lutheran Services developed proprietary software called "We Care Connect" to help us obtain reliable information about our clients after they leave rehab. This software platform now drives a call center that provides us with real-time access to our clients, through a good old fashioned phone call for clients who prefer that, an email prompt for those who prefer that, or the use of a mobile app for those who prefer that.

We contact these clients in one of those three ways at 24 hours and 72 hours post-discharge, and then again at 7 days, 21 days and 30 days. This gives us the opportunity to ask important questions like:

- Do you understand your discharge instructions?
- Did you have all the medications that you need on discharge?

- Have you fallen?
- Have you had to seek non-emergency medical care besides your follow up visit?
- Do you have your pain meds?
- Did the home health agency visit you in the first 24 hours?

Yes or no answers to these trigger questions will prompt our system to immediately send an email to someone in our shop who is responsible for responding to and resolving the issue that has arisen. That staff member is alerted, for example, that Mrs. Jones left here three days ago without understanding her discharge instructions.

We have a protocol in place for responding and resolving these situations and the software lets us know when this follow-up takes place. The system will send emails higher up the chain if an appropriate action is not taken. This feature gives us both the accountability that we need and also the assurance that we are on top of things.

Benefits

The We Care Connect system has several benefits.

- **Families love it.** They know we have a system to make sure that whatever brought the client to rehab won't happen again. Clients take our call because they know it is designed to keep them safe and healthy and at home.
- **Our partners love it too.** Now we have very powerful data to share with our health care partners. This data is so much better than what we would get by sending out a survey to clients 30 days after discharge.
- **It is versatile.** This platform allows us to make other types of calls. So we use it to call home care clients, new housing residents, families in our hospice program, and new employees. We call new employees seven days out and ask a series of questions as part of our retention and orientation program.

Using Data to Provide Housing Plus Services

Nancy Eldridge
Executive Director
Cathedral Square Corporation
Burlington, Vermont

Stefani Hartsfield
Operations Manager
Support and Services At Home
Burlington, Vermont

When we first designed Support and Services At Home (SASH) in 2009, we operated the program at one, 82-unit housing community whose residents had a high level of need for services and supports.

Today, we operate SASH at 138 sites in Vermont. This includes all of our state's public housing authorities, mobile home parks, and Section 202 and Section 8 buildings. We now serve 4,400 participants representing the oldest and poorest Vermonters. We will be able to operate the program with funds from the Medicare Medical Home Demonstration Program through December 2016.

Through the SASH model, an inter-professional team of health care and service providers work with a housing site to help residents and nearby community members remain independent. The SASH team in each housing property is comprised of a full-time SASH coordinator and a SASH wellness nurse, as well as nurses, caseworkers, mental health professionals and service providers from community-based organizations.

Basically, SASH works to preserve the health and well being of housing residents by integrating the work of medical homes, hospitals, and key home and community-based provider organizations, including home health and mental health agencies and Area Agencies on Aging. We have a memorandum of understanding with 65 organizations that have agreed, among other things, to share information with us about patients and clients who live in SASH buildings.

Affordable housing providers in most communities are the first to know when a resident is having some complex mental health issues. Before SASH, a housing provider that called a mental health agency to get help for that resident wouldn't get very far because the housing provider was the individual's landlord. After SASH, housing providers and mental health agencies are on the same team. Housing providers are able to pick up the phone and get the help a residents needs. That's because SASH participants sign disclosure forms saying that they are willing to have us share this data with our partners, with the medical home, and with the hospital. This has made a world of difference in terms of how we care for our participants.

How Data Helps the SASH Program Work

The SASH program uses data in a number of ways:

1. We use a central clinical registry that is integrated with hospitals and medical homes. Health care providers populate the registry through automatic data feeds from their electronic health records (EHR). SASH doesn't have an EHR, so we manually enter data into the registry so hospitals and medical homes can access it.
2. We do a thorough assessment of each SASH participant. We enter this assessment data into the clinical registry, along with the very informed care plan that we have created based on that assessment. During the assessment, we collect information about medications, allergies, chronic conditions, advance directives and falls. We also conduct screenings around cognition, nutrition and other things. We use this data to help SASH participants identify their health risks and set measurable goals to address those risks.
3. We have the ability to aggregate our assessment data. We then take that aggregated data and line it up with a directory of evidence-based practices that we can bring into a property to address the health needs of a specific resident population.
4. We are also able to aggregate assessment data statewide so we can see major health trends. We can see, for example, if we are not doing a very good job of getting people to sign up for advance directives. Then we can decide that this is the next issue we need to tackle.

