

ACHIEVING BETTER
CHRONIC CARE AT LOWER
COSTS ACROSS THE HEALTH
CARE CONTINUUM FOR
OLDER AMERICANS



QUALITY. INDEPENDENCE. IMPACT.



ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

Achieving Better Chronic Care at Lower Costs Across the Health Care Continuum for Older Americans

The Engelberg Center for Health Care Reform gratefully acknowledges the support of The John A. Hartford Foundation and The SCAN Foundation, notably the following individuals:

CORINNE RIEDER, EdD

Executive Director and Treasurer, The John A. Hartford Foundation

CHRISTOPHER LANGSTON, PhD

Program Director, The John A. Hartford Foundation

AMY BERMAN, RN

Program Officer, The John A. Hartford Foundation

MARCUS ESOBEDO

Program Associate, The John A. Hartford Foundation

BRUCE CHERNOF, MD

President and Chief Executive Officer, The SCAN Foundation

RENÉ SEIDEL, DIPL. SOZ. PAED (FH)

Vice President of Programs and Operations, The SCAN Foundation

GRETCHEN ALKEMA, PhD

Vice President, Policy and Communications, The SCAN Foundation

ERIN WESTPHAL, MS

Program Officer, The SCAN Foundation

The Engelberg Center for Health Care Reform is committed to producing innovative solutions that will drive reform of our nation's health care system. The Center's mission is to develop data-driven, practical policy solutions that promote broad access to high-quality, affordable, and innovative care in the United States. The Center conducts research, makes policy recommendations, and facilitates the development of new consensus around key issues and provides technical support to implement and evaluate new solutions in collaboration with a broad range of stakeholders.

Improvements in the efficiency and quality of care delivered by the U.S. health care system is largely dependent on reforming the way that care is supported, reimbursed, and delivered to older Americans, who often have multiple chronic illnesses and are in need of long-term services and supports (such as home and community-based services, intermediate care facilities for people with mental retardation/developmental disabilities, or nursing homes). Our rapidly growing older Americans population, which is expected to double by 2030, faces unique health care challenges, making this population among the most expensive individuals in the health care system.¹ Individuals with multiple chronic illnesses warrant particular attention: while they represent only 20 percent of Medicare beneficiaries, they account for approximately 80 percent of Medicare spending. In addition, many older Americans require long-term services and supports (LTSS). Payers like Medicare, Medicaid, older individuals and their families, and private plans spend over \$200 billion a year on LTSS (over 10 percent of U.S. health expenditures). LTSS costs are expected to double in the next 30 years.²

The recently passed health care reform bills – the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (ACA) – include a range of new payment and delivery system reforms designed to improve the overall performance of the health care system and contain the costs of expanding health insurance coverage. Initiatives in the law reflect considerable evidence that addressing the overuse, underuse, and misuse of medical therapies can help “bend the curve” of rising health care spending. The legislation addresses how payment reforms should incorporate long-term care delivery. Future payment and delivery reforms can make a big difference in helping individuals with multiple chronic diseases that face many preventable complications and duplicative or poorly coordinated services.

This paper addresses many of the challenges facing individuals with chronic conditions and functional

impairments and identifies new opportunities for the integration of medical services and social supports tailored to older Americans and supported by new payment designs.

A conference hosted by the Engelberg Center for Health Care Reform at Brookings helped inform the potential solutions to improve the cost and quality of care across the health care continuum for older Americans as discussed below.

CHALLENGES ACROSS THE CARE CONTINUUM

Challenges to improving the delivery of care to older Americans across the service continuum include fragmented financing and care, the lack of integration between medical services and social supports, and the need for more effective measures to evaluate long-term services and supports.

