

THE BROOKINGS INSTITUTION

HEALTH CARE REFORM AND OLDER AMERICANS:
ACHIEVING BETTER CHRONIC CARE AT LOWER COSTS

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Welcoming Remarks:

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PANEL I: PERSPECTIVES ON HEALTH CARE REFORM AND OLDER ADULTS:

Moderator:

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Panelists:

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P R O C E E D I N G S

DR. McCLELLAN: Good morning, everyone. I'd like to ask everyone to take their seats. That includes all of you back there at the back. Hello back there.

It's a long meeting room because we had such a good turnout this morning. So, we appreciate all of your coming, and we have a lot to cover today, so I'd like to get started pretty much on time. I'm going to give people about another minute to sit down. There are a bit more chairs up towards the front. Please make some new friends if you don't see somebody you know that you can sit next to. We'd like to get everybody seated. Thank you.

All right, while the rest of you are coming in, let me just again say welcome to everyone who made it today. We really appreciate the interest in this event and strong turnout that we've received. This is obviously a very important time in health care and in health care reform, particularly in health care reforms that all of you around the country who are working on these issues, thinking about these issues, can continue to lead. It's more critical than ever to work together to find effective and practical ways to truly reform health care, do what we call here at the Engelberg Center at Brookings real health care reform -- changing the way that health care works for the better.

This was a topic in the President's State of the Union Address last night. He emphasized that whatever the barriers and complications are in the legislative process, one fundamental fact had not changed, that we need health care reform and we need to find effective solutions to improving quality and lowering costs, and that was one the lines that got I think a bipartisan standing ovation last night.

Now we may not have complete agreement on all of the best ways to do that, but one area where I think there is tremendous opportunity is in improving the care of frail,

older Americans, many of whom have multiple health care needs, related support needs and are living with functional impairments. If you look at the numbers, this is where the numbers really matter for our health care costs and for the burden of disease in this country.

There are almost 11 million Americans who receive long-term services and support. About half of this population is over 65. The demand for these services is expected to double over the coming decades.

A recent paper in Health Affairs estimated that total spending on long-term care services in 2009 was close to \$150 billion, most of which is paid for by public programs, by Medicare and Medicaid, and obviously these services represent a substantial part of the spending in these overall programs. Between 1999 and 2007, spending on Medicaid finance long-term care and support services grew by 39 percent. In Medicare, expenditures on post-acute care increased by 75 percent over the same period.

And it's not just the spending on long-term services and support that matters. That spending, those services, the services that are provided formally and funded by these programs as well as those that are provided informally by many Americans who are family members and those they care for and about, account for a big impact on the overall health care cost burden in this country. After all, these are the individuals who have the most serious health care needs. They're the individuals who often have the hardest time navigating our current health care system, getting from one setting to another, really testing the limits of our current health care system in terms of its gaps in coordination of care and dealing with transitions of care and dealing with evidence-based opportunities to prevent complications of chronic conditions.

This is the population that's on the front lines, and it accounts for the bulk of those costs and opportunities for improvements in care.

This is the population where effective long-term services and community support that can promote independent, promote better quality of life, promote self-management, can implement evidence-based approaches to prevent complications of chronic diseases have the greatest opportunity for getting us more bang for the buck in health care, much more value for our health care spending.

This is the population that accounts for the bulk of costs, people with multiple chronic diseases.

This is the population that accounts for a substantial part of opportunities for improving quality of care. For example, in 2006, about one-quarter or 25 percent of all patients discharged from a hospital to skilled nursing facilities were readmitted to the hospital less than a month later. Meanwhile, about 40 percent of people receiving home health services are hospitalized annually, and 1 in 6 nursing home residents are hospitalized within any given 6-month period.

This is where the burden of disease is.

This is where the burden of health care costs are and where if we are going to get on a sustainable path, if we are going to find that kind of bipartisan solution that every member of Congress stood up and applauded for last night, this is the population that needs to be addressed effectively.

The good news is, and the reason we're here today is that if you look around the country, there are many promising reforms, models for reforms, ideas for reforms to solve this problem being implemented right now.

Today, we're going to hear about programs like independence at home and guided care, models that seeks to support older Americans with chronic conditions and complex health needs.

We'll discuss what's going on with community-based services, like aging and disability research center networks that are being effectively linked to the medical system in new ways around the country, blurring the lines between what's traditional health care and what's the most effective, personalized way of delivering care for these people with multiple chronic needs.

We'll hear about a range of new and emerging quality improvement and quality measurement programs, focusing on these core gaps in quality in our health care system, around transitions of care, around personal experience and satisfaction with care in a range of different non-traditional, non-institutional settings.

And to make these kinds of reforms most effective and sustainable, we're going to talk about what needs to be done in terms of payment reforms, financing policies, other policy changes, to make these better approaches to delivering care more likely to happen. What are the kinds of policy reforms that are needed to get these real health care reforms, to make our health care system higher quality and more sustainable?

And I'm sure we'll also talk about other aspects of pending health care legislation, the CLASS Act, the implications for quality improvement efforts in legislation of these kinds of policies and so forth.

So this is an effort to make sure that health care reform focuses where it really needs to focus if it's going to succeed, and that's on caring for these vulnerable, very challenging populations where we can have such an impact on quality of care and cost in our health care system. We're going to find and talk about new and better ways to measure the effects of these reforms on quality of care, on quality of life, on personal experience with care, on cost. We're going to talk about ways that this new evidence can be used to expand programs that actually work, maybe in conjunction with new steps to accountability for results in our health care system.

And so, as a result of all of this, whatever the final direction of health care reform legislation looks like, and I couldn't agree more with the President, that this issue is not going away and there's going to be further legislation in this area, there will be new opportunities for implementing and testing a range of new payment systems, of delivery reforms, of integrating financing in new ways, of taking other policy steps that will support effective reforms in health care delivery for vulnerable populations, including older adults with these kinds of functional impairments. And that's what we want to provide a foundation, a better foundation, a stronger foundation to support today.

I'm looking around the room, and I'm seeing not only a full room but what looks like some overflow at the back, and we'll try to do what we can to accommodate seats for everyone. But again, we really appreciate the strong interest in this meeting today. We've also got about 80 additional people participating via live web cast from around the country. We have an overflow room across the hall for people who want to find a seat, especially way at the back there again. Thank you very much for coming.

I know you all agree that this is a very timely meeting, and we value all of your input, and we're going to find ways to get it as we go through the day. We're going to be talking about practical considerations for implementing new payment delivery system reforms, for supporting the kinds of delivery, health care delivery reforms that I've just been outlining.

Now, in a second, I'm going to thank our sponsors and our partners in this important work, this ongoing work, to get to a better health care system, but first I want to provide a few housekeeping notes.

We are intending to make this event interactive. Each of the panels is going to start out with some opening remarks from our participants, but those are going to be relatively brief. You're not going to see much in the way of PowerPoints today. You're

going to hear about ideas, and you're going to hear about them concisely and very much in what we hope will be a crisp set of conversations -- conversations involving our panelists but also conversations involving you. So, as each of these panel discussions are continuing, we're going to take questions from all of you, or brief comments. If you'd like to ask a question, and a microphone will come to you. There's a lot of people with roving microphones around the room.

And I want to remind everyone that this meeting is being recorded, and it's being web cast live. So all of you should consider these discussions on the records.

And finally, for our speakers here today -- Nadia, if you could raise your hand there in the front row -- Nadia Nguyen is an extremely effective timekeeper. We are going to try to keep this on schedule to make sure we have plenty of time for that discussion that I just described.

So, again, thank you for coming today and I am very pleased now to thank and introduce two of our sponsors, our partners in this broad policy effort. That begins with Bruce Chernof, the president and CEO of the SCAN Foundation. I'd like to turn to Bruce for a few remarks right now. Thank you.

DR. CHERNOF: Well, first, I want to welcome everybody and say good morning. It's great to see all of you here today. We want to start by thanking Brookings in fact and, Mark, your leadership in bringing together folks.

This is an incredibly important time. It's an incredibly uncertain time. But the work that we're going to do today, that you all are going to participate in, is critical to taking the next steps in building a better system.

We're also very thankful to be here in partnership with the John A. Hartford Foundation.

The SCAN Foundation is a fairly young foundation. We're about a year and a half old. We focus specifically on advancing sustainable continuum of quality care for seniors. We are interested in doing that in partnership with the disability community. We care a lot about raising public awareness to kind of create long-term services and supports as a national public priority, thinking about realistic policy options around financing and delivery, and finally thinking about how you advance promising programs because at the end of the day you can have lots of wonderful ideas, but it's really about the folks who deliver the services and test those delivery models to make sure that they're both efficacious and effective.

And we are thankful that we have a partner like the John A. Hartford Foundation, who has been working in this area for many, many years, and not only in their programmatic work but in their workforce development work. I think that's a tremendous foundation for a young foundation like ourselves to build off of.