Outcomes

Initial findings from an ongoing evaluation of the SASH program shows that SASH has been able to reduce Medicare costs by $1,800-$2,200 per person per year in the second year of the program.

Being able to show outcomes like this has really made SASH relevant in statewide conversations with our health care partners. Now that we can show data about the health status of residents, we are welcome at the table.

Bringing Wellness Home

Denise Rabidoux
Executive Director
Evangelical Homes of Michigan
Saline, Michigan

Stephen Hopkins
Executive Director
LifeChoice Solutions
Saline, Michigan

Several years ago, Evangelical Homes of Michigan made a conscious decision to ask older adults some questions about how they wanted to live. The more questions we asked, the more inspired we were to look at a new and different market that we hadn't been serving: people who were already living in their homes. Consumers told us that, lo and behold, they wanted to stay in those homes.

That was pretty interesting to us. We had been marketing a "move-in" message to people who were boldly telling us that they would rather not move at all. We started thinking about doing new work. That new work became a continuing care at home program called LifeChoices.

In exchange for an entrance fee and a monthly fee, LifeChoices agrees to deliver a wide spectrum of services, including home care, to independent older adults who live in their own homes. Our wellness initiative is a huge component of our programming. We also provide environmental services, services to keep the home safe, wellness services and socialization.

This is a whole new ballgame for us. We are no longer simply reacting to illness and disability by providing services. Instead, we are delivering, orchestrating and scheduling services to help prevent illness and keep our members healthy and independent.

There are currently 50 LifeChoices members. The average age of members is 74, but we have members as young as 62 and as old as 92.

LifeChoice Solutions, a companion program, provides an "a la carte" menu of support products that promote wellness, safety and independence. These products include wireless technology for fall detection, and two health and wellness platforms.

Keys to Success

- **The right software.** We use many partners and we manage many prospects, so there is a large Customer Relations Management (CRM) side to both the LifeChoices and LifeChoice Solutions programs. Our vendors are very diverse, and range from a nurse to a plumber to a tech-support person to a carpenter to a driver. All of these services must be scheduled, recorded and billed. Evangelical Homes of Michigan needed a robust CRM program to meet this need.
- **Robust research.** We started on our journey by researching our consumer. We wanted to understand what older adults want so we could work to create a solution that works, based on their needs, wants and desires.
- **An innovative culture.** We have worked hard to create a culture of innovation. This culture has helped Evangelical Homes of Michigan to grow into an organization that is willing to do anything for anybody.

Reducing Isolation through a Virtual Senior Center

David Dring
Executive Director, Selfhelp Innovations
Selfhelp Community Services
New York, New York

Selfhelp Community Services houses about 1,300 people in nine different buildings across New York City. We also operate senior centers, case management organizations and community guardianship programs. We provide services to older adults living with Alzheimer's disease and their caregivers. We also implement an array of client-centered technologies including telehealth and a Virtual Senior Center.

Telehealth

Selfhelp has installed telehealth devices with electronic blood pressure cuffs, glucose meters, medication reminders and weight scales in clients' homes to keep track of their health status on a daily basis. Data is transmitted by telephone lines to a registered nurse at Selfhelp. The nurse reviews the data on a daily basis and alerts home health clinicians when an intervention is necessary.

The market for this basic telehealth technology has been expanded greatly through Selfhelp's Internet-connected telehealth kiosks. These all-in-one touchscreen devices, which are located in the lobbies of congregate housing communities, allow residents to manage their chronic conditions in a convenient and cost-effective way.

The kiosks are equipped with Bluetooth-enabled blood pressure cuffs, blood oxygen saturation measurement clips, and weight scales. Housing residents activate the kiosks with a swipe card containing information about the resident's health profile. The unit sends vital sign measurements to a telehealth nurse who will launch an appropriate intervention if those values are out of normal range.

Virtual Senior Center

Our Virtual Senior Center program is designed to combat isolation by linking homebound seniors electronically to senior centers, community-based organizations, and to one another.

This technology solution features an all-in-one computer with an interface that allows participants to participate in large activities at one of our senior centers and share experiences with a virtual community. Since 2010, the program has grown from 20 to 200 participants. Funding comes from grants, financial support from the City of New York, and a new pay-for-service model.

