

INNOVATIVE COMMUNITIES:

breaking down barriers

for the **good** of consumers
and their family caregivers



ltqqa
LONG-TERM
QUALITY ALLIANCE

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mission statement

To improve the effectiveness and efficiency of care and the quality of life of people receiving long-term services and supports by fostering person- and family-centered quality measurement and advancing innovative best practices.

acknowledgements

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The Summit was conceived and implemented by two Long-Term Quality Alliance (LTQA) Workgroups: The Outreach/Public Awareness Workgroup, led by Larry Minnix, president and chief executive officer of LeadingAge, formerly the American Association of Homes and Services for the Aging, in Washington, D.C.; and the Quality Improvement/Best Practices Workgroup, led by Amy Boutwell, director of strategic improvement policy at the Institute for Healthcare Improvement in Cambridge, Mass.



Discussions that took place during the Innovative Communities Summit were facilitated by Kermit Eide, president of K.M. Eide and Associates in Williamsburg, Va., and Maribeth Fidler, founding partner of Cygnet Strategy LLC in Lancaster, Pa.



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introduction and overview

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Alma's mother arrives in Washington, D.C. in 2008 for what is supposed to be a short visit with her daughter, son-in-law, and teenage grandson. However, it quickly becomes clear to Alma that her mother is not going home anytime soon. Clearly, Alma's mother is more impaired than her family realized.

Without hesitation, Alma and her family decide that they will offer Mom a home with them for as long as she needs it. They know this is the right thing to do, but they also understand that it will not be easy. Alma and her husband both work full time and their son attends school. Consequently, Alma's mother spends a good deal of her waking hours alone.

Alma's mother is a retired domestic worker and qualifies easily for Medicaid. But getting Alma's mother the home- and community-based services she needs proves more difficult. Despite the fact that she now lives in one of the nation's most service-rich areas, Alma's mother receives no services. Instead, she receives a place on a Medicaid waiting list.

On a snowy holiday weekend in early 2009, Alma's mother has a medical emergency. Alma calls "911" and her mother's medical odyssey begins. She is taken to one hospital, and then transferred to another. Neither hospital seems to have a handle on her condition. Her primary care physician is never called. A few days later, Alma's mother is sent back home with no services or supports to ease her transition and no one to help manage her care. Except Alma, that is.

Alma does her best, but her mother's condition continues to deteriorate. Doctor and hospital visits become more frequent. Prescriptions multiply. Unfortunately, Alma's mother does not recover. After a few months of illness and family strain, Alma's mother dies. A few days later, Alma receives a call. Her mother has moved up to number 176 on the waiting list for Medicaid waiver services.

The story of Alma and her mother is all too real for millions of older Americans who, each year, leave hospitals without the support they and their families need to help them transition back into the community. All too often, initial hospitalizations lead to rehospitalizations or, as in the case of Alma's mother, to extremely poor outcomes.

Alma's story has served as to galvanize the Long-Term Quality Alliance (LTQA) since its launch in early 2010 because it puts a real face on the heartbreaking challenges that many older people, their families, and their caregivers face each and every day. The story spurred LTQA organizers to action because it illustrated all too clearly our nation's collective failure to help older consumers and their families understand and navigate a fragmented health care system. On a broader scale, it also illustrates our nation's failure to fix that health care system by offering physicians, hospitals, providers of long-term services and supports, and community-based service providers the incentives they need to step across the barriers that keep them from working together for the good of consumers and their families.

Fittingly, Alma's story also served to galvanize the 150 individuals who gathered in Washington, D.C., on December 10, 2010, to participate in LTQA's Innovative Communities Summit. Hailing from all regions of the country, Summit participants represented a wide variety of organizations that create policies and provide services and supports that impact the lives of older people and people with disabilities. Participants came from organizations representing federal and state government; advocacy and service organizations serving older consumers, individuals with disabilities, and their caregivers; national, state

and local professional associations; the aging network; hospitals and health systems; and organizations that provide acute care, long-term services and supports, housing, and home- and community-based services. Our participants were policy makers, social scientists, social workers, nurses, physicians, researchers, case managers, educators, students, business leaders, elected officials, and marketing professionals — all the stakeholders we will need at the table in order to truly reform the system through which consumers receive health care, services, and supports in their later years.

Despite their geographic diversity, participants shared a common, and strong, interest in working together to reform that health-and-service system so that Alma's story would become a distant memory of the ways things "used to work."