For us, we just see this as a critical issue at this point in time, and, as Mark alluded to, it's a federal issue. Nobody should miss the fact that long-term services and supports already is very much a public program, whether anybody wants that to be the case or not. Between the federal dollars that are spent in the Medicare program for long-term services and supports, even though technically Medicare is all about the 100 days and that's kind of the end of it, that's really not true. When you start to look at things like home and community-based services payments that are made as part of Part B, for example, it's much greater than people would imagine. So Medicare is already playing an explicit role and a fairly significant implicit role in a very inefficient, unrecognized way.

Then you have Medicaid, which really becomes the provider of last resort for those services that Medicare does not provide, particularly for those without other means or other insurance.

So you have this kind of disorganized program that's patched together, where there's already an enormous federal responsibility. So doing nothing is not a really functional option when you're already really engaged. There is an opportunity to build systems that deliver higher quality, that are person, patient, family and caregiver-centered, and actually improve outcomes, both from a quality of health and quality of life perspective.

This is also a very important state issue. So our foundation is based in California. And for those of you who are not from that coast, we're in real trouble in California, just in case anybody missed that. We are about \$20 billion short, give or take a couple billion, to closing our budget deficit, and that budget deficit stretches out in the future.

Our governor has proposed a strategy to start to close that gap, which would literally take several billion dollars out of the health and human services budget, a significant component of that out of services for frail elders and those with disabilities. That's an enormous problem. There is no other safety net for those folks who are receiving services.

And there are two really hard realities about taking those kinds of actions. One is it will immediately increase -- immediately increase -- within a budget year. So maybe not in the first four months, maybe not in the first six months, but certainly within six to twelve months, you're going to start to see your Medicaid costs increase because when there are no other safety nets available, it is the emergency room and the hospital beds that absorb those individuals, which is a terrible place to be unless you really need to be here. It's fine if you've got an acute problem, but if you have a housing problem, a supported services problem, that's not the right place to receive those services.

The other real challenge, and California being an example, is there's a subset of folks where skilled nursing facilities are a really good choice, but for many folks that's not their first choice. Most folks would prefer to stay at home, in their community, with their family. So we're not talking about aging in isolation here. We're talking about aging with family and with a community that you care about, that you keep the quality of life that you keep your self-definition, which is hard to do if you're moved from where you've lived for a long period of time.

Unfortunately, at least in California's experience, once you end up in a skilled facility, you're pretty much there. Our efforts at diversion have been not even modestly successful. And it's not for lack of trying. It's a really hard thing to do. Once you evaporate somebody's home in the broadest context, not just where they live, but the support around them and the community and network of friends and caregivers, both family and non-family caregivers, you lose. Recreating it is much harder than supporting it.

So, while there's been an expansion in California of home and community-based services, a fairly substantial one, and for folks who are genuinely needy, that hasn't also translated into a decrease in nursing home beds.

So one of the things that I'm personally really concerned about, and I think California is a reflection of where other states are, is that we're going to see a degradation of services, particularly as states face their budget crises. If the FMAP increase that existed in ARRA funding goes away, that will create yet another cliff within publically funded programs. We're going to face a really important challenge in providing services, and those services that are entitlements face the biggest challenges of all. So this is not just a federal problem, but it's really a states problem, and California is just a harbinger I think of what other states are facing and will face.

Our message here I think is kind of simple today, that long-term services and supports are part of a thoughtful payment reform discussion, and what we really appreciate in Mark's leadership and Brookings's leadership is to help begin that discussion.

Somehow, payment reform gets kind of ratcheted down pretty quickly to what about the acute care event and just a little bit around that, or maybe that and a little bit of post-acute stuff and you're good. You know that's true to an extent, and that's an important discussion, but it's not the entire discussion. And frankly, the best way to get somebody out of a hospital and keep them out of a hospital successfully is a strategy that will help them remain at home, whatever that home is, and it could be a group setting -- it's not necessarily a house or an apartment, but whatever their home setting is -- successfully. That is the best way to not then reabsorb another round of acute care costs for a failed transition.

The single most difficult time for a patient, the single greatest risk is when you have a transition of care. So I'm a general internist by training and practiced for a bunch of years before getting into this life. It's always clear when you're in practice. It's not getting into the hospital that's hard. It's not the move from the emergency room to the hospital bed; that one is the easy step. But it's the step from an ICU to a floor bed, and the single most challenging step is from a floor bed back into the community and what are the systems of supports that make that successful.

I think one of our challenges today then is to think beyond just the medical tools that are a part of that transition but also the social tools that are part of that transition because a thoughtful investment there can actually lead to a meaningful transition -- one that's about quality of life, and one that's about personal and individual self-determination, and one that's also about quality of health.

I think that we see the current dialogue here in Washington as being challenged maybe at the moment, but this has been a very fruitful year for long-term services and supports. If you look at what's in both the Senate and the House bills, whatever happens to them, I think there are many more things than one might have imagined would be in those that are valuable for those who need long-term services and supports.

We included some work from our foundation, just sort of looking at a side-by-side of both the Senate and House bills, and we do believe at a certain level Pandora's box has been opened to a degree in a pretty significant way. Whatever comes of this, we hope that the acknowledgements of these issues sort of points out to the delivery system discussion, the reform discussion, the value of long-term services and supports as part of a comprehensive approach to health care reform, and a comprehensive approach to thoughtful payment reform.

We really, at the end of the day, think that this notion of helping people settle back into their homes, homes in that largest context, in terms of community, in terms of place of where you live, in terms of support system, is what will really help make the health care system overall more successful, more efficient and more effective.

We thank you all for being here today. We thank the presenters for their hard work. And we look forward to the outcome.

DR. McCLELLAN: Bruce, thanks very much for those terrific comments.

And, as Bruce alluded to in his remarks, we're very pleased to have the involvement of the John Hartford Foundation, and I'd like to turn now to Chris Langston, the program director at the Hartford Foundation who's been, as Bruce said, very much involved in leadership on long-term services and support issues for quite some time.

Chris.

MR. LANGSTON: So, good morning, everybody. On behalf of the trustees and staff of the John A. Hartford Foundation, please allow me to add my welcome to that of Dr. McClellan and Dr. Chernof.

I'd like to acknowledge my boss -- always a good idea -- Dr. Corinne Rieder, the foundation's executive director, and my colleagues Marcus Escobedo and Amy Berman who, along with the Brookings staff, helped bring everybody here together and make this a logistically pleasant day, I hope.

I'd like to thank, of course, our distinguished speakers and the contribution that I hope they'll be making to our thoughts today.

And I would also most like to thank all of you in the audience. I know that this is a very uncertain and difficult time for those of us who believe in the importance of health care reform, and so I very much appreciate taking your time up today, and I hope it will be worthwhile.

I'm Chris Langston. I'm the program director at the foundation. Our mission is to improve the health and health care of older adults in the United States, and I'm very excited about the potential of this conversation to advance that mission.

Just to address one issue up front, we believe aging is a good thing. On an individual level, as they say, consider the alternative. From a societal standpoint, I think it is also a good thing, but society needs to change in many ways to enable people to continue to participate, to maximize their independence over the life course, and to preserve their dignity at all times possible. And among the social institutions that need to change, I think health care and long-term care is one of those.

So, for a few minutes, I'd like to just introduce you to a little bit more about the foundation and our history for two reasons. One, you should know whose buying you

lunch I think, and second I think our history actually in a lot of ways mirrors the trajectory of health care and what's brought us together today.

So the Hartford Foundation is over 80 years old. I'm wearing a 75th Anniversary pin that's a couple of years old. And it was founded and endowed by John A. Hartford, a CEO of the A&P grocery store chain. So, do enjoy lunch.

At its peak of assets, the foundation was the fourth largest in the United States, and for many years it very quietly invested in medical research and developing medical technologies like dialysis, kidney transplantation, laser surgery and even the ICU that have turned out to have a tremendous benefit on human welfare, but also can be seen as examples of the high technology, high cost approach to health care that has really dominated health care thinking, that acute care model.

In the '70s and '80, as NIH spending eclipsed our resources and our endowment lost value, the foundation actually began to turn at that point to thinking about health care quality improvement and cost containment along with workforce issues in the care of older adults in specific. In our health care cost and quality work, I think we were well ahead of our time. While many of the people and things we supported at that time have come into their own in the last couple of years, for a long time, they were howling in the wilderness. For example, the foundation made early investments with Jack Wennberg and the Dartmouth Atlas, and was actually the first external grant funder of the Institute for Health Care Improvement, a long time ago.

But given the environment of the collapse of the prior round of health care reform in the 1990s, the foundation reallocated its resources entirely to focus exclusively on aging and health, and improving the capacity of the U.S. health care system and workforce to care for older people. In this way, we are very proud to have made an important capacity-building investment through grantees such as you'll hear from today.