Our research has shown that the Virtual Senior Center program is addressing the isolation of participants. During a six-month study, we found that almost 40 percent of our participants increased their feelings of being connected. The program also increased perceptions of health status. Participants self-reported a better health status after being part of the Virtual Senior Center, even though they still had the same chronic conditions and were still living alone.

Plans for the Future

As we look to the future, Selfhelp would like to position the Virtual Senior Center as a platform that could be integrated with other technologies, including telehealth and remote monitoring tools. In addition, we would also like to use aggregated data we collect through our technologies to communicate our value to current and prospective partners and ensure the sustainability of the program.

Reducing Readmissions and Building Partnerships with Telehealth

Athena Lu Kreiser
Director of Strategic Planning
Jewish Home Lifecare
New York, New York

Jewish Home Lifecare offers a spectrum of aging services that each year serve more than 10,000 older adults in nine different counties in the New York metropolitan area. We offer home care, medical and social adult day services, senior housing, care management services, and sub-acute and long-term care in three nursing homes.

Our organization began using telehealth technology so we could receive more information about our clients on a regular basis. We began this adventure in 2002 with the goal of reducing our re-hospitalization rates for home care clients with congestive heart failure (CHF). Prior to the telehealth implementation, our home care clients with CHF had average re-hospitalization rates of up to 16 percent. Using telehealth, we were able to reduce that rate to below five percent.

A pivotal component of our telehealth program is the ability to dialog with clients. In addition to collecting blood pressure or weight readings, the telehealth units allow us to collect information about clients' falls, pain, palliative care, and chronic disease management. The dialogs are interactive, so clients receive feedback based on how they respond to a dialog question. We also include trivia questions to help keep clients more engaged in the process.

Based on our early success with telehealth, Jewish Home Lifecare began looking at ways to expand its use of this technology. We installed telehealth kiosks in our adult day health centers, which allowed our clinicians to have more focused interactions with clients and to streamline the type of coaching and teaching they provided. We installed similar kiosks in three buildings managed by Selfhelp Community Services. Individuals with cardiac conditions and diabetes who used the kiosks showed improved health literacy rates.

We have also used telehealth kiosks to reduce re-hospitalizations for clients in our sub-acute units and patients in a local hospital. Individuals who used the kiosks had lower re-hospitalization rates than patients who did not use the kiosks.

Telehealth Pilots

Jewish Home Lifecare continually explores new technologies. That exploration led to three recent pilots:

- We partnered with Panasonic to place a telehealth device in clients' homes. The Home Gateway uses an ordinary television set to take vital signs and ask dialog questions. Outcomes from the three-month pilot showed that clients achieved medication adherence rates of about 97 percent and decreased their rates of hospitalizations and emergency room visits.
- We worked with Panasonic to test a touchscreen tablet that helps home care clients self-manage their health conditions and connect to members of the health care team. Older users practiced on the devices while receiving care in our sub-acute units and then took the devices home with them when

they were discharged. At home, they used the devices to answer questions about their health status, collect and send vital sign data, manage their appointments and communicate with their caregiver.

- We are working with eCaring on an initiative that allows our home health aides to record information about a client's activities of daily living into an iPad program. A telehealth nurse monitors this information remotely and follows up with the client when necessary. During our pilot, the program allowed a managed care company to prevent hospitalizations by following up with members in a timely manner when health issue arose.

All of these telehealth technologies promote chronic disease management and illustrate the importance of patient activation measures and behavior coaching in conjunction with clients' data and responses. The challenge for organizations is to decide how they will act on all of this information.