Long-Term Quality Alliance

The Innovative Communities Summit represented the first of many opportunities for LTQA to serve as a neutral convener of broad-based groups concerned about and committed to advancing change within the nation's health care system in order to improve effectiveness and efficiency of care and quality of life while saving health care dollars. This was the primary goal of the steering committee that evolved into the launch of LTQA in 2010 under the expert guidance of Dr. Mark McClellan, former administrator of the Centers for Medicare and Medicaid Services (CMS) and currently director of the Engelberg Center for Health Care Reform, and Leonard D. Schaeffer Chair in Health Policy Studies, at the Brookings Institution. That diverse steering committee sought to capitalize on the new mandate

in Washington to reform the current health care system, primarily through the Affordable Care Act. LTQA's leaders hoped that such reform would create measures that help shed light on how consumers and family caregivers experience long-term services and supports and that gauge the quality of the services they receive both at home and in health and long-term care settings. LTQA also wanted to engage consumers and their caregivers in efforts that improve care transitions and coordination, promote earlier access to palliative and end-of-life care, and minimize unnecessary overuse of services. All the while, LTQA's organizers were cognizant of the fact that no reform would be successful or sustainable unless and until we took steps to introduce efficiencies into the system that would trim costs and support and strengthen the workforce that we depend on to provide critical care and services to older consumers.

Establishing Innovative Communities

The Innovative Communities Summit focused a spotlight on a central theme that drives the Alliance's work. While action on the national level is certainly integral to health care reform, LTQA is convinced that the most important health reform victories will take place at the local level, in cities and towns around the country. A broad range of community stakeholders — including physicians, hospitals, Area Agencies on Aging, long-term and post-acute care providers, visiting nurses, affordable housing providers, adult day health programs, home care agencies, and consumers, to name only a few — is needed to help older people and people with disabilities remain healthy and independent. Health care reform will not succeed unless all of these local

stakeholders pool their collective energy, break down the silos in which they operate, and work together to devise and implement strategies and interventions that advance and improve care. Those strategies and interventions must be aligned with the needs, preferences, and values of consumers and their family caregivers.

LTQA is fully committed to helping communities around the nation take this collective action. For this reason, community delegations of three-to-five individuals were invited to attend the Summit and explore the possibility of participating in a multi-year project for which LTQA intends to seek funding. Such a project would be designed to provide a number of local Innovative Communities with the support and assistance they need to create multi-sector cooperatives. Those cooperatives would unite local health and service providers, as well as consumers and their caregivers, in a broad-based coordinated effort that advances LTQA's mission to increase the quality of and accessibility to care and services that promote wellness and independence, reduce unnecessary hospitalizations, improve care transitions, and save health care dollars.

Avoidable Hospitalization and Care Transitions

It came as no surprise to participants at the LTQA Innovative Communities Summit that hospitalizations and care transitions would be among the day's major themes. That's because transitions across care settings are common occurrences for frail elders, particularly for those with complex medical conditions. The number of patients discharged from hospital to home health care increased 53 percent between 1997 and 2006,

while the number of patients discharged to nursing homes or rehabilitation facilities increased by 25 percent during the same period.¹ The real impact of these increases become apparent when you consider that nearly half of community-dwelling older adults discharged from a hospital to a nursing or rehabilitation facility experienced four or more care transitions to another institution over the next 12-month period.²

Transitions across settings have become increasingly recognized as critical junctures that can affect the health and functional ability of vulnerable older people.³ When people are hospitalized or admitted to a nursing home, they typically receive care from providers who are not familiar with their medical history, medications, and care preferences. Older adults with temporary or permanent cognitive impairments who leave an institution may not understand discharge instructions. Ironically, caregivers are often left out of the discharge process, even though they play a critical role in providing care following a stay in an acute- or post-acute care facility. As a result, patients often fail to follow up with recommended care and medications, their primary care physicians are not kept informed of the patient's condition, and family caregivers endure additional strain. The real tragedy is that many hospitalizations are avoidable.

The work of LTQA Board Member Amy Boutwell, director of strategic improvement policy at the

Institute for Healthcare Improvement (IHI), sheds an important light on the serious nature of poor transitions and rehospitalizations. In a 2009 report for The Commonwealth Fund about the State Action on Avoidable Rehospitalizations Initiative (STAAR),⁴ Boutwell and her colleagues at IHI reported that more than a quarter (28%) of initial hospitalizations are avoidable while the same is true for 76 percent of Medicare rehospitalizations.