But now, as Dr. McClellan said, we've really come full circle, and these two interests have merged. Improving the quality of our health care for older adults is an integral part of the health care reform issue overall, as is integrating acute and long-term care. As everyone knows, it's the 20 percent of people with the multiple chronic illnesses who drive 80 percent of costs. However, what many people outside of this room at least seem to miss often is the fact is that this 20 percent are predominantly older people.

Dr. Chernof and Dr. McClellan have already talked a fair amount about long-term care issues. Just to be sure that we keep both sides in mind, older adults actually represent on average 50 percent of hospital occupancy on the acute care side, despite being around 13 percent of the population, and 19.6 percent of older adults discharged from the hospital are readmitted within 30 days. It's a very general and very serious problem -- a failure in my view -- of untold impact on families and patients, as well as the cost implications.

On the outpatient side, older adults represent about 30 percent of the visits to the average general internist, and yet the care delivered for really prototypical geriatric issues like falls, incontinence or dementia, averages about 30 percent of indicated quality of care processes -- substantially lower than the 50 percent figure that we hit generally, which is already a cause for national concern.

As these facts have become more clear and as the demographic shifts our society faces are only accelerating, the impact that aging has on health care spending is more and more clear, as is the failure of the system to deliver safe, reliable, high quality and patient-centered care, particularly for older adults and those with chronic conditions. Fortunately, the people and ideas that we've been able to support for over the last 20 years I think are really ready to make a contribution on how we should move forward to make things better.

Today, you'll hear, I think, about some of the politically-speaking least controversial parts of health care reform such as accountable care organizations, medical homes and bundled payments. Regardless of what happens in the next couple of weeks and months, I think these things will be back.

So, as we create and implement these new financing and organizational structures to deliver quality care that better meets the needs of older adults and provides better value, I want to leave you with three questions to think about, to guide that future implementation when it comes.

First, at an organizational and clinical level, do we really know what we expect health care providers are going to do differently to achieve different outcomes?

Without doing something different, it's madness to expect different outcomes to occur. Changing incentives, such as these mechanisms largely do, is not a magic wand to get the outcomes we want. CMS and ourselves have funded plenty of failed demonstrations, such that we should know that there are many more ways to fail than to succeed in improving health care outcomes and lowering costs, particularly for this very challenging population which is both under-researched and very, very difficult to change. And I think finally if clinical change is hard, organizational change is even harder.

Second question, do we know who will be doing all this work that we want and how prepared they are to do it?

Despite our best efforts at the Hartford Foundation, the cadre of geriatric specialists is very small. Only a few percent of physicians, social workers or nurses specialize in geriatrics or gerontology. Worse, the preparation of generalists remains woefully inadequate, as documented by the recent Institute of Medicine study, "Retooling the Health Care Workforce for an Aging America."

In redesigning delivery, we are fundamentally redesigning the health care workforce. This may offer an important, new political alignment in a post-health care reform environment now focused on jobs. The U.S. imports thousands of nurses and physicians each year and under-invests tragically in the direct care workforce who provide the hands-on care to the most frail in their homes and institutions. I think there's room for improvement here.

Finally, my third question, do we know what outcomes we want? Do we know what we should be incenting? What is it that's going to benefit older people and what do they want?

If we don't know what outcomes we should be measuring, we run the risk of either not improving quality as we try to lower costs or in improving some aspects of technical quality that don't meet the needs or interests of the people we really wish to serve.

So I hope that our conversation today will begin to answer some of these questions, and the foundation looks forward to working with all of you as we move forward to improve quality of health care for older adults and all Americans.

DR. McCLELLAN: Thanks very much.

Just looking around the room, you all, and I know many of you very well, and this is the quietest that I've seen you in quite some time. So, maybe if I could, to just get things going, if I could ask for a round of applause for Hartford and for SCAN for what they are doing. And by what they're doing, I don't mean just buying you lunch today.

And I'd also like to give a special welcome to Corinne Rieder, who's here from the Foundation. Thank you very much for your support and attendance.

So we're going to get right to work. If I could ask the first panel panelists to come up to the front while I introduce them. Just to orient you again, we're going to have two panels before lunch. You really are going to have work for that lunch.

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And this first discussion is going to focus on different perspectives linking health care reform, real health care reform, and the policies that can support it, as we introduce and expand on some of the topics that you heard about already in our introductory remarks.

That's going to be followed by a second panel that's going to focus in more on measuring performance. Chris alluded to these issues. And it's hard to do. It's hard, especially, to measure the right thing and use those measures effectively.

Then over lunch we're going to talk about some opportunities for improving care, some of those real health care delivery reforms in a little bit more detail.

And then a final panel putting it all together on integrating payment reforms, performance measurement and delivery models that work.

After this session ends, I did want to let you know that there is going to be a kind of open reception and discussion with the Long-Term Quality Alliance. And all of you are welcome to stay for that. I'll have a little bit more to say about that later on today. It's going to go into some of these issues in a little bit more depth and it's a good way to find out what's going on with the new LTQA effort.

So, let's get right to it. This panel is going to highlight a range of perspectives on national health reform, focusing on some of the key payment and delivery system reforms in legislation nationally and being tried out around the country that affect older adults in a range of institutional and community-based settings. This includes the potential impacts of payment changes on care experiences and outcomes. Again, that link between the payment reforms and the delivery system itself, and efforts to improve both together.

Beyond current legislative proposals, though, we also want to highlight some concrete examples of these reforms that are already underway around the country. If

we know some ways to deliver care more effectively, and how it can be financed more effectively, and how it can produce measurable improvements in outcomes that matter, what are the key steps for making these kinds of reforms more widespread? This is an issue, as you heard about in the introduction that we're going to keep coming back to during the course of today.

And we've got a terrific set of panelists to address these issues. So I'm going to introduce them briefly. I got their bios, and they're people who are already quite well known in these fields.

First, Kathy Greenlee, the administrator on Aging for the U.S. Department of Health and Human Services. Kathy was appointed by President Obama as the fourth Assistant Secretary for Aging at HHS, and confirmed by the Senate last July. She previously served as Secretary of Aging for the state of Kansas. Welcome, Kathy.

Also, Steven Dawson, of the Paraprofessional Healthcare Institute. Steven is the president of PHI, which is the nationally recognized nonprofit that promotes quality care through quality jobs within the elder care and disability service sector.

Also, Carol Raphael, of the Visiting Nurse Service of New York. She's the president and chief executive officer there. It is the largest, and a very diverse, nonprofit home health agency in the United States.

And then certainly not least, Chad Boulton from the Johns Hopkins Bloomberg School of Public Health, where he's a professor of health policy and management. Starting this past December, Dr. Boulton began a health and aging policy fellowship funded by Atlantic Philanthropies. He's stationed at CMS -- good for you -- where he's working with the Office of Research, Development, and Information, and the Center for Medicare Management. Which, I tell you, those groups have to come together to try to find ways to try out and then implement on a larger scale the kinds of reforms that we're talking about. And so Chad's

obviously right in the midst with CMS leadership and staff in developing the kinds of programs, regulations, and proposals that should enable the kinds of things we're talking about today to happen.

So it's a great group to start with. And I'd like to remind them all to turn off their Blackberries with those microphones on. And, Kathy, maybe if we could start with you first.

MS. GREENLEE: And you want us to stay here?

DR. McCLELLAN: Yeah, stay right there.

MS. GREENLEE: Stay with (inaudible).

Good morning, everyone. I think I've been in Washington --

DR. McCLELLAN: Can you all hear?

MS. GREENLEE: I've been in Washington for about seven months, so I know three or four of you, maybe a few more. But I appreciate coming this morning and being able to introduce myself. I know you'll be joined later in the day by Richard Frank, who has a lot of information on chronic disease that he will give you, as well as Dr. Carolyn Clancy from AHRQ. So I've had a chance to meet with both of them, and thrilled to be part of the Administration, and working in the field of aging.

What I wanted to do with my time was talk about, from my perspective, the best way to knit together the social supports in chronic care support and the medical support, so the merging of the medical model and the social model with regard to seniors. And some opportunities that I see, in general, in a health kind of conversation, and in specific with regard to health reform, you know, what are the chances now to continue to bring these two fields together?

And the first one I wanted to talk about was the concept of a medical home because that's very much in conversation, and just kind of play through that a little bit. In

one of the many meetings I've had since I started, I met with some geriatricians -- you're a geriatrician, I think. I met with some geriatricians from the American Geriatric Society and we talked about this concept of a medical home. And really, we had a chuckle, in a good sort of way, because what the geriatricians told me is this is what we do. That as a geriatrician, the medical home model has always been the description of their scope of practice. Because to successfully serve elders, geriatricians know you need to bring in the medical supports, you need to bring in the social supports and be able to tell people where they can go to get them, and you need to work with the family because the family is so much of the backbone of a long-term care system.