Appendix

Major CAST Accomplishments

Oct. 2014 – March 2015

- Published *Strategic Planning and Strategic IT Planning for Long-Term and Post-Acute Care (LTPAC) Providers: A "How To" Workbook*, the first of a three-component Strategic Information Technology (IT) Planning initiative that CAST is undertaking. The workbook provides an overview and detailed explanations of strategic planning, strategic and operational IT planning, and IT infrastructure. Additional components will include a set of provider case studies, and online interactive educational modules that capture the strategic IT planning process and refer readers to the relevant sections of the Workbook, other tools and resources.
- Released the first-ever Medication Management portfolio of tools to help providers better understand, plan for, select and implement medication management technologies. The portfolio includes a whitepaper, a selection matrix comparing 15 products across 305 functionalities and features, an easy-to-use online selection tool, and a collection of three provider case studies.
- Published the CAST Commission Proceedings, entitled *Collaborating on Change: How Payer, Health Care and Academic Partnerships Can Advance the Missions of Aging Services Organizations*.
- Partnered with Ziegler on a second survey to explore technology adoption among the largest 150 members of LeadingAge.
- Continues to be recognized by think tanks and policymaking bodies as a key resource to help inform technology policy. For example, CAST Executive Director Majd Alwan was recently invited to participate in a workshop on aging by the President's Council of Advisors on Science and Technology.
- Continued to advocate for including long-term and post-acute care providers as active participants in health information exchange activities and other activities funded by the American Recovery and Reinvestment Act of 2009. Potential activities include state-designated Health Information Exchange 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 initiatives funded by the Health Information Technology for Economic and Clinical Health (HITECH) Act.
- Continued to support the efforts of LeadingAge state-affiliates to implement technology education, technology surveys aimed at gauging technology adoption, and other technology-related activities, including technology policy and advocacy efforts.
- Raised the visibility of CAST and its members in leading media outlets, including print and electronic newspapers, magazines, trade and industry publications.

CAST Research Update: March 2015

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

Strategic IT Planning

CAST released *Strategic Planning and Strategic IT Planning for Long-Term and Post-Acute Care (LTPAC) Providers: A "How To" Workbook*, the first of a three-component Strategic IT Planning initiative that CAST is undertaking. The workbook provides an overview and detailed explanations of strategic planning, strategic and operational IT planning, and IT infrastructure. Additional components will include a set of provider case studies and online interactive educational modules that capture the strategic IT planning process and refer readers to other tools and resources.

Technology Adoption

CAST partnered with Ziegler on a second survey of technology adoption among the largest 150 members of LeadingAge. The LeadingAge/Ziegler 150 (LZ 150) report revealed that:

- Three-quarters (74.7%) of the largest 150 not-for-profit senior living communities have adopted electronic medical records and/or electronic health records (EMR/EHR). A similar percentage (76.6%) of senior living communities have adopted electronic point of care or point of service documentation systems.
- The majority of LZ 150 organizations reported implementing some type of safety technology, including user-activated emergency response systems (75.2%) and access control/wander management systems (73.1%). A smaller percentage of LZ 150 organizations reported implementing automatic fall detectors (33%).
- In the area of health and wellness technologies, more than half (57.8%) of LZ 150 organizations reported having physical exercise and rehabilitation technologies.
- LZ 150 organizations have the greatest opportunity for enhanced technological capacity in three areas where adoption is lowest:
  - Telehealth/remote patient monitoring (4%).
  - Telecare/telemonitoring/behavioral monitoring (7.6%).
  - Medication monitoring technologies (21.2%).

Medication Management

CAST released its medication management portfolio of tools, which includes:

- A whitepaper explaining:
  - The different types of medication management technologies available.
  - The applicability of these technologies to different phases of medication management and various care settings.
  - The benefits of medication management technologies.
  - Potential revenue streams and business models that support these technologies.
  - The most important planning steps an organization needs to take to prepare for selecting and implementing a medication management solution.

- A selection matrix containing 15 products from 14 vendors, compared across more than 305 different functionalities and features.
- An easy-to-use online Medication Management Technology Selection Tool helps providers focus in on products that meet their business lines and include "must-have" features.
- A companion set of case studies focusing on the impact of using medication management technologies on care quality and outcomes.

LeadingAge Legislative Update: Jan. 23, 2015

Congressional Outlook

The 114th Congress convened Jan. 6, 2015. Because Republicans won a majority in the Senate, the leadership of the full Senate and of its committees has shifted to Republicans. In addition, Republicans have gained more seats on key committees in both the House and the Senate because of their expanded majorities.

In the next three months, Congress will work on two issues of paramount importance to LeadingAge and its members:

- **2016 Budget:** According to the Congressional Budget Act, the President is supposed to submit his budget proposal for the next fiscal year to Congress on the first Monday in February, which was Feb. 2 this year. From there, Congress is supposed to develop a budget plan, spending bills and, potentially, budget reconciliation legislation. Appropriations committees are expected to develop their bills during the spring, and hold hearings before the summer.

Last year, we had a reprieve from across-the-board spending cuts, known as sequestration, in the non-defense discretionary spending category that includes senior housing and home and community-based services programs under the Older Americans Act. Sequestration will return for fiscal 2016, however, unless Congress finds a way to pass spending bills in line with the caps contained in the Budget Control Act of 2011.