Who is at highest risk for rehospitalization? According to the IHI report, it is patients with chronic illnesses like heart failure and chronic obstructive pulmonary disease; the frail elderly; patients residing in nursing homes or who receive home health care services; patients nearing the end of life; and individuals with psychiatric illness, substance abuse, and complex social challenges, including poverty. As a group, individuals with more than five chronic conditions have the most complex medical conditions and highest rates of rehospitalization.

As mentioned earlier, hospitalizations and rehospitalizations are hard on patients, because they often compromise health and emotional well-being. But they are also extremely expensive. Avoidable hospitalizations cost approximately \$29 billion while avoidable rehospitalizations among Medicare patients alone account for \$15 billion in spending annually, according to IHI.

¹ Agency for Healthcare Research and Quality. 2008. "Hospital Discharge to Home Health, Nursing Homes Increasing." *AHRQ News and Numbers*, Oct. 23.

² Ma, E., et al. 2004. "Quantifying Post-Hospital Care Transitions in Older Patients." *Journal of the American Medical Directors Association*, (5) 71-74.

³ AARP. 2009. "Chronic Care: A Call to Action for Health Reform." Beyond 50.09. Washington, D.C.: AARP Public Policy Institute.

⁴ Boutwell, A., et al. 2009. *State Action on Avoidable Rehospitalizations (STAAR) Initiative: Applying Early Evidence and Experience in Front-line Process Improvements to Develop a State-based Strategy*. Cambridge, MA: Institute for Healthcare Improvement.

Collaboration is Key

Improving care transitions and reducing rehospitalizations will not be easy, but LTQA believes it is possible and a worthy strategy to improve quality of care and quality of life for older people and people with disabilities. Clearly, the time is right for such an initiative. The Affordable Care Act⁵ signed into law in early 2010 directs Medicare to recover payments made to hospitals for unnecessary readmissions within 30 days of discharge. Beginning in October 2012, a hospital's total Medicare payments could be reduced by up to three percent over three years. The looming mandate could very well give hospitals the incentive they need to participate in the kind of multi-sector collaboratives that LTQA would like to support.

Granted, our current health care system is not wired for collaboration. Separate funding streams, regulations, and care practices in each sector have served to separate providers from one another, not unite them in the care of their common consumer. By the time consumers require a hospitalization, therefore, they are receiving care from multiple providers, who operate in different settings, receive reimbursement from separate government programs, follow different rules, and don't communicate with one another. Of primary concern is the fact that, operating in relative isolation, these providers are each developing separate care plans for the same consumer, each giving that consumer different instructions about self-care, and each writing prescriptions that, taken together, could cause overmedication or adverse drug interactions.

In such a fragmented system, it remains the responsibility of the consumer to bridge the gap between and among providers. This is a challenge for all health consumers. But in the case of frail or ill consumers and their overburdened caregivers, the results are often disastrous, as the figures presented here illustrate.

Collective Impact

Despite these many challenges, LTQA remains convinced that collaboration is not only possible, but is already taking place in a number of communities around the country. Participants in the LTQA Innovative Communities Summit heard from three of those communities. (See page 9.) In addition, each participant came to the Summit with an important resource that served as a backdrop for much of the day's discussions. That resource, a December 2010 article published in the *Stanford Social Innovation Review*,⁶ explored a new "Collective Impact" approach to community change that could provide a model for the Innovative Communities that LTQA would like to foster and support.

In the article, authors John Kania and Mark Kramer describe the experiences of Strive, a nonprofit organization that has succeeded in using a community-wide collaborative to improve student success in three large, cash-strapped school districts in Ohio and Kentucky. Despite its focus on education, Strive's success has many lessons for LTQA and its Innovative Communities initiative. For one thing,

⁵ Read the full text of the "Patient Protection and Affordable Care Act (HR 3590)" at: <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

⁶ Kania, John and M. Kramer. 2011. "Collective Impact." *Stanford Social Innovation Review*, Winter.

both Strive and LTQA are focusing on an extremely complex problem that resists easy fixes. The authors suggest that Strive succeeded where others have failed because “a core group of community leaders decided to abandon their individual agendas in favor of a collective approach.” Participants in LTQA’s Summit felt that similar efforts to “check our egos at the door” would go a long way toward building the same kind of success within Innovative Communities.