So as we move forward and talk more and more about medical homes, I hope we invite a geriatrician to every single conversation if we want seniors to be included because they have a tremendous wealth of practice in how to make this all work.

It was about a year ago, when I was serving as the Secretary of Aging in Kansas, I was also an ex-officio member of the Board of the Kansas Health Policy Authority, which is the single state Medicaid agency in Kansas. And I was invited to New Orleans to attend a National Governors Association Health Policy Academy specifically on medical homes. So I listened to a couple of days of workshops just on this topic. And I noticed a theme when it came to aging. And the theme was aging as a footnote, quite literally. That I would watch presentations and watch the PowerPoint slides, and on about the 15th or 16th slide, there would be a footnote: This information does not include Medicare data.

So we knew, in just watching, that as people are studying the opportunities for medical homes, most often seniors, because Medicare data wasn't included and Medicare beneficiaries weren't included, were not part of the initial analysis. And because I've been an advocate for seniors for a long time, I did there what I always do, which is raise my hand and say I think this is very promising for seniors. I hope we can bring seniors and

the practitioners who work with seniors into the conversation.

So I'm very excited about what I've seen since I came to Washington. Secretary Sebelius has talked about her support in terms of having CMS work directly with the states on how Medicare can come to the table and support medical homes. And I think it's a promising dynamic. And a laboratory right now, even though it's not necessarily a new idea, but certainly a pertinent one right now, on how we can bring these systems together.

We think our half of that or our piece of that at the Administration on Aging is to focus a little bit more on the Older Americans Act. So I want to talk about that briefly, as well. What you may not know, or what I think has gotten lost, is that the Older Americans Act was born the same year as Medicare and Medicaid. And there are some differences in those programs. One would be size. When you think of Medicare -- we're all health policy people -- here when we think of Medicare and Medicaid there are three words that go through our minds almost like a scroll: Medicare, Medicaid, and money. Those all come together. And we automatically start talking about the significant burden on the fisc for those programs.

The piece that's missing, and we all know it's there, is this concept of services. That the entitlement is not to the money, the entitlement are to the services. And the thing that distinguishes the Older Americans Act, other than in size, is that it is not an entitlement in the same way. When someone is eligible for Medicare or Medicaid, once you're eligible you are eligible for everything; all of the services come in a bundle. And all of those services are expensive. And because it's an entitlement, there's no way for the government to be selective: you get this; you get that; and you don't.

The Older Americans Act was not designed in that way. So, unfortunately, when people think of the Older Americans Act, they never think Older Americans Act and money, they think Older Americans Act and no money because we have not grown. And I

think what would be helpful would be to go back and connect that conversation of services, and have more common conversation between the entitlement programs and the Older Americans Act around services.

The beauty of the Act is that it is not an entitlement, but it is tailored. Because the aging process is not monolithic, what people need as they age is different. And what the Older Americans Act provides is an array of services to support both health and independence that can be tailored to a specific individual and can increase as that person needs more assistance with ADLs or IADLs.

And I think this is the great opportunity to come back and talk about opportunities here. Because we now have 45 years experience with running this Act, and can help come to the table and say there are some opportunities here. Because the services that are least expensive on the social side are not entitlements and must be supported.

Our responsibility, for those of us who are running those programs, is to demonstrate that they work, that they're cost effective, and that they can be taken to scale. So we all need to work together on innovative practices and best practices. And we have been working for the past several years at AOA to make sure that there's a scientific base to what we're doing. So whether it's chronic disease self-management or it's false prevention, that we can show that there are outcomes to the programs that we're administering.

We're very excited that medical home is one opportunity to have this conversation, but there certainly are others in health reform. I mean, the whole conversation about preventative benefits under Medicare, we want our network to be at the table to talk about those. The value of our network, because we're so specific, is that we are good at information referral, we're good at case management, we're good at identifying the needs and the blend, and can work with consumers and their families to bring that forward.

We will talk more and more in the next year also about the role of family caregivers, and are very pleased that the President and Vice President earlier this week announced \$102 million to come specifically to the Administration on Aging to support family caregivers. And those will be both the Native American programs, Lifespan Respite, as well as the Family Caregiver Program and the direct support for seniors who need adult day care and other kind of respite services.

So we think the dynamic is right to move forward and use health reform really as an opportunity to continue to talk about the need to work together I think on both fronts, both the social side and as well the medical side.

There are other things that Richard Frank will talk about that we've been tracking: the Class Act, in particular, as a funding mechanism; the terrible cost of prescription drugs and what we'll be doing in health reform to address that for seniors. And because we know that all the seniors used to be younger, we also are interested in this group that are 50 to 64 because we've seen the data as well that people who don't have insurance become more expensive once they are eligible for Medicare. And so we want to be involved in how we can outreach to a younger population.

One more plug and I'll turn it over. We are about to go through a national dialogue on reauthorizing the Older Americans Act. And this is not a surprise to me, but I'm turning 50 in 2 months, and I'm on the end of the baby boom generation. The first boomers turn 65 next year. And so the time has come to really look at the reauthorization of the Older Americans Act as an opportunity because we now need to build the system that we need right now.

So, I'm glad to be here. Glad to talk to you.

DR. McCLELLAN: Kathy, thanks. And that is a very important policy opportunity to come up. Glad you concluded on that. But you also remarked about the

importance of support for caregivers.

And if I could turn to Steven, I know you're, with your work with the Paraprofessional Healthcare Institute, very much tied to those kinds of issues as well.

MR. DAWSON: Thank you. Excuse me. Thank you, everyone. Good morning. And we want to thank Brookings, but also, a good thing, our funders, both SCAN Foundation and Hartford Foundation, which are funding this event, but also our major funders at PHI.

And I've been asked to talk about the direct care workforce. And these are mostly the women who provide the care for your loved ones, who are allowed to help them stay at home as they age. I'm sure in many cases they've allowed you to get to work because you knew that someone was there caring for one of your loved ones. These are the home health aides, the personal care workers, the certified nurse aides in a range of settings: nursing homes, home care agencies, assisted-living facilities.

What's most important to understand is that they are a huge workforce. And I think Mark mentioned about \$160 billion or so in long-term services and support. Well, about half of that, probably, about \$80 billion is going to the payment and support of this workforce. That means there's over 3 million direct care workers in the country. They are the fastest growing occupation in the United States. They'll be 4 million within the next 6 years. That means there'll be more direct care workers than there will be grade school teachers, K to 12. There'll be more direct care workers than clerks or fast food workers or RNs.

So it is a critical element within elder care services and disability services, important to the economy, important to elder care services itself or providers because about 7 out of 10 elder care workers is a direct care worker. And it's certainly important to the consumers in residence as being a lifeline to their support.

And yet we have a business model that has an unfortunate low investment, high turnover, low return model. And to just give you a few examples of that, in terms of how little we really invest. In over an 8-month period ending in 2007, if you were in real wages, adjusted for inflation, per capita spending on health care has increased 30 percent, salaries for doctors and RNs increased 16 percent, and for home care workers wages decreased 3 percent. And in a really bitter irony, even though these workers serve the health care system, two out of five home care workers do not have, themselves, health insurance. I could go on, but Mark asked me to be positive.

So, I've done this work long enough to know that we cannot successfully change policy. Everyone nods their head, but no one really responds to the argument that these are poor workers and they're exploited and they should be paid more. Even though that's true, what we really have to do is create a very positive argument that, in fact, these workers are of enormous value to the system, but they're really underutilized. We're paying about \$80 billion a year, 70 cents on the dollar of your tax dollars, and yet we're really not getting what we could from that value. And that what we need to do is design models in which the direct care workforce and family caregivers together are supported so they can play a much more value added role in the system.

So just to place that into a little bit larger context. What we really have throughout the system, rather than the highest and best use kind of model, where we're trying to get the most out of each of our levels of providers, we have the lowest and the least model. We have doctors who do what RNs can do. We have RNs doing what LPNs can do. We have LPNs doing what aides can do. And with proper support and training, we have aides doing what family members can do.

And so why we do that is because we're rich. I mean, we can afford to be inefficient. At least we could afford that, at least before. And now, when we're realizing that

that's really -- we've really run out of resources in that regard, we really have to reverse the model and create models of care in which we're taking the very best out of each level, so that each level above can perform at their highest level. And this is where the new models of care framework comes in because I fear that we may be repeating, in some ways, the same mistake in these new models of care, over professionalizing them, having models in which -- that does not take advantage of the fact that we already are paying for people in the homes who already have family caregivers there. We need to create new models of care in which we are making the best use of what we're already paying for, what we already have available. And that there are beginning elements of that, in terms of positive examples, in terms of senior aide models, in terms of additional training that allows for a little bit more responsibility and a little bit more pay. But actually, so far, they've been pretty marginal. And what I hope in these new discussions is that we can create a significantly higher level of responsibility for the paid caregivers, something between the aide and the LPN, and which without having to go to college these workers could be performing many more responsibilities. And again, you're already paying for them, let's make much better use for them.