Fragmentation of Financing and Care

Current funding structures need reform to promote the stability of, and encourage innovation in, care for older Americans, particularly long-term services and supports. Medicaid is currently the largest payer of long-term services and supports, but growing state budget deficits may make this funding source unreliable for the future.³ In addition, Medicaid and Medicare reimbursement systems are not well-aligned, leading to less efficient service delivery, higher administrative burdens for individuals, families, and providers, and higher overall health care system costs. Fostering cooperation between these two payers could help ensure the availability of funding for long-term services and supports and avoid cost shifting between Medicare and Medicaid, and between states and the federal government.

Furthermore, fee-for-service reimbursement at large leads to fragmented service delivery, especially when dealing with complicated care requirements like transitions between care settings (e.g. from hospitals to nursing homes or home care after an acute illness). Recognizing that transitions,

especially those including functional impairments, can increase the risk for readmissions, lead to poor health outcomes, and higher health care spending in the coming decades, the Centers for Medicare and Medicaid (CMS) reports hospital quality information. “Hospital Compare” reports information on 30-day readmissions rates for heart attacks, heart failure, and pneumonia and can help older Americans make care transitions choices. Ultimately, new payment reform designs are needed to help promote holistic care, delivered by a team of professionals and caregivers, which supports complex care requirements and incorporates social supports into care plans. This must be done in partnership with, and with the approval of, private payers.

Lack of Integration between Medical Services and Social Supports

Social supports for older Americans may include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), transportation, meals, bathing, and care management that can help keep individuals in their homes longer. The lack of integration between medical services and social supports and the lack of funding for essential social supports present another challenge to improved care for older Americans. Frequently, social supports are from informal caregivers or funded by Medicaid waivers and out-of-pocket

Investment in the direct-service workforce, which includes nearly three million home health aides, personal care workers, and certified nurse aides in nursing homes, home care agencies, and assisted-living facilities, represents a key opportunity for improving integration between medical services and social supports.⁴ Although nearly half of the nation’s spending on long-term services and supports pays for direct-care workers, these workers are often insufficiently trained, underpaid, and underutilized. Training models that better prepare this workforce are critical – particularly those that promote integrated care and improve

chronic care and general geriatric capacity. New training opportunities could lead to expanded care responsibilities and reduce overall health care costs by allowing doctors to focus on targeted medical services. In addition, informal caregivers make up the largest direct service workforce component. Investment in caregiver services like respite, training, counseling, and stress reduction is an important way to improve care and lower costs.

Need for More Effective Measures

Without valid measures of performance that are trusted by providers, payers, and the general public, it is difficult to determine which care delivery reforms increase quality while reducing costs and how to best improve less effective care strategies. This is particularly true for older individuals and those with functional impairments, both of whom typically have the most to gain from such reforms. Therefore, developing ways to accurately measure the quality and efficiency of care for older Americans across the long-term care spectrum is necessary for assessing the effectiveness of current care and payment models.

Performance measurement should target the distinct needs and goals of chronically ill patients through patient- and family-focused measures. This includes having performance measures that focus on the quality and continuity of relationships that health care workers have with their patients. This type of measurement would help incentivize the social aspects of chronic care and more accurately reflect the particular health goals of older Americans.

Recognizing the challenges associated with developing and implementing outcome measures, the first focus should be on structural and process measures. Although outcome measures can provide crucial information, the need for larger sample sizes, remoteness of outcomes to the clinical process, variation in provider inputs, and complicated risk adjustment create barriers to effectively use these measures. Moving forward, there should

be an increased focus on using patient-centered, technically accurate measures to evaluate the unique experiences of older Americans requiring long-term care and incentivize holistic care that includes both medical services and social supports.

PROMISING CARE STRATEGIES

Despite these challenges, a number of care delivery and payment models already underway around the country have the potential to improve outcomes and reduce costs for older Americans. These models and policy directions include the following:

- Infrastructure development, such as electronic health records and increased data analytic capacity, to better coordinate care and improve value on a broad scale;
- New integrated care delivery strategies, which include community-based services and build on electronic data to provide insights about how best to make targeted improvements in care for specific high-risk, high-cost patient populations; and,
- Payment methods that incentivize the delivery of high-value care across the entire care continuum and guarantee that investments in infrastructure and quality improvements are sustainable over time.