Additionally, Summit participants agreed that the reasons behind Strive’s success could easily become the reasons behind our success:

1. **Holistic approach.** Strive decided that fixing one part of the education system wouldn’t bring about sustainable success unless all parts of the system improved at the same time.
2. **Emphasis on teamwork.** Strive recognized that no single organization could accomplish system transformation alone.
3. **Tapping existing resources.** Strive did not create a new program. Instead it focused the entire educational community on a single set of goals that were measured in the same way.
4. **A dedicated infrastructure.** In a particularly unique approach, Strive partners didn’t collaborate as a group of separate organizations with their own agendas. Instead, the improvement initiative operated through a central infrastructure, a dedicated staff, and a

process that united all the participants through a common agenda, shared measurement, continuous communication, and mutually reinforcing activities.

The experience of Strive, and similar initiatives highlighted in the *Stanford Review* paper, suggest that large-scale social change comes from better cross-sector coordination, not from isolated intervention by individual organizations. LTQA could not agree more. The path we take in creating Innovative Communities may be different from the “Collective Impact” approach, but we believe this model is worth referring back to as we move forward.

Key Presentations

Much of the work of the LTQA Innovative Communities Summit took place around 15 round tables, which were arranged within a large meeting space at the Georgetown Conference Center in Washington, D.C. At those tables, Summit participants conferred with members of their own delegations. They also shared their stories and ideas with federal policy makers, aging and disability advocates, and members of delegations from other parts of the country. In addition, the participants heard several presentations designed to inform and inspire them.

After sharing Alma’s story with participants, LTQA Board Member Larry Minnix challenged the communities present to commit themselves to working together over the next five years to develop Innovative Communities. Minnix, president and chief executive officer of LeadingAging, formerly

the American Association of Homes and Services for the Aging, expressed his interest in seeing Innovative Communities develop best practices “that demonstrate large-scale results, which can be reported to the government and shared among colleagues nationwide, and which say, ‘We can solve this problem.’” LTQA Board Member Amy Boutwell applauded participants’ willingness to put consumers “at the center of what we do every day.” When providers can ask those consumers the right questions, and listen carefully to their answers, “they understand that their purpose is to make the system work better for people over time and across settings,” she said.

LTQA Board Member (*ex officio*) Kathy Greenlee, the assistant secretary of aging, was on hand to demonstrate the Administration on Aging’s (AoA) interest in working with LTQA and the Centers of Medicare and Medicaid Services (CMS) to improve the lives of older consumers. In addition, Greenlee underscored the need to prepare for the impact that successful Innovative Communities could have on the aging network.

“I believe strongly that the opportunity we have now to work on Innovative Communities and care transitions is finally and appropriately a way to blend the medical model and the social model, to have a holistic approach for acute care, long-term care, and social services,” she said. “But when we are successful, we will create a huge demand for the supportive services that AoA offers, including meals, attendant care, and caregiver support. We need to think about how we are going to support these services. It will take all of us to get it done.”

LTQA Board Member (*ex officio*) Dr. Paul McGann, deputy chief medical officer in the Office of Clinical Standards and Quality at CMS, described the transformational changes that have taken place within his agency since the arrival of its new Administrator Dr. Donald Berwick. But he encouraged participants to look to themselves, rather than to government, for the solutions that will transform a fragmented health system.

“I’m here to tell you that we want to be a partner, and we want to help you in this effort,” he told Summit participants. “But you are going to have to find the leadership and the courage to lead a new movement that is committed to people and to quality. I can pledge to you that as long as I am at CMS, we will be right behind you and do everything in our power to help.”

Organization of This Report

The remainder of this report attempts to give readers a feel for the energy, optimism, and good will that was on display during LTQA’s Innovative Communities Summit. Participants arrived ready to dream about a different future for older consumers and consumers with disabilities. As the day progressed, an assembly of 150 separate individuals became a cohesive group that worked together to devise cross-sector strategies that could someday allow us to successfully improve the quality of care and quality of life for the people we serve and, in the process, save health care dollars.