Just in terms of -- two last points. In terms of encouraging at the administrative levels, we've been meeting with many of the agencies' leaders, and Assistant Secretary Greenlee included. And what's been enormously encouraging is that for the first time when we'd go to talk with each, each is saying that they are reaching out to other agencies, to HRSA, to CMS, across the agencies to the Department of Labor, and that there's a real commitment that we're hearing to take advantage of each other's resources and really cooperate or to change these models.

And then legislatively, whether health care reform is a damaged brand now or not, but it's really clear that what's ascendant is jobs and job creation. And that in this

arena we have opportunities to take these ideas and implement them inside some of the new legislative initiatives, reauthorization of Workforce Investment Act, jobs bills in which we could get the health care workforce solidly supported within those new -- within that momentum, legislative.

Thank you.

DR. McCLELLAN: Thank you very much, Steven.

Carol, you've got some experience with some of these different models --

MS. RAPHAEL: Right, right.

DR. McCLELLAN: -- of delivering care and with working with some of these other types of health professionals in conjunction with nurses. Please.

MS. RAPHAEL: Okay. I just wanted to start by reemphasizing a point that I think you made, and several other people have made, which is there's a tremendous intersection between those people who have chronic disease and those people who need long-term support and services. Our population at the Visiting Nurse Service of New York, on any given day the average patient has 3 to 4 chronic conditions with two co-morbidities, takes 10 medications on average, sometimes up to 18 different medications. When we recently did a survey we found that one-third of our patients had depression, which really stunned us. And they have functional impairments. And they really are the intersection of the medical system and the social support system. These two systems are inextricably linked. And I think as we think about health care reform we have to be sure we keep that in mind.

I wanted to talk about what I saw as three opportunities from the direction that health care reform is going because I'm looking at this as the direction it's taking us, no matter how it kind of plays out and the mechanisms that it uses, two gaps that I see and sort of one important cautionary note as we think about implementation.

The three opportunities that I see are first of all, I think there is an emphasis on experimentation, and looking at models that will integrate care across providers and different professionals and paraprofessionals without requiring an organizational change, without requiring that organizations have to get together and become one entity. And I look at several models. I, in particular, look at the models that involve the medical home. And I agree wholeheartedly with Kathy that we have to take that medical home model and look at the aging population because we deal with a lot of dual eligibles. We all know that of the Medicaid population 18 percent are dual eligibles, but they account for 46 percent, almost half of the cost of Medicaid. And for Medicare it's 19 percent of the Medicare population are duals and they account for 31 percent of Medicare costs, almost one-third.

So it really is important that we think about a medical home model that will work for this population; that is enhanced primary care; that has one of my favorite terms, coined by David Reuben in the audience, teaminess, really brings the team together, but that is also home based because much of our population is not mobile. They cannot get to a primary care physician's office easily. So we have to go to them and we have to really make sure that their medical home is their home where they spend most of their time, not an office.

The second model that I think is very promising has to do with transitional care. And I have to say I have seen a lot of heads of hospitals begin to pay enormous attention to the issue of readmissions. It is definitely on their radar screen. And while we all say transitions are vulnerable points, I think they're also an opportunity to begin to integrate, to build partnerships.

We have trained our 2,500 nurses on the best of the Naylor and Coleman model. And now we use an algorithm for everyone who's discharged from a hospital. And we bring home about 5,000 patients a month. We have an algorithm that can very

accurately predict their risk of rehospitalization. If they come out high, we move in. And we really make sure they have a follow-up appointment with a physician. We do a lot of work on medication reconciliation. They have an emergency plan that's attached to their refrigerator so they don't end up in the ER in the middle of the night. And just in the last year alone we have brought down our readmission rates by 4 percent. And we now have begun some really strong partnerships with hospitals in targeting their population.

And then the third model that I would point to has to do with ARA and high tech, and the potential of health information technology to be the virtual integrator. Besides our own use of an electronic health record, and it would be inconceivable to take care of 30,000 patients a day in 30,000 different locations without having an electronic health record, but more importantly we have begun exchanges. And we are actually exchanging information about allergies, medications, procedures, lab results with some of our partners in the hospital and physician community. And we're testing now real-time electronic transmission with primary care physicians with whom we share patients. And I think that is a very promising development that we ought to continue to nurture.

The gaps. I'd say there are two key gaps. And one I relate to Dr. Chernof, and that is that we continue to have the long-term support and services system rely heavily, heavily, heavily on the shoulders of Medicaid. And that is very fragile foundation for a system. I mean, I'm very relieved when I hear about California. My own state, New York, has a \$7.4 billion budget gap on a \$134 billion budget. But 20 percent of the state's expenditures are for Medicaid. So it is inevitable as it tries to close that budget gap that it will have to make reductions to the Medicaid program.

Besides that, I think Medicaid tends to medicalize the program. I think one of the reasons we have high rates and an imbalance leading toward institutionalization is due to the fact that we rely on Medicaid. I think you have very complicated eligibility rules.

You have cycles of scandal and then cleansing in the quality area. I just think that it is a very uneasy foundation to build a long-term system on.

The second gap, and here I relate to what Chris said very fervently, is who will do the work. How well prepared are they. And I was part of the Institute of Medicine Committee on Retooling the Workforce for an Aging America, and we came to the conclusion that we can't just rely on specialists in geriatrics, as important as they are. Because on any given day 50 percent of the people in any hospital are going to be older Americans, it has to be part of the mainstream that you have geriatric competence. And I will tell you, I see with our nurses. They don't have the skills for tomorrow. They can do all of the tasks very confidently, but can they communicate? Can they aggregate and interpret data? Can they coordinate care? Can they do the kind of assessments that they need to do?

And one of the things I've been really excited about is the Hartford Foundation, in partnership with Atlantic Philanthropies, has been funding something we call the Champ Program, which is to really inject into the mainstream of home healthcare services -- geriatric confidence.

And it has really taken off. We have created a virtual learning community, and we have 96 agencies now involved in this effort, and we're starting with medication management practices and taking the best practices and trying to inoculate everyone. And we have seen some dramatic improvements in terms of skills and competencies.

And I think that could be a model for how we think about moving ahead to really raise the bar on geriatric competence in our entire workforce.

And then my sort of last cautionary note, as we think about how are we going to implement this? How are we going to make the future different from the past, and have successful models?

Chad, you did a literature review for the Institute of Medicine Committee, and you looked at all of the successful models, and there were some where research had really proven they got results. And yet, dissemination was miniscule.

So I think the challenge for me is how do we find a rapid cycle methodology to really disseminate and get uptake and bring something to scale.

And then my second sort of challenge is how do we change the relationship between the academic-policy sector and those of us who are practitioners, because when I get a model, the academic and sort of research sector wants that pure model to remain as it is.

And they can then evaluate it. But I instantly see that it has to be modified. It's like when you go into the shower, you don't the perfect temperature. You have to move the hot and the cold 'til you get there.

Well, that's what these models are like. But I am inhibited from beginning to change or listening to my front lines who tell me I want to do this differently. It would be simpler if we could just make this change, because I am in this straitjacket, being evaluated so that theoretically we can determine whether or not to move forward with this.

DR. McCLELLAN: Great. Those are actually great comments to transition to Chad with, since you've been kind of across the borders on exactly some of those issues.

MR. BOULT: Thanks. Thanks to all of you for coming today and for our sponsors and funders.

As Mark mentioned, I'm doing a fellowship at CMS, and in my first month there, the first thing I learned was when I speak to groups like this I have to acknowledge that my comments are my own. They do not represent necessarily CMS or the government, and my colleagues at Hopkins want me to say the same thing them. So, it's all on me.

I think everyone here understands intuitively that chronic care today in this

country is marked by uneven or poor quality, inefficiency, and ineffectiveness. It's a disaster, and we really have to make some substantial changes for reasons that you've heard a lot about already this morning.

What I'm going to do my few minutes to talk to you is to discuss some of the models that, as Carol mentioned, we found that have some evidence that they -- they're alternatives to today's system or non-system of care, and they actually work.

They don't -- they're not perfect and they need their -- have their hot and cold adjusted a bit from time to time, but they do work. And then I'll finish up with some comments about policy changes that will be necessary in order to disseminate these models and have them become the standard of care in our country.

Carol, you took all my thunder, but back in '07, when this IOM Committee was preparing its report on the retooling a workforce for an aging America, they asked me to summarize a little -- of 20 years of literature on models of care that had been show to be more effective than what we have today.