Implementing these reforms in a coordinated fashion will help to ensure that these mutually reinforcing reforms have the greatest impact on both curbing the growth rate of health care spending and improving the quality of care provided to older Americans. Fortunately, much progress is already being made around the country in each of the three areas described above and will be further supported by the new health reform law.

Described below are examples of a number strategies, which if implemented broadly and in combination, could help to move the health care system in a direction that provides more coordinated, patient-centered, and efficient care for the growing number of older Americans.

Establishing a Strong Infrastructure for Reform

Both the health reform law and the American Reinvestment and Recovery Act of 2009 (ARRA) have provided means to help accelerate changes at the national level to improve long-term services and supports. ARRA provided unprecedented financing for the “meaningful use” of electronic health record infrastructure. Specifically, ARRA authorized \$17.2 billion for the Centers for Medicare & Medicaid Services (CMS) to assist eligible providers and hospitals in building a health IT infrastructure that results in meaningful use of health IT.

An enhanced health IT infrastructure can inform the development of effective care delivery and payment system reforms, improve care coordination efforts, reduce medical errors, and enhance care quality by promoting care management and enabling quality and cost to be measured at the patient level. However, for this infrastructure to be most effective, it must incorporate evidence-based guidelines that are relevant to the health needs of older Americans with multiple chronic conditions and/or functional impairments.

Through the strategic use of health IT, two promising sites are improving care coordination and delivery for older Americans.

Visiting Nurse Service of New York (VNSNY).

VNSNY uses electronic health records (EHRs) to help manage care for approximately 30,000 patients per day, in 30,000 different locations. VNSNY uses records to exchange information on patient allergies, medications, procedures, and lab results with its hospital and physician partners. They are currently working on real-time electronic data transmission with patients’ primary care physicians.

VNSNY also provides all its nurses, rehabilitation therapists, dieticians, and social workers a laptop computer with wireless access to the VNSNY databases, including a medication database that checks if there may be any negative interactions between medications. The VNSNY created a

password-protected website for patients and doctors where personalized care instructions can be posted. The agency has also developed a TeleHealth program that allows patients to submit their vital signs electronically to a VNSNY nurse coordinator or send a digital picture of a wound to a VNSNY doctor so he or she can determine whether a visit is necessary.

Care Management Plus. Care Management Plus, a cooperative project between the Oregon Health & Science University and the John A. Hartford Foundation, is currently being used in more than 90 clinics, provides special geriatric training to help care managers educate, motivate, and communicate with at-risk patients, their families, and caregivers.⁵ By tracking patient-provider conversations about goals, priorities, and health issues, the program allows caregivers to carefully follow the health status of far more patients than would be possible otherwise. In an initial study done on nearly 4,000 patients, Care Management Plus was shown to reduce exacerbation of illness, improve quality of care, reduce hospitalizations, decrease mortality rates, and reduce costs for patients with chronic complex illnesses.⁶

Making Targeted Care Delivery Improvements

In addition, a range of innovative, integrated care delivery models link traditional medical services with social supports in ways that can reduce complications, enhance outcomes, and improve care transitions. The examples highlighted below are just some of the strategies shown to improve the quality of care for older Americans.

Guided Care. Under the interdisciplinary Guided Care model, developed in 2001 by a team of researchers at Johns Hopkins, primary care practices hire a highly skilled nurse to track, assess, and manage patients with multiple chronic illnesses.⁷ The nurse completes a comprehensive home visit for these patients and uses health IT

to craft an evidence-based care plan that includes all responsibilities of both the care provider and patient. That plan is then distributed to the patient, the patient's family, and the primary doctor. The nurse works closely with the patient's family or home care provider to include in the plan needed social supports and also acts as a facilitator for the patient's and family's use of community services. Early results showed improvements in care quality, as well as a reduction in total costs, rates of hospital admissions, days admitted, and emergency room visits.⁸ The net cost savings offset the cost of adding a nurse to a practice.⁹