The report you are about to read follows, as much as possible, the Summit discussions as they evolved throughout the day, including:

- **Case studies.** Leaders of three Innovative Communities informed and inspired participants with presentations about the impressive work that is already underway in North Carolina, Vermont, and Michigan.
- **A vision for the future.** During late-morning and early-afternoon work sessions, Summit participants created a common vision for a more collaborative future.
- **A role for LTQA.** At the Summit's conclusion, participants identified the role they hoped LTQA would play in creating a national collaborative of multi-sector Innovative Communities.

case studies



Chapel Hill,
North Carolina

community connections

- *Patricia Sprigg, President and Chief Executive Officer*
- *Heather Altman, Project Director, Community Connections*
- *Carol Woods Retirement Community*

When construction of the Carol Woods Retirement Community began in the mid-1970s, it wasn't an outside developer that designed the community's layout or obtained the necessary permits and financing. It was an active group of local residents, many of them retired professors who had spent many years living in Chapel Hill and teaching at the University of North Carolina (UNC). The group banded together with the common goal to establish a place where they could live after retirement while enjoying the amenities they desired, accessing the services they needed, and remaining active members of the city they had come to love.

Over the past 31 years, the community spirit of its founders is still alive among Carol Woods' 467 residents and its not-for-profit board of directors. That spirit led Carol Woods to spearhead a community-wide collaborative, known as Community Connections, which is designed to bring primary, acute, and long-term care providers, community-based organizations, and consumers together to make sure that older community residents and citizens with disabilities get the services they need, when and where they need them.

As a popular destination for retirees, and one of the fastest growing Medicaid spenders in the nation, North Carolina and its individual counties have long been concerned about the impact that an aging Baby Boom population would have on their communities. In 2004, local leaders in Orange County (where Carol Woods is located) faced these issues head-on by developing a Master Aging Plan that identified the types of services that the county's current and future aging population would need. Carol Woods President and Chief Executive Officer Patricia Sprigg, who co-chaired the county planning process, took seriously the conclusions of the Master Aging Plan, particularly its identification of transitions between care settings as a major challenge for older citizens as their health care needs and level of functioning changes over time. In 2006, Sprigg led Carol Woods' effort to apply for a one-year planning grant from The Duke Endowment that would support a formal assessment of the factors impacting the health and safety of older citizens in their community. That planning

grant led to a subsequent grant from the same foundation, which gave Carol Woods \$996,000 to create a community infrastructure that would educate consumers about local service options; foster better communication and collaboration among social service and medical organizations; decrease fragmentation and duplication of services; and improve innovative transitional care supports.

How It Works

The first and most surprising finding from Carol Woods' one-year planning grant was that the service-rich Chapel Hill community didn't necessarily need to add more services to its safety net for older people. However, those services were fragmented, duplicative, and often unknown to consumers. Based on that finding, the steering committee switched its approach from one solely focused on service development to one that also included a focus on service integration and education. Specific programs and interventions included:

- **Community Engagement Event.** Early in its three-year grant, the Community Connections team held a two-day Community Engagement Event, which attracted 87 community stakeholders. Those stakeholders included consumers, public and private health and social service providers from the aging and disability communities, as well as UNC and its hospital. Participants worked together to map the community's current services, identify barriers to smooth care transitions and service use, set priorities for community action, and establish

workgroups that would begin addressing those priority areas. Those workgroups continue to meet regularly and to include participants from the original Community Engagement Event.

As a result of work by the "Patient Advocacy at Transitions" workgroup, for example, Community Connections partners now serve on the Readmissions Task Force at UNC Hospital and have spearheaded an initiative to provide follow-up phone calls to older adults after hospital discharge. Community Connections partners are also involved in efforts to educate hospital discharge planners about community services that can help older consumers transition back into the community after a hospital stay. The "Outreach Network to Consumers and Providers about Services" workgroup supports an annual Resource Connections Fair that provides information about local services to 200 community residents.

- **Aging and Disability Resource Center.** Community Connections helped its two target counties apply for and receive a grant to establish an Aging and Disability Resource Center (ADRC) that would provide an infrastructure to engage and unite health and service providers. ADRCs are funded, through grants to the states, by the Administration on Aging and the Centers for Medicare and Medicaid Services. In North Carolina, ADRCs are called Community Resource Connections for Aging and Disabilities (CRCs). Seventeen local agencies now

participate in the local Chatham-Orange County CRC, which connects older consumers and people with disabilities to information about and referral to a host of long-term services and supports. The CRC infrastructure has also served to unite community agencies and providers around a common purpose and to provide a measure of sustainability to the Community Connections initiative and the partnerships that it helped launch.