The cap on non-defense discretionary spending for 2016 means that programs like senior housing and community-based services will compete with other budget priorities like education, the environment and transportation for 2016 funding. Increases will be difficult to achieve and we probably will have to defend aging services programs against spending cuts.

Sequestration continues for Medicare reimbursement to health care providers. We will urge Congress not to extend this sequestration beyond 2024 and not to make Medicare cuts a piggybank for spending in other areas of the budget.

- **Medicare sustainable growth rate:** Aside from budget issues affecting Medicare, Congress once again will confront the flawed physician payment formula. The present, temporary "doc fix" expired on March 31. Before then, Congress passed a permanent correction to the physician payment formula.

  We had a direct stake in this issue because some areas of post-acute care reimbursement are tied to the physician payment formula. In addition, we will continue to push for Congress to include therapy cap reform or elimination in the doc fix legislation and to address the problem of observation days.

Senior Housing

Before adjourning in December, the 113th Congress passed a "cromnibus" fiscal 2015 spending measure. This bill gave Section 202 housing $420 million for 2015, which represents a $35 million increase over fiscal 2014. The $420 million total includes $70 million for service coordinators.

The housing with services demonstration project was technically zeroed out, but the bill allows $16 million above the $420 million given to Section 202 for "elderly housing."

Medicare

In the new Congress, we will continue working on the following outstanding issues for long-term services and supports:

- **Observation days:** A new bill will have to be introduced to require that all the time a Medicare beneficiary spends in the hospital will be counted toward the three-day stay requirement. We will continue working for this legislation, or alternatively, will work to resolve the issue under potential legislation relating to Medicare coverage of short hospital stays.
- **Therapy caps:** The exceptions process was set through March 31, 2015. Congress extended this process until Dec. 31, 2017 in the SGR Bill.
- **Post-acute payment reform:** The 113th Congress passed the IMPACT Act, Public Law 113-185, which requires the development of standardized patient assessment data and quality measures reporting across the spectrum of long-term services and supports. We will now be working on implementation with the Department of Health and Human Services and the Centers for Medicare and Medicaid Services.
- **Adult day services:** We anticipate reintroduction of legislation to authorize adult day services providers to be certified to provide Medicare-covered home health services. We will continue working for effective Medicare coverage of these cost-effective services.
- **Technology in home health:** The Fostering Independence Through Technology (FITT) Act, to provide incentives for home health agencies to use technology to remotely monitor the Medicare beneficiaries they serve, will need to be reintroduced. It will continue to have our strong support.

Medicaid

We may see renewed interest in Medicaid per capita caps and other spending cut proposals as Congress develops a budget for fiscal 2016. We will continue to oppose any Medicaid policy changes that would reduce federal Medicaid funding to the states.

Long-term Services and Supports Financing

We continue advocating, both directly and in coalition with other stakeholders, to develop a more effective financing structure for the services LeadingAge members provide. Our Financing Task Force report, *Pathways to Coverage,* is the foundation of our advocacy work.

Older Americans Act Home and Community-based Services

One of the very first bills filed in this Congress will reauthorize the Older Americans Act. Older Americans Act programs have operated for several years without official authorization. We have been working with numerous other stakeholder organizations to get reauthorization legislation passed by Congress. A bipartisan bill—S. 192—has been introduced by Sens. Alexander (R-TN), Murray (D-WA), Burr (R-NC), and Sanders (I-VT). It is similar to legislation that was introduced in the last Congress. The holdup last year was a dispute over the funding formula for states, but that dispute has apparently been resolved and is reflected in new language in the current bill. The Committee on Health, Education, Labor & Pensions was "marking up" the bill on Jan. 28. We are waiting for a House version.

Home- and Community- Based Services Programs: 2015 Funding

The "cromnibus" spending bill for 2015 provided funding at 2014 levels for these programs, some of which are under the Older Americans Act:

- Community Services Block grants - $674,000,000.
- National Family Caregiver Program (Title IIIE) - $145,586,000. (This program pays for adult day services, in-home care.)
- Congregate meals - $438,191,000.
- Home delivered meals - $216,397,000.
- HCBS grants to the States (Title III B) - $347,724,000. (These grants pay for adult day services, in-home.)
- Lifespan respite program - $2,360,000.
- Aging and Disability Resource Centers - $6,119,000.
- Low Income Home Energy Assistance (LIHEAP) - $3.39 billion. (This program provides home energy assistance for low income households.)
- Community Services Employment Program for Older Americans - $434,371,000.