So I did that and then finally just last month, it came out in the Journal of American Geriatrics Societies. So, if you want to see it, either after the meeting today or look it up, it's in here.

It's a compilation of the 15 models that we found that did have some hard, high-quality scientific evidence showing that they achieved some better results. None of them are perfect and none of them have been extremely well studied, but two of them are models that we've already heard about -- and I'm going to spend a little time talking about one of them in particular.

The transitional care model is perhaps one of the better studied; that is Mary Naylor's and Eric Holman's model where they help people to move from the hospital to the post-acute setting effectively so that they don't have to get unnecessarily readmitted

right away.

The other that I'm going to talk about is what we call interdisciplinary primary care. That's kind of a broad topic and there are a number of model types within that, and some of the people in this room have developed some of those models.

I'm going to talk specifically about one of them, the one that my colleagues and I at Hopkins had developed and just finished a three-year randomized trial of, and that is called guided care. It's one of the interdisciplinary primary care models, but we do have some evidence, and I'll tell you a bit about that.

But first of all, how does it work? What is this alternative model? Well, it's incredibly simple when you look at it in the broad sense. It's having a primary care practice hire a very skilled registered nurse, and add that nurse to the staff.

That nurse then works with the primary care doctors in the service of the patients of the practice who have multiple chronic conditions, the ones that are the most complex and difficult to care for.

So what does that nurse do? Well, it begins with a home visit. For about two hours, the nurse does a comprehensive assessment at the patient's home of everything, not only the biomedical aspects of care, but the nutritional, the environmental, the family caregivers. It's part of a structured assessment.

The nurse then enters that data into a health information technology system that generates for the nurse and others an evidence-based plan of care that incorporates all of that individual patient's chronic conditions.

The nurse then gets feedback on that plan from the patient, family, and primary care doctor, with the idea that if everyone contributes, then everyone will own it. And then there's a version that's put up on the refrigerator, with a magnet and in plastic, so that it serves as a reminder about the patient's and the family's role in the plan -- what to eat,

what to do with physical activity, what medicines to take, what to check in terms of one's self monitoring, and what to do if there are problems.

So this is all in the way of just setting up the system.

Once it's set, the nurse, working with the physician, then monitors these patients, proactively, every month; doesn't wait for the patient to get sick and show up in the office or the emergency department; calls or visits or sees them when they're coming in the office anyway and monitors their symptoms; monitors how they're doing with their chronic diseases and just as important uses something called motivational interviewing to encourage the patient and the family members to be, you know, involved and engaged in their own care, so understanding their conditions, checking their own blood pressure and weight and identifying problems that come up, sometimes changing health behaviors, like diet and exercise and smoking and that sort of thing.

So all this is part of these monthly contacts, and, over time, the idea is that the patient, the family they get more involved in self-care, at the same time the nurse is monitoring how they're doing.

Another major role of this nurse is coordination. Now remember these are people that are seeing 8, 10 different doctors and lots of other healthcare providers during a typical year, and so all those right now are on different wavelengths. They're not communicating with each other.

So the nurse uses this care plan that's developed as a communication tool to make sure everyone knows the same plan, and the nurse constantly updates that as things change.

The nurse also provides support for family caregivers, realizing that they're the unsung heroes of chronic care. They're the ones doing all the work in the background, with no acknowledgment, no training, and certainly little reward.

So the nurse pays a lot of attention to educating and supporting those people as well.

And the final, and, by all means, not the least, important activity is the connecting of the medical system with the community agencies. So the nurse has a database of all the community agencies -- the Meals on Wheels, the transportation system, the adult day care, the senior centers, and so on -- and knows this patient very well. So the nurse can facilitate the patient family's use of these community services and, in the other direction, can inform the primary doctor what's going on.

This patient -- you know this patient is getting adult day care. Most doctors have no idea what's going on outside the traditional medical care system.

So that's it. That's the model in a nutshell, and we've just finished a three-year randomized clinical trial at eight locations in the Baltimore-Washington, D.C. area. We only have the first year of data, primarily to -- and we've published, but I'll summarize some of the main outcomes for you. It's gratifying.

Early results show that clearly quality of care is dramatically improved, as you can imagine with this kind of attention to people with complex needs.

Second, and very important to some, it has a net cost savings associated with it. In other words, people do not need to go into hospitals as frequently when they're getting this kind of care, because problems are identified early and prevented, and so, as a result, the savings from that more than offsets the cost of adding the nurse to the practice.

So, economically, it seems to have some viability.

Other outcomes that have been positive have been physician satisfaction, patient satisfaction, and caregiver. We surveyed the family caregivers, too, and they showed an impressive improvement in the strain that they felt, because they had this nurse carrying a cell phone that they could call when they ran into problems.

So it's looking positive. It's at the beginning. We have more data to analyze. But we're so encouraged that with the help of the John A. Hartford Foundation, we have prepared tools to help practices and organizations around the country to adopt this model. And they include a book, which is here. This is a -- called "Guided Care." It's an implementation manual -- very practical for practices to use to adopt this model, should they choose to.

We've also created an online course for doctors to learn how to do this work; on online course for nurses, similarly it's followed up, if they pass the test, with a certificate in guided care nursing.

And guidance on selecting health information technology. These are tools if diffusion that we've made available.

But what's missing here is a payment; is a business model. See the insurance companies are the ones that are saving the money, and the practice is the one that's having to pay the nurse.

So the logical business model -- it's not the only one, but the most logical one -- is for insurers to make a capitated payment to practices so that they can afford to have this nurse to do this work, and that's what some early managed care organizations actually have begun to adopt.

Now just a final couple of words about provider education. It's great to have a model that seems to work, but the people in it -- the doctors, the nurses, the social workers, pharmacists, everyone working in this model -- needs certain expertise about geriatrics, about chronic care, and really important about how to work as a team.

Right now, in our professional schools, I'm embarrassed to say that we don't do -- we don't train -- we train nurses to be nurses and doctors to be doctors, and we don't train them to work together. And we need to change that. We need high-level policy

change to drive change in the educational systems.

We need to require that our educational institutions provide this or else they don't get funded. We need to insist that certification of professionals, such as doctors, nurses, and social workers, requires expertise in these areas where they don't get certified. If they don't pass their test, they don't get specialty designation, and they don't even get licensed.

This is hardball, but it's what it's going to take to change this very recalcitrant medical and other educational systems.

So I'm going to just finish there with a -- hopefully, on an up note that the reform that we're all talking about and are going to continue to talk about it's not just about covering all the people. It's not just about cutting costs. It's also about better care, and we really have to develop all these in parallel with each other.

Promising models, as I've mentioned, this one is not the only one, but there are others -- are out there. They're available, but they need this extra effort for new payment models for new educational systems if they're ever going to be disseminated into the mainstream. And the thing that can drive all these changes, I believe that because I work at CMS now, is policy change.

Thank you very much.

DR. McCLELLAN: Great. Thanks. Thanks, Chad.

You know, in listening to all of you it seemed to me that there was a fair amount of common ground about the kinds of models of care that should be implemented, and that common ground is perhaps not in the same place as a lot of the common broader policy understanding about what coordination of care means. You know, it's -- and opening comments about how much of that discussion is going to focus more on the acute side and doing things right in the hospital or during the physician visit to prevent people from going

into the hospital.

But when you all talk about medical home, for example, it didn't sound all that medical, at least in the traditional sense. You mentioned -- or you mentioned that it's a really home home or just a home. The focus ought to be on keeping an individual well situated in the community, in their place of living or at least something that's more broadly focused on health; involves a whole range of health professionals, maybe not even with the geriatrician or the physician with geriatrics skills having a primary role in some way.

Your model, Chad, was really built around nursing, and, as you described, even the -- there is a lot of potential for other people who are right there in the home and providing services to do more.

Is that -- am I taking away the right general direction for this -- from this panel? Comments on that?

MR. BOULT: I think so. I think that it's a paradigm shift. You know, we tend to think traditionally that healthcare is delivered by doctors and then other people that kind of work under the doctors, and I think we need to move away from that from paradigm to realize that in team care, doctors know some things and have some value, and so do nurses, and so do social workers, and so do direct care workers, and so does everyone.

And it's -- and we need to really foster this ability -- and it doesn't just come naturally -- the ability to work together as a team. It requires specific training and selection of people who are inclined to work in that way.

MS. RAPHAEL: And, you know, I don't believe we're going to be able to solve the primary care shortage unless we do have enhanced roles for nurses and really consider them part of the future primary care workforce, the same way, I think, as we look ahead at structural nursing shortages. I think we can use direct care workers very differently.

We have been trying to think about career ladders, where you really could gain a lot more competencies, but you have to get pay that goes along with that.

For example, for our hospice program, we actually certify aides in end of life and palliative care, because those are different cases, and that's a step on the career ladder.

So I think there is a lot of opportunity to think differently about the workforce and the future models.