■ **Matching Funds and Seed Money.**

Having almost \$1 million to spend within two counties has helped to elevate the credibility of the Community Connections project among local stakeholders. Community Connections funds have helped local partners implement and expand evidence-based programs that address hospital transition, chronic disease self-management, and falls prevention; conduct a randomized-controlled trial to study the impact of a phone-call follow-up program for older adults discharged from the UNC Emergency Department; and launch a telehealth pilot at a local community health center. In addition, Community Connections funds allowed local partners, including the State of North Carolina, to garner more than \$2 million in additional grants for the region.

Accomplishments

Community Connections measures its success by gauging how the experience of consumers who use local services has been enhanced by a new

cooperation among local care and service providers. For example, discharge planners trained through Community Connections and the Chatham-Orange CRC are now better equipped to guide consumers to services that can ease their transition from hospital to home. Equally important, consumers experience a smoother transition to those services, thanks to the CRC, workgroup activities, the annual resource fair, and efforts within local agencies to cross-train staff so they know about the services offered by a variety of agencies and organizations, not just their own.

Service providers have benefitted from Community Connections as well, according to a follow-up survey that the initiative conducted among stakeholders. Almost all (89%) of the respondents said they have learned something new about available programs and services as a result of their involvement in Community Connections. Ninety-four percent reported increasing their own connections with their colleagues in other agencies. Two-thirds said that they had begun or increased their focus on transition issues (64%) and that they had increased their partnerships with health care providers to improve transitions (66%).

Next Steps

Carol Woods recently received an additional \$296,000 from The Duke Endowment to continue the Community Connections initiative for another two years. This third grant will focus Community Connections on the task of developing best practices around transitions from hospital to home and helping CRC sites throughout the state implement evidence-based care transitions interventions.



Burlington,
Vermont

support
and services
at home
a care
partnership

■ Nancy R. Eldridge, Executive Director

■ Cathedral Square Corporation

In 2005, the State of Vermont adopted a Section 1115 Medicaid Waiver, essentially guaranteeing that Medicaid beneficiaries requiring a nursing home level of care could receive that care in any setting they chose, including their own homes or other residential settings. On the surface, the waiver supported a goal that consumers and their advocates had endorsed for years: allowing consumers to stay in their own homes for as long as possible. However, the state was inviting a substantial number of older citizens to age in place without first having developed a system of home- and community-based services to support that choice.

At the same time, affordable housing providers like Cathedral Square Corporation in Burlington began to see their housing environments change as more residents showed signs of increasing frailty, cognitive decline, and complex medical conditions. Resident

assessments conducted by Cathedral Square in several of its 20 independent housing buildings tell that story all too well: only 47 percent of residents were able to pass a cognitive screening test, 37 percent reported that they had fallen in the past year, and 50 percent said they were taking six or more medications.

Future residents of independent housing are likely to display even greater needs for services and support as Vermont readies itself for an explosion in its aging population. By the year 2017, one in every three Vermonters will be 55 and older and the state anticipates a 42-percent increase in the number of older people with a disability who will be living in a community setting. The number of nursing home beds in the state will continue to decline, guaranteeing that seniors at all levels of care will remain in public housing and nonprofit senior housing despite cognitive impairments and multiple chronic conditions. While programs like the Program of All-Inclusive Care for the Elderly (PACE) do help some housing residents age in place, a limited number of residents meet their eligibility requirements.

Eager to support its own residents, but cognizant of the fact that a “boutique” program would not be sustainable, Cathedral Square began working with other Vermont housing providers, state legislators, and LeadingAge (formerly the American Association of Homes and Services for the Aging) to develop a housing-with-services model that would reduce avoidable costs to Medicaid and Medicare, provide essential services to housing residents who wanted to age in place, and be replicable elsewhere. The model, called Support And Services at Home (SASH), is considered somewhat revolutionary because it creates an entirely new role for housing

providers, transforming them from landlords into advocates that monitor the health and well-being of their older residents and provide or coordinate services that allow those residents to remain independent and safe in their own apartments.

The program's sustainability comes from the fact that SASH was integrated into Vermont's new health reform initiative after Cathedral Square completed a business-case model that projected a cumulative savings in Medicare expenditures, net of all SASH program costs. Vermont's health care reform initiative is organized around a medical home model through which coordinated care is provided by an interdisciplinary community health team that supports the patient's primary care physician. Beginning in July 2011, a Medicare-funded SASH program will extend the capacity of those community health teams in 112 housing developments throughout the state. Vermont's goal is a true transformation of its long-term care system, and full integration with the acute and primary care delivery systems, through a scalable and sustainable housing-with-services model.