Programs for All-Inclusive Care for the Elderly (PACE). PACE combines varying funding streams to deliver a comprehensive set of services for older Americans focused on the health and well-being of the individual. PACE caters to individuals 55 years or older that require nursing home care and provides all needed medical and supportive services across the continuum of care in an effort to maintain individuals' independence. PACE also coordinates medical care and social supports, including primary care, medical specialists, home health care, respite care, necessary hospital and nursing care, prescription drugs, nutritional counseling, social work, personal care, physical, occupational, and recreational therapies, and other needed social and medical care.

The Care Transitions Program. The Care Transitions Program¹⁰ is a four-week program that uses a transition coach to provide services to patients with complex needs. These include specific tools and self-management skills relevant for the transition from hospital to home. This program aims to support patients and families by implementing system level interventions to improve quality and safety. The program also aims to increase skills among healthcare providers, and develop health IT-supported performance measures and public reporting mechanisms that can promote the exchange of health information across care settings.

The Transitional Care Model. The Transitional Care Model¹¹ uses a transitional care nurse to coordinate patients moving from the hospital to their home. Collaborating with the patients' physicians and family caregivers, the transitional care nurse provides a comprehensive assessment of patient and family caregiver needs, coordinates patients' discharge plans with the hospital care team and the family, and helps to implement this care plan in the patient's home. The transitional care nurse is available to their assigned patients through home visits and by phone for 1 to 3 months after the patients discharge.

The Visiting Nurse Service of New York Transitional Care Model. The VNSNY uses an innovative and effective hybrid transitional care model that couples the care transition models discussed above with an algorithm that predicts a patient's risk of readmission.¹² Based on risk scores, the VNSNY will target high-risk patients for more intensive care and attention, including follow-up appointments and a focus on medication reconciliation. Use of this model reduced readmissions rate by four percent last year and has helped to build strong partnerships with hospitals.¹³

As noted above, critical to the long-term success of these programs is a measurement infrastructure that address the unique health needs of older Americans and that can measure the impact of these reforms.

The Long Term Quality Alliance (LTQA) is working to address this gap by advancing the development and testing of quality measures that serve patients and family care-givers receiving long-term services and supports, and that position providers to apply best practices to enhance quality of life, improve care, and reduce costs. Initially, the LTQA will focus initially on how to improve transitions in care and avoid unnecessary hospital admissions among frail and chronically ill people receiving long term services and supports. The LTQA includes providers of long-term services and supports, policymakers, researchers, and consumer and family care-giver advocates.

Innovative Payment Models to Make Infrastructure and Care Delivery Reforms Effective and Sustainable

Although investments in health IT infrastructure and new care delivery models have the potential to improve the quality of long-term services and supports, sustainable payment reform strategies that reverse perverse incentives and reward high quality care are needed in our current fee-for-service system. Fortunately, promising models intended to incentivize investments in infrastructure and staff, such as Accountable Care Organizations (ACOs), the Patient-Centered Medical Home, and bundled payments are already being developed and tested.

Accountable Care Organizations (ACOs). In the ACO model, groups of physicians, hospitals, and other providers collaborate for the opportunity to receive shared-savings bonuses from payers for meeting quality improvement targets and demonstrating reductions in overall spending growth for a defined population of patients. Unlike traditional pay-for-performance programs, which often add to total costs by paying out incremental financial bonuses in exchange for meeting certain benchmarks on process measures, ACOs place a much greater emphasis on measuring and rewarding results at the level of a population of patients. In addition, the ability to earn shared savings can justify investments in infrastructure and care delivery interventions that are shown to result in better outcomes with less overall resource use.

ACOs attempt to alter the current set of perverse payment incentives in the health care system by encouraging the type of increased quality that is demonstrated in the care delivery models discussed above but at lower costs. Furthermore, ACOs are structured to be able to work in conjunction with other payment reform models, including the Patient-Centered Medical Home and bundled payment models described below.