MR. DAWSON: Could I add -- Chad mentioned and Carol mentioned the teamingness, the importance of teams, and that what we have found for the direct care workforce to be supported and for these models to work that these new models of care requires a different set of skills -- of communication, problem solving, self-management of your emotions while you're dealing with these issues, (inaudible) of leadership -- and that these are really not soft skills, but really essential skills to unlock any change model, and that there's not been enough emphasis certainly in schooling, but in the field.

But what we have found -- and again, with support from the Hartford Foundation, that these are teachable skills, that they're learnable skills, and they're essential for the model like they Greenhouse Project -- Robert Jenkins' work, where there's completely different responsibilities. You just cannot tell someone to -- or a nurse to stop being so clinically oriented, start being person directed, go.

But that's what we do. And that, in fact, there are skills that are available -- problem solving, communications.

MS. GREENLEE: Mark, if I could chime back in? When the guided care nurse gets it right, does the care plan and calls for services, we want to be there. And some people will be able to privately pay for adult day services -- should do that. Some people will not. And we don't want to be in a policy position where people have to sign up for Medicaid

to get adult day care.

Or people have to go to the nursing home to get respite at night; that the fiscal policy should almost be deconstructed to go back to find what the services are that are motivating people to seek a funding stream.

And we believe that's where we can be more helpful. But, because of the differences in budget policy, it's harder to get attention to these sorts of programs, but if you replicated your model everywhere, there will need to be more meals, and there will need to be more adult day care, and more respite.

And so, that next system is immediately impacted, and has to be addressed from a budget policy perspective as well. It's not for everyone, because there are private resources that should come to bear. But there's a role, I think, for us -- and can help think -- drive down the costs of Medicare or Medicaid or certainly keep them from escalating at the pace we're (inaudible).

DR. McCLELLAN: And that fits in with your comment earlier about AOA not being an entitlement, but being a targeted set of funding that can try to help lead these efforts forward, and you mentioned that the financing often isn't there.

So for this model, or this general set of directions for better models for care that you all have been talking about. Another area of consensus from the group seemed to be it hasn't really diffused very well. It's hard to learn. It's a different set of skills from what we set up with our current structure of health professionals. And the financing isn't really there.

You said that you can take all these steps, get better care, and the consequence is you lose money in your practices. Is that -- have you all found some steps around that or is going to take more radical policy changes?

MS. RAPHAEL: Well, the one step we have found is we, you know, at the

prodding of the CMS, agreed to become a Medicare Advantage Special Needs Plan for dual eligibles, where we get the premium, and, therefore, we can distribute the premium to home-based services and primary care.

We have a very, very low ratio of the dollar that goes to in-patient care compared to other Medicare Advantage Plans, and we've been able to have partnerships with physicians. We have a large number of Hispanic elderly in our plan, so we have a partnership with an IPA that serves Hispanic elderly.

We have a pay-for-performance model, where we pay them based on outcomes, and we've been able to do risk assessment and really have much more contact.

And changing the whole mindset, because what you want to do is prevent a fall, so you want to go into the home and really see if this person is likely to fall, what their balance is like, and what issues they're facing, and start from that end of the spectrum rather than when they fall, and, you know, fracture the hip, and then you zoom in.

And then thinking about rehabilitation in terms of what is it that they want to do. I mean they want to be able to get around their home and their neighborhood, and doing it from that vantage point and how does the caregiver fit in.

So, in that area, we have been able to do medical management and do community-based partnerships in a different way.

But the challenge there is how to work with the state Medicaid program, because as a Medicare Special Needs Plan, we have to have a contract with Medicaid --

DR. McCLELLAN: As well?

MS. RAPHAEL: -- and as well, and that's been a real challenge.

DR. McCLELLAN: Agreement. I think we're going to be coming back to these issues today. Let me go to our audience. We've got our roving mics and I see a couple of questions there, towards the middle, already.

When you ask your questions, please stand up and tell us who you are.

MS. PINKOWITZ: Can we make a comment?

DR. McCLELLAN: Okay.

MS. PINKOWITZ: Rather than a question?

DR. McCLELLAN: Uh-huh.

MS. PINKOWITZ: Okay. Hi.

DR. McCLELLAN: Precise, though.

MS. PINKOWITZ: Jackie Pinkowitz , vice chair of Consumer Consortium on Assisted Living, and, like Chad, this is personal, not a representation of the Consortium.

I would hope that as you consider guided care and integrated partners in care that we start incorporating our mindset to the family caregiver, not as a caregiver, because, as a care manager, and that means, I think, we have to have a very different mindset about that care manager as a true partner in care.

The majority of us boomers who are involved in this we are online all the time. We are involved in every aspect of elder care for our loved ones.

And there's a big difference between saying you want to give respite to a family caregiver. I want you to say I'm a partner in Chad's interdisciplinary care team. Thank you.

DR. McCLELLAN: Just to add to that, there are a lot of -- there's a lot of families that I talk to where, as you said, typically a woman involved feels like she is doing all that, often without the kind of support that you described in --

MR. BOULT: Yeah. Let me expand a little bit on the -- in the guided care model.

The attention that is given to the family care manager or care provider, whatever: At the beginning, at that first assessment, the nurse actually does a structured

assessment of the family caregiver, usually identifying one woman who's either a wife or a daughter and identifying what that person's doing, how trained they are, how confident they feel in what they're doing, and what they need in the way of help.

So that's just by way of assessment. And then the nurse provides as much as possible to that person, educating them on generically how to best be a caregiver, regardless of the person's condition -- how to keep from burning out, which is a disaster -- and what are the conditions that your loved one has that you're helping to manage.

So that's all by way of initiation, and then, on an ongoing basis, the nurse checks not only with the patient, but with the caregiver specifically on care-giving issues. Once a quarter, the nurse will call the caregiver and say how are you doing? Are you able to keep -- are you burning out? Do you need any extra referrals or are there any community resources that might be useful to you?

So there is a lot of attention. And I agree with you in the concept that these people are the core, really, of the long-term care system for people who are living at home, and we really need to promote and encourage those people.

MS. GREENLEE: If I could chime in? I think caregivers as a force are untapped and unleashed at this point.

MR. BOULT: Right.

DR. McCLELLAN: They're also unhappy.

MS. GREENLEE: Unhappy at this point; yes. That all goes together. But - and I've not worked with -- directly with the developmental disabilities system, but, from what I've observed and talked about, the parents of the children with disabilities were the caregivers who drove the system change and demanded the care for their children.

And I think as we talk about caregivers, we will have intergenerational issues of younger people caring for seniors, but an increasing number of seniors who are

themselves caregivers, because we have longer life, healthier seniors. And I think caregivers as a group can begin to change more of these systems more quickly, because we've seen them do it in the past.

DR. McCLELLAN: We have seen them doing it in the past, and if I can just push on this a little bit, a very interesting point.

With those younger populations, the direction that they pushed in was some Medicaid financing reform that moved much more in the direction of people controlling the resources --

MS. GREENLEE: Right.

DR. McCLELLAN: -- spent on their behalf rather than, as you said, you know, with the traditional entitlement is an entitlement to a specific set of services, which may or may not be the best for that particular family or individual. Is that same kind of movement possible here? Is that the right direction?

MR. DAWSON: There's certainly been -- some of the DNA that has come out of the disabilities community is beginning (inaudible). It just is -- it's just obviously true that the disabilities community, if you're part of that, you have an ongoing experience of being disabled. You have younger people who may be more cognitively intact and more aggressive, and so they've been able to maintain a very (inaudible), very focused on the states. So they're very strongly focused, and that's harder to maintain when you're talking about the elderly community, which it may be going in and that system may have (inaudible) much more episodic.

And so, that's one reason why I think the disability community has been much more successful in creating person-directed models, with far fewer resources. You know, there are (inaudible), and yet, they've been able to really have a great fundamental influence in terms of creating a much more person-directed model.

DR. McCLELLAN: Go to the next question.

DR. POPLIN: Hi. I'm Dr. Caroline Poplin . I'm an internist. I retired from Bethesda Naval Hospital, where, about 70 percent of my patients were elderly retirees or spouses.

I wanted to pick up on something that Ms. Raphael said about the disconnect between the academic world, which produces models, and the practicing world.

It's always puzzled me that the academic world has never reached out to us to find out what we primary care physicians of the elderly think would help us or where we -- what we see the problems as. What I think is the problem with the medical home is that it depends on volume to support all that overhead.

You have to take care of more and more patients in order to support your nurse practitioner, your diabetic educator, your social worker. What doctors want is not to see more patients in shorter times.

We want to see fewer patients and have the time to do the coordination of care that we're really trained to do, not making the trains run on time; making sure that the cardiology plans are in line with the renal plans are in line with the neurology plans for the stroke patient.