How It Works

Funds from the Vermont legislature, the Vermont Health Foundation, and the MacArthur Foundation allowed Cathedral Square to develop the SASH model and pilot test it in one apartment building from August 2009 to August 2010. Key to the design process was involving 60 elderly residents in the development of the model. The model revolves around a SASH site team comprised of a full-time SASH coordinator and a wellness nurse employed by the housing development, an acute-care nurse assigned to the site by the Visiting Nurse

Association (VNA), a case manager assigned by the Area Agency on Aging (AAA), an intake nurse from the Program of All-Inclusive Care for the Elderly (PACE), a community mental health provider, and representatives of other home- and community-based service providers. The University of Vermont (UVM), Albany School of Pharmacy, and the Area Health Education Centers Program at the UVM College of Medicine sent students, including a full-time geriatric fellow, to the SASH site.

The SASH coordinator carries out a number of tasks that keep the SASH program on track at each site. He or she keeps tabs on resident well-being, especially high-need residents identified by the site team; tracks residents who are hospitalized or discharged from hospitals and nursing homes; and maintains resident health records and the team's communication logs. In addition, the coordinator is responsible for bringing about transformational change within the housing organization by training and encouraging property managers, custodians, resident services coordinators, and activity directors to observe resident behavior, notice changes in health or functional status, and inform the SASH team about residents who require additional support.

In addition to checking on ill residents, monitoring vital signs, and supporting residents' medication management, the wellness nurse will eventually serve as a liaison between SASH site teams and the community health teams that the State of Vermont will designate to participate in its medical home model of health reform. This connection will help SASH sites assist local medical practices in caring for residents with high needs.

When a resident joins the SASH program, he or she is interviewed by the SASH coordinator and receives

a functional and cognitive assessment from the SASH team. Based on these assessments, the team carries out two types of consumer-centered planning processes within the housing development:

■ **An Individual Healthy Aging Plan:**
The SASH team uses the individual's assessment data to help the resident identify health-improvement goals that he or she wants to pursue, such as losing weight, getting more exercise, or eating a more nutritional diet. The team provides guidance and coaching to help the resident meet those goals.

■ **A Community Healthy Aging Plan:**
The team aggregates the information found in all the resident assessments to create a healthy aging plan for the entire congregate setting and to implement programming from which all residents can benefit. Specific interventions are taken from a directory of evidence-based practices in five key areas: falls, medication management, chronic condition control, lifestyle practices, and cognitive and mental health issues. For example, the SASH test site introduced a building-wide program called "Eat Less, Move More" after assessment data showed that many residents were at risk for poor nutrition and did not get regular exercise.

The SASH team meets for two hours twice a month to discuss general health and information needs in the building as well as the specific needs of high-risk residents. The VNA nurse and the AAA case manager who serve on the team also provide direct care to residents in the building and can

bring direct knowledge about high-needs residents to the team meeting and personally follow up on team recommendations for additional health-related interventions.

Each site's SASH team is connected to an umbrella group called the Local Table, which consists of high-level representatives from SASH partners. The Local Table meets several times per year to share information about the work of each partner, track the progress of SASH teams, keep partners up-to-date on the progress of the state's health reform initiative, and ensure that the SASH initiative is an integral part of this statewide systems change.

Accomplishments

During its one-year testing stage, SASH interventions helped reduce hospital admissions by 19 percent among housing residents at the test site. In addition, not one SASH participant who was discharged from the hospital during the test period experienced a readmission. Falls have been reduced by 22 percent, residents at moderate nutritional risk fell by 19 percent, and the percentage of physically inactive residents was reduced by 10 percent. SASH has also proven that it represents a wise use of resources. The State of Vermont recently projected that its health reform initiative, combined with SASH, will save Medicare \$40 million by reducing older consumers' use of inpatient hospital and physician services, hospital outpatient and emergency room services, pharmacies, and nursing home days.


These outcomes have helped to cement SASH's credibility with sometimes skeptical housing providers, who have signed up to participate in

its statewide rollout in mid-2011. In addition, service providers who work at the SASH test site now endorse the program because SASH has demonstrated that it can help them carry out their missions more effectively.

Next Steps

The SASH initiative will receive \$10.2 million in Medicare funds — which represents a capitated amount of \$700 per participant per year — to roll out the program to 112 housing sites in July 2011. The expanded program will bring 75 new jobs to Vermont: 60 SASH coordinators and 15 wellness nurses. Cathedral Square is currently seeking additional funds from other sources so it can add dollars to Medicare’s per-participant cap.