The Patient-Centered Medical Home. This hybrid care delivery and payment reform model works to integrate and coordinate care by strengthening the relationship between the physician, patient, and patient’s family.¹⁴ The model employs a team-based care structure, blending medical and social supports. The models also encourage the provision of care in lower cost settings, such as the patient’s home. The medical home model builds on the current payment system by rewarding providers based on quality measures and providing a monthly management fee to help support investments in health IT and management tools.¹⁵ This holistic approach to care delivery has been proven to improve both health outcomes and patient satisfaction with their care.¹⁶ By supporting the development of lasting relationships between formal caregivers, patients, and informal care givers, as well as supporting care outside formal care delivery settings, the PCMH has potential to improve the quality of care for older Americans.

Bundled Payments. Bundled payments – which compensate providers with a single payment related to a treatment or condition – have the potential to improve care for older Americans, especially those with multiple, chronic conditions. Under this payment model, providers assume financial risk for the cost of services and work, which can incentivize the delivery of more efficient care.

Bundled payments are already widely used in both Medicare and the private sector and have been shown to reduce overall spending. Examples include Medicare’s Prospective Payment Systems (PPS) demonstration¹⁷ and Participating Heart Bypass Center Demonstration (CABG).¹⁸ Medicare also launched the Acute Care Episode (ACE) demonstration in 2009, which provides global payments for acute care episodes within Medicare fee-for-service.¹⁹ Additionally, Prometheus Payment Pilots²⁰ and Geisinger’s ProvenCare²¹ are employing alternative bundled payment models. The new health care reform law also authorized new pilot and demonstration programs to include bundled payments for both Medicare and Medicaid.

Many of these efforts to develop infrastructure, improve care delivery interventions, and develop accountability-based payments are still in early stages and are being implemented in a piece-meal fashion. However, if implemented in a coordinated manner, they could offer a significant opportunity to reduce costs and improve quality of care delivered to older Americans.

Additional technical work is needed to find effective, replicable ways to improve care transitions, expand programs that seek to align multiple public- and private-payer funding sources, and couple care delivery reforms with sustainable payment models. Payment models that are effective from both a care and business perspective, and are supported by government policies, present the best vehicle for disseminating reforms to long-term services and supports.

EXPANDING AND SUPPORTING STRATEGIES TO IMPROVE CARE FOR OLDER AMERICANS

While there are many promising strategies available to reform the way care is delivered to older Americans, it is critical to find ways to disseminate and implement these strategies. These reforms often call for investments in additional staff or infrastructure and additional technical work is still needed to encourage collaboration between the public and private sector, increase geriatric competency across provider groups, and ensure care delivery and payment reforms incorporate the unique needs of older Americans. Coupling care delivery reforms with sustainable payment methods will encourage providers to re-think the way they deliver important services to older Americans. The following federal partners can support improved care delivery and payment strategies for reforms designed to improve the quality of life of older Americans.

Centers for Medicare & Medicaid Services (CMS). Medicare is intended to cover acute and post-acute care for older Americans, as well as pay for some prescription drug benefits, necessary home

health services, part-time or intermittent skilled nursing care, or physical, speech, or occupational therapy for home bound beneficiaries. Medicare, however, is not designed to provide coverage of long-term services and supports; instead Medicaid covers over 62 percent of all long-term services and supports spending, or \$119 billion. The reforms in the ACA, discussed in more detail below, includes many important provisions that are directly related to individuals with multiple chronic conditions and functional impairments.

The Federal Coordinated Health Care Office (CHCO), The Federal Coordinated Health Care Office, authorized by the Affordable Care Act, will integrate care for individuals who are dually eligible for Medicaid and Medicare and coordinate federal and state efforts. Dual eligibles have complex chronic conditions and functional impairments, and they are a very costly group for CMS and state Medicaid offices. CHCO will integrate benefits and delivery; reduce cost-shifting between Medicare, Medicaid, and other payers; and improve care quality for dual eligibles.