Instead, we have to supervise a bunch of paraprofessionals and sign up lots of patients to support all of those other ancillary personnel.

It might be better to say, for instance, pay more for a patient with -- according to the number of chronic conditions they have. Pay something for somebody with three, and then more every -- this for somebody with four or five, pay a visit and a half for a post discharge appointment. There are lots of simple ways without getting together an elaborate system with tremendous responsibilities and then supervise everybody and make sure that they're performing right. I mean, what will happen is, physicians will vote with their

feet. They'll become cardiologists.

SPEAKER: It does sound like you're headed for a model in which, done well, people aren't going to be going in to see their physicians all that often.

MS. RAPHAEL: Well, no, and actually we're doing home visiting physicians and nurse practitioner programs, so we do have them interact, but it is in more of a home environment.

DR. McCLELLAN: And some of the other -- and Chad, you talked about the importance of this, sort of, care coordination system which sounds like a combination of IT, information technology tools, you alluded to that, too, Carol, and just a team approach, this teaminess again, which seems to -- done right, it seems like it would take a lot of pressure off the physician.

MR. BOULT: Right. These are different models. One model says -- it is based on the idea that the physician can do it all given enough time --

MS. GREENLEE: Right.

MR. BOULT: -- can coordinate, educate, empower, all that. I think that may be close to what you're suggesting.

The tension is between that model and the team model which says, you know, doctors aren't necessarily well trained or well suited for all of those responsibilities. Certainly some of them like the high level things, but they may not be the best person to be educating their patients, empowering the family caregivers, connecting with community resources. It may be that we're in that luxurious position if we try that, that we're paying somebody to do work that someone less expensive could do.

MS. GREENLEE: That's true.

MR. BOULT: That's the tension between those two models.

MS. GREENLEE: But for multiple chronic -- patients with multiple chronic

conditions, you absolutely -- those are the patients who need a physician, not --

DR. McCLELLAN: I think we're going to keep coming back to this issue. Very, very good point. I mean, look, this is a fundamental issue about how do you -- what is the right role, most efficient role of a physician, in the context of caring for these very complex patients? I think what you're hearing from this panel, and I think it's going to keep coming up today, is that there may be some models that involve much broader support but they're not very well supported now by our regulations, financing, and so forth.

Another question back there. Larry?

LARRY: It's clear that we're all beginning to recognize the problem around chronic care. There are clearly things that can be done about it that work. If we look at the two health care bills that have been approved in Congress to date, if the best parts of both of those bills were enacted, how would you judge how much more quickly patient-directed chronic care with aligned incentives and program definition regulation, how would all of this be accelerated with those bills and when do you think we would look back and say, you know, we finally generally have it right? How would those bills help solve these problems in your view.

DR. McCLELLAN: Good question.

MR. BOULT: I think it's a great question. In my opinion -- I mean, I was really hoping that this bill would pass, but even that said, they aren't very strong. Neither of those bills is particularly strong at changing the health care delivery system. They're focused on covering more people and some attention to reigning in costs, but the extent to which it would change delivery is limited to, you know, a few pilot and demonstration projects that are called for and the creation of an innovation center at CMS that would be the shop through which more proposals for innovation would pass through.

But realize, those all have to be tested, so in terms of willingness to step out in

these bills and say, we will now have homecare that's comprehensive, we will now have accountable care organizations, we will now have medical homes -- it didn't do that. It didn't take that sort of step. So, I'm not sure where it's going, of course, no one is, but it really wasn't going to change things overnight anyway.

MS. RAPHAEL: I mean, my sort of own view, I agree completely with Chad is, you know, I keep thinking about what would it take to really move things along and we all came back to the issue around payment, that, you know, you don't have a business model yet for guided care even though you have an evaluation that's produced positive results. So, I do think, what is it that we could do that blends the accountable care organizations, the medical homes, that would create some kind of payment that recognized and valued different providers getting together in a team-like approach and that would make it so everyone wanted to be this sort of entity, this virtual entity. It would become very prestigious. It would be something that was a fast moving train and you wanted to get on that fast moving train.

I think somehow that's what we have to think about doing, and we have to take some of these demos and anoint some areas to test things, but then we've got to move that quickly and not wait 20 years, or the classic 17 years, to sort of get it out there, and I don't know how we kind of get there, but we tout the Geisinger's, the Mayo's, the Cleveland Clinics.

So, what would be comparable that we could tout in the domain that we're trying to really --

DR. McCLELLAN: Well, let me pick up on this and say something in defense of Congress. Just to be clear, I do that from time to time. A lot of the members who care deeply about these issues came to people like us, people like you probably and asked, okay, we want to do something to improve care delivery. We recognize that these long-term

services and support (inaudible) chronic illness is not doing very well now and could be done much better, what do we do? And I think in fairness, the answer they got back was, well, there are a lot of ideas out there that look like they might work, but we're not exactly sure which one is best, under which circumstances, and what exact policies would be best to support that.

For example, this morning, the kind of model that you all have been talking about, I wouldn't even call it a medical home, it's more like a health home or like yours, it's a home-home. That's different than some of the models that they have been considering on medical home. If they legislated a version of that didn't put this big emphasis on family care giving and other health professionals being involved, it may not lead us to the kinds of policies that we want to see.

Accountable care organizations, many people do have in mind places like Geisinger and Mayo, which are terrific, but I'm not sure those are the best or the only models for providing the kind of community-based caring. Maybe it's a special needs plan like the one that you all run.

So, I do think that there are some real questions that are reflected in the legislation that we haven't had a compelling and concise answer to.

So, let me put it back to you all. What would be the step to get to the steps needed to get to that much quicker cycle time to figure out which of these approaches, models, really work, and how can they be supported by policies where we could be confident that we're spending the money in ways that are going to get to better care?

We can leave that to the next panel, too.

MR. DAWSON: To the extent that we're still dependent very much on the Medicaid budgets, as Carol said, and what Bruce said in terms of what's happening in California and elsewhere, unless and until we have some degree of stability in the Medicaid

budgets of the states, we won't be able to do larger scale demonstrations of what we're talking about.

And so as a necessary precursor there's going to have to be some stability in the Medicaid budgets, otherwise I don't see where these models are going to come from.

MS. RAPHAEL: Right. And I would also say there has to be some different structural relationship between the federal and state governments and whether the two centers, you know, that are set up can foster that, I don't know, but right now a lot of energy goes into cost shifting. If we could harness that energy that goes into cost shifting and figure out a different partnership, I think that would help us move this.

MR. DAWSON: Well, and also the loss of the (inaudible) act, if we don't get that -- you know, that would have had some long-term, I think, profound impact.

DR. McCLELLAN: That would be financing controlled by individuals --

MS. RAPHAEL: Right, and change, you know, who the eligibility -- because, you know, using behavioral economics trying to get people really to participate.

SPEAKER: Mark, if I could just throw back in a related topic, I testified for years on a Medicaid budget, a long term care Medicaid budget, and I always took to the legislature in Kansas, the first information about what the seniors themselves were paying, that for many of our long term care programs, it's a wrap around service on Medicaid. They were supporting people who were financially upside down, the medically needy, that there are resources in the system that are peoples' own resources, many retirees who have private retirement and Social Security, have money. They don't have enough money to afford the systems that we have in place.

And so, if we're reconstructing where long term care will go, we have to include that as a resource and someone's ability to manage their own retirement and their own money, what they can afford to buy should be as much of a conversation as what we

can afford as a government to pay, because they're there, they're paying it, and they become invisible because we're always thinking Medicaid is a poverty program. Not necessarily when you're talking about middle class people on long term care.

DR. McCLELLAN: Right. And Chad, you're going to go implement all this at ORDI right away, right?

MR. BOULT: I just want to get back to your original question about, so Congress hears all these recommendations but nobody's really sure enough to say, well, we should just implement something nationwide. So, they're left, well, what are we going to do except test a bunch of different -- let a thousand flowers bloom?

I think maybe something that we should think about for the future is a -- what one of my colleagues calls the health care Fed, some agency that brings together the best minds, that really are as untainted as possible for special interests, but have at heart the welfare of the nation's people, and can sift through the evidence that's available, and it's not complete evidence, and make recommendations to Congress.

Because right now, as far as I understand, Congress staff, they hear from this interest group and that interest group and this scientist and that scientist, and it's very hard for them to assimilate all that information. There isn't anybody out there really that does that in an unbiased way, but it might be a great service to the promulgation of future legislation for health care reform.

DR. McCLELLAN: Well, we certainly need to get better evidence, and I'd like to thank all of the panelists for teeing up what's going to be a great set of issues to follow up on today and for our further policy work. Thank you all very much.

And with that, we're going to transition straight into our next panel, which is, I think, going to pick up right where we left off on how do we get from here to there. A very key part of that involves measurement of what we really want which is these better

outcomes for chronically ill individuals.