The cromnibus bill provided $4 million in new funding for an Elder Justice Act initiative to encourage states to prevent and respond to elder abuse.

Long-term care for aging veterans and those wounded in Iraq and Afghanistan received $7.04 billion under the cromnibus. The funding includes both institutional and home-based care. The agreement provides $90 million for grants for the construction of state extended care facilities.

Taxes

There could be renewed interest in major tax reform legislation this year, possibly based on groundwork done in the last Congress. If Congress does not pass a tax overhaul this year, the issue's chances for congressional action will diminish due to election-year politics that will likely complicate the legislative process in 2016.

We will monitor the work on this legislation closely to make sure that current tax benefits for charitable contributions and tax-exempt organizations are preserved.

We also continue to work on extensions of expiring tax breaks, including the IRA tax-free rollover and the minimum 9% credit rate for the low-income housing tax credit.

CAST State Technology Update: March 2015

State-level Technology Activities

In our continuing effort to track technology activities in the states, CAST held two conference calls prior to preparing this update.

The first conference call featured a presentation by Scott Code and Majd Alwan on CAST updates and future CAST initiatives.

The second conference call featured a presentation on "Reducing the Use of Psychotropic Drugs and Improving Quality Of Life through Entertaining Technology-Driven Activities" presented by Jack York of It's Never 2 Late and Josh Hansen of WesternHome Communities.

State Updates: New York

New York Governor Andrew Cuomo signed into law a bill requiring private insurers to cover telehealth and telemedicine coverage starting Jan. 1, 2016. New York joins 21 other states in the country in providing "parity" between what is reimbursable by Medicare and what must be reimbursed by all other insurers.

The new law expands the definition of telehealth to include telephone and remote patient monitoring. It also defines the scope of eligible distant site providers to include:

- Physicians.
- Physician assistants.
- Hospitals.
- Dentists.
- Home care and hospice agencies.
- Nurses.
- Midwives.
- Podiatrists.
- Optometrists.
- Ophthalmic dispensers.
- Psychologists.
- Social workers.
- Speech language pathologists and audiologists.

Standards & Interoperability Update: March 2015

LTPAC HIT Summit & Roadmap

The annual LTPAC HIT Summit is scheduled to convene in Baltimore June 21-23, 2015. The collaborative continues to develop a new roadmap publication that will focus on the connected worker, connected person (patient), connected provider, health intelligence and quality, and evolving business imperative. There is a growing sense that the discussion is moving from creating the building blocks of interoperability to interoperating.

Meaningful Use and Regulatory Health IT

At its recent annual summit, the Office of the National Coordinator for Health Information Technology (ONC) described the current state of its efforts, as outlined in several recently released documents:

- *A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure* (June 2014) provides a useful overview of priorities and strategies to advance the impact of health IT.
- The HHS Health IT Strategic Plan has just completed its comment period.
- *The Nationwide Interoperablity Roadmap* and *2015 Interoperability Standards Advisory* were released in Jan. 2015 in draft and are now in the comment stage. The Standards Advisory will become an annual publication that will serve as the basic reference for standards.

These four reports provide a meaningful framework against which organizations can enhance their own plans for health IT and health information exchange. While significant ongoing standards work is necessary, this body of work supports the idea that interoperability efforts can move from early adopters and incentive-driven activities to more widespread application. The IMPACT Act provides additional timelines for developing common assessment and outcome measurement across hospital and post-acute care provider types.

Real Opportunities for Interoperability

Recent interoperability efforts and opportunities to engage long-term and post-acute care (LTPAC) providers have been driven largely by ad hoc, research- and grant-based, or Meaningful Use incentives. The U.S. Department of Health and Human Services recently announced accelerated targets for moving Medicare reimbursement from volume-based to value-based (50% target by 2018, 30% by 2016). We expect that LTPAC providers will increasingly participate in new kinds of partnerships requiring greater information exchange. In general, we are seeing LTPAC health IT vendors supporting interoperability with physicians, labs, pharmacies, payers and medical devices. They are also participating in simple health information exchange using continuity of care documents and direct secure messaging through a health information service provider.

CAST has historically provided leadership in coordinating the annual Interoperability Showcase at the LTPAC Health IT Summit. With the shift from concept, pilots and research toward production interoperation, CAST is exploring joint efforts with the CIO Consortium and the LTPAC Health IT Collaborative to develop, publish and showcase production interoperability case studies, implementation guides and operating practices.