The Administration on Aging (AoA). The AoA supports critical social services for older Americans living in the community. Through the Older Americans Act, the AoA provides an array of services to support both health and independence that can be tailored to specific individuals, increasing as they need more assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).²² This includes supporting the less expensive, but extremely important, home and community-based services. It also focuses on empowering older Americans and their caregivers so that they can make informed decisions, and it ensures the rights of older people to prevent any abuse, neglect, or exploitation.

Office of the National Coordinator (ONC). The ONC coordinates the development of a nationwide health IT infrastructure. Collecting and sharing data on “meaningful use” measures relevant to older

Americans is a critical aspect of coordinating care both within and across care settings. However, many current measures and data collection practices only focus on “adult” indicators that do not take into account many of the unique health needs of older Americans, particularly those with functional impairment. Working with the ONC to develop measures and data collection practices can help to ensure that evidence-based approaches for delivering care to older Americans and models for preventing unnecessary readmissions and prescription drug complications are supported and advanced.

Centers for Disease Control and Prevention (CDC). The CDC provides information and promotes health through partnerships to enhance health decisions regarding issues pertaining to public health and safety. The CDC has great capacity to make real impact on improving the lives of older Americans. By collecting and disseminating data on issues pertinent to the health of older Americans, the CDC can help clarify the needs, concerns, and quality of care being delivered to older Americans.

For example, The State of Mental Health and Aging in America is a CDC project that provides data on six indicators related to the mental health of adults over the age of 50. The data derived from this project helps communities develop evidence-based programs and approaches towards addressing late-life depression and other mental health issues relating to older Americans. The CDC Health Action Network (HAN) ensures that communities have rapid and timely access to emergent health information, highly-trained health personnel, and evidence-based practices and procedures for effective public health preparedness, response, and service on a 24/7 basis.²³

The Agency for Healthcare Research and Quality (ARHQ). ARHQ has invested heavily in patient-centered outcomes research, also known as comparative effectiveness research. AHRQ, in cooperation with the Federal Coordinating Council and the Institute of Medicine, is now

working to expand the definition of care delivery interventions to include elements that lay outside the traditional clinical scope. AHRQ is also the national leader in developing quality measures for home and community based services that are offered under state Medicaid programs. The agency is also supporting research that works to optimize prevention in health care management for individuals with multiple chronic illnesses. Finally, AHRQ is working to make sure integrated care has the needed infrastructure in place to be effective by supporting health IT. This includes an Active Aging project which supports individuals by enhancing community-based care through health IT. This kind of support could help to propel promising care delivery strategies focused on older Americans into practice.

Health Care Reform and Older Americans

The new law offers significant opportunities to improve the delivery and quality of long-term services and supports across the care continuum. In particular, it provides new funding for home and community-based services, which can help promote coordination between medical and social services, as well as support for the direct-care workforce. It also creates a voluntary, federally-administered insurance program known as the CLASS (Community Living Assistance Services and Supports) Independence Benefit Plan to provide coverage for long-term care needs. Financed through voluntary payroll deductions, the program will support community living assistance through cash benefits to individuals with substantial impairments.

The new health care reform law also supports Medicaid's provision of long-term services and supports through a number of different federal programs and demonstrations that increase and streamline funding by:

- Extending the Medicaid Money Follows the Person Rebalancing Demonstration through September 2016;
- Allocating additional funds to the Aging and Disability Resource Center Initiatives;
- Providing states new options for offering home and community-based services;
- Establishing the Community First Choice Option in Medicaid to provide home and community-based attendant services and supports to individuals with disabilities requiring an institutional level of care; and
- Encouraging states to increase the proportion of non-institutionally-based long-term services and supports by enhancing federal matching payments for these services (State Balancing Incentive Program).²⁴

The law also uses a number of different mechanisms to promote transparency and accessibility and improve care quality in nursing homes. In addition, it creates a national nurse aid registry and a national background check program for employees of long-term care facilities and providers.

With respect to supporting the direct-care workforce, the law allocates funding for demonstration programs that focus on developing core geriatric competencies for personal and home care aides. Grants are also available for training direct-care workers employed in long-term care settings, including nursing homes, assisted living facilities, home care settings, and other settings deemed appropriate. The Elder Justice provisions contained within the law provide a number of grants and incentives for improved training, career ladders, and wages and benefits of long-term care-focused staff. It also includes several other educational and training programs to promote health care professions, including funds for those willing to work in medically underserved areas and for the development of a community health workforce. Several health care workforce commissions and panels have also been authorized to inform and oversee reforms, including the Personal Care Attendants Workforce Advisory panel.

Finally, the law established the Center for Medicare and Medicaid Innovation (CMI) inside CMS, which will test innovative payment and service delivery models that have the potential to reduce health care costs while improving care. This could include reforms aimed at improving care for older Americans through better care integration and coordination and payments that support value rather than quantity and intensity of care.

CONCLUSION

The care delivery and payment models discussed throughout this paper provide insight into how future reforms that aim to improve care across the continuum for older Americans can be most effective. First, care delivery models are greatly enhanced when they are supported by a robust health IT infrastructure focused on the unique needs of older Americans, such as relevant evidence-based care plans, cross-checks on medications, and tools to increase geriatric competency. Second, care delivery strategies should integrate medical services and social supports through a team of providers that include doctors, nurses, health aides, family

caregivers, and the patient. Third, care delivery strategies need to be accurately evaluated using performance measures that incorporate individual patient goals and consider quality of life, as well as account for the unique needs of older Americans. Finally, care delivery strategies should be supported by payment reforms that incentivize quality care rather than volume and intensity of services, and help recruit and support a larger healthcare workforce better trained in geriatrics and team-based approaches.

As the ACA is implemented in the coming months and years, it will be critical for all stakeholders to focus collectively on the principles outlined above. Without payment reforms to support integrated care strategies and the adoption of better health IT infrastructure, care for older Americans will remain fragmented and costly; however, the integration of the health IT infrastructure, care strategies, payment reforms outlined above could result in real and lasting improvements in the care provided to older Americans with chronic conditions and functional impairments.

ENDNOTES

1. Institute of Medicine of the National Academies. Retooling for an Aging America: Building the Health Care Workforce. Washington (DC): The National Academies Press; 2008. Available from: <http://www.iom.edu/Reports/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce.aspx>
2. Doty M, Koren MJ, Davis K. Data Brief: Health Care Opinion Leaders' View on the Future of Long-Term Care [internet]. New York (NY): The CommonWealth Fund; 2008 Aug [cited 2010 Mar]. Available from: http://www.commonwealthfund.org/~media/Files/Publications/Data%20Brief/2008/Jul/Health%20Care%20Opinion%20Leaders%20Views%20on%20the%20Future%20of%20Long%20Term%20Care/Doty_hltcareopinionleadersviewslong%20termcare_1157_db%20pdf.pdf
3. The Engelberg Center for Health Care Reform. Health Care Reform and Older Americans: Achieving Better Chronic Care at Lower Costs [Event transcripts]. Washington (DC): The Brookings Institution; 2010. Available from: http://www.brookings.edu/events/2010/0128_older_health_care.aspx
4. National Health Policy Forum. The Basics: National Spending for Long-Term Services and Supports. Washington (DC): 2010. Available from: http://www.nhpf.org/library/the-basics/Basics_LongTermServicesSupports_04-30-10.pdf
5. Care Management Plus Website. Portland (OR): Oregon Health & Science University. Available from: <http://caremanagementplus.org/>
6. Dorr D, Wilcox A, Bruncker C, Burdon R, Donnelly S. The Effect of Technology-Supported, Multidisease Care Management on the Mortality and Hospitalization of Seniors. *J Am Geriatr Soc.* 2008 Dec; 56(12): 2203-2210.
7. Guided Care Website. Baltimore (MD): John Hopkins, Bloomberg School of Public Health; 2010. Available from: <http://www.guidedcare.org/>
8. Boulton C, Green AF, Boulton L, Pacala J, Snyder C, Leff B. Successful Models of Comprehensive Care for Older Adults with Chronic Conditions: Evidence for the Institute of Medicine's 'Retooling for an Aging America' Report. *J Am Geriatr Soc.* 2009; 57(12): 2328 – 2337.
9. The Engelberg Center for Health Care Reform. Health Care Reform and Older Americans: Achieving Better Chronic Care at Lower Costs [Event transcripts]. Washington (DC): The Brookings Institution; 2010. Available from: http://www.brookings.edu/events/2010/0128_older_health_care.aspx
10. The Care Transitions Program Website. Denver (CO): University of Colorado Denver, School of Medicine; 2007. Available from: <http://www.caretransitions.org>
11. Transitional Care Model Website. Health Workforce Solutions LLC and the Robert Wood Johnson Foundation; 2008. Available from: http://www.innovativecaremodels.com/care_models/21/overview
12. Rosati R, Huang L. Development and testing of an analytical model to identify home health care patients at risk for hospitalization within the first 60 days of care. *Home Health Care Serv Q.* 2007; 26(4): 21 – 36.
13. The Engelberg Center for Health Care Reform. Health Care Reform and Older Americans: Achieving Better Chronic Care at Lower Costs [Event transcripts]. Washington (DC): The Brookings Institution; 2010. Available from: http://www.brookings.edu/events/2010/0128_older_health_care.aspx
14. Patient Centered Primary Care Collaborative Website. Joint Principles of the Patient Centered Medical Home. Washington (DC): 2009. Available from: <http://www.pcpc.net/node/14>
15. Fisher E. Building a Medical Neighborhood for the Medical Home. *N Engl J Med.* 2008; 359(12): 1203.
16. Rosenthal T. The Medical Home: Growing Evidence to Support a New Approach to Primary Care. *J Am Board Fam Med;* 2008 21(5): 427 – 440
17. Coulam RF, Gaumer GL. Medicare's Prospective Payment System: A Critical Appraisal. *Health Care Financ Rev Annu Suppl.* 1991: 45-77.

18. Cromwell J, et al. Medicare Participating Heart Bypass Center Demonstration: Final Report. Health Care Financing Administration. 1998. Available from: http://www.cms.gov/reports/downloads/oregon2_1998_3.pdf
19. Centers for Medicare & Medicaid Services. Solicitation for Applications: Acute Care Episode Demonstration [internet]. Baltimore (MD): US Dept of Health and Human Services; 2009. Available from: <http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACESolicitation.pdf>
20. Gosfield AG. PROMETHEUS Payment: Getting Beyond P4P. *Group Pract J*. 2006; 55(9): 14-19.
21. Casale AS, et al. ProvenCare: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care. *Ann Surg*. 2007; 246(4): 613-623.
22. The Engelberg Center for Health Care Reform. Health Care Reform and Older Americans: Achieving Better Chronic Care at Lower Costs [Event transcripts]. Washington (DC): The Brookings Institution; 2010. Available from: http://www.brookings.edu/events/2010/0128_older_health_care.aspx
23. Health Action Network Webpage. Atlanta (GA): Center for Disease Control and Prevention; 2002. Available from: <http://www2a.cdc.gov/han/index.asp>
24. The Henry J. Kaiser Family Foundation. Focus on Health Reform: Summary of New Health Reform Law. Menlo Park (CA): 2010]. Available from: <http://www.kff.org/healthreform/upload/8061.pdf>



QUALITY. INDEPENDENCE. IMPACT.



ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

1775 Massachusetts Ave., NW, • Washington, DC 20036 • www.brookings.edu/healthreform