Future plans call for tweaking the SASH program design so SASH teams can serve older consumers living in communities that surround SASH sites. SASH also hopes to connect all of its sites to Vermont’s health information exchange in order to facilitate the secure sharing of resident health data between SASH sites and community health teams participating in Vermont’s health reform initiative.



Farmington Hills,
Michigan

detroit
community
action
to reduce
hospitalizations

- Nancy Vecchioni, RN, MSN, CPHQ
Vice President of Medicare Operations
- MPRO — Michigan’s Quality Improvement Organization

A group of five hospitals in the Detroit area have banded together to form a cooperative initiative aimed specifically at reducing rehospitalizations in Michigan’s largest and poorest urban area, where high needs and a dearth of resources present major health challenges to a dwindling population. A number of statistics clearly illustrate the challenges facing Detroit residents and those who provide them with health care:

- The city’s Medicare hospital readmission rate stands at 25 percent, the highest in the State of Michigan.
- Detroit’s population has decreased from 1.8 million to 871,000 in the past

50 years, leaving not only fewer people within the metropolitan area, but fewer services.

- The city's median income is \$29,500, compared to \$37,000 for the nation as a whole. At 34 percent, the city's poverty rate is the highest in Michigan and the highest among the nation's cities. Thirty percent of the population is unemployed and more than 17 percent is uninsured. Almost 20,000 residents are homeless.
- Detroit residents are more likely than other Americans to have heart disease and diabetes. Over 28 percent of residents have a disability.
- One fifth of the population has no transportation and few residents have access to a grocery store or pharmacy. Even though diet is a major risk factor for chronic disease, half of the city's food stamp retailers are liquor stores, gas stations, and bakeries.

Detroit's five hospitals are trying to change these statistics through a four-state pilot program called STate Action on Avoidable Rehospitalizations (STAAR) that is directed by the Institute for Healthcare Improvement, with support from The Commonwealth Fund. The Detroit initiative — called Detroit Community Action to Reduce Rehospitalization (Detroit CARR) — operates under the auspices of Michigan's STAAR program (MI STA*AR), which is managed for IHI by MPRO, Michigan's quality improvement organization, and the Michigan Health and Hospital Association (MHA). MI STA*AR organizers believe that, if successful, Detroit CARR could serve as a model

not only for the rest of Michigan, but for at-risk urban areas throughout the nation. If efforts to reduce rehospitalizations can work in Detroit, they theorize, they can work anywhere.

How It Works

Based on the belief that hospitals cannot reduce rehospitalization rates by themselves, the MI STA*AR initiative is designed to create local health care/community cooperatives through which providers of primary, acute, and long-term care, as well as community-based service providers, come together to take ownership for the safety of patients.

Each of the 28 hospitals that joined MI STA*AR in May 2009 — including the five hospitals in Detroit — began the process to reduce rehospitalizations by building its own transition team. That team includes post-acute providers, physician offices, home health agencies, home- and community-based service providers, consumers, and other local organizations deemed to have a stake and a role to play in reducing rehospitalizations.

Once transition teams are established, the hospitals are free to adopt specific strategies that the teams feel are best suited to the patient population and local community. Taking a “rapid cycle change” approach, the typical hospital transition team chooses to focus initially on one of the four key STAAR strategy areas until all strategies are addressed. STARR strategies include: enhanced admission assessment for post-discharge needs, enhanced teaching and learning, patient and family-centered handover communication, and post-acute care and follow-up.

Next, the team chooses one or two hospital units in which to test strategic interventions in order to “get the bugs out.” When the intervention proves successful in this small setting, it is then gradually expanded throughout the hospital. Among the interventions that MI STA*AR and Detroit CARR participants have tested in this way include:

- **Before discharge.** Several Detroit hospitals have found that beginning discharge planning upon admission gives hospital staff a chance to spend more time educating patients about discharge instructions and more time to order post-discharge services that can take several days to arrange. Using a “teach back” strategy, hospitals provide the patient with post-discharge instructions regarding medication or other issues and then ask the patient to repeat those instructions aloud. This exercise allows hospital staff members to check whether the patient understands the instructions and to evaluate the effectiveness of teaching methods.
- **After discharge.** In order to ensure continuity in patient care after discharge, several Detroit hospitals provide a three-to-30-day supply of medication to the patient at the time of discharge in order to ensure that the patient continues to take medications that were prescribed during his or her hospital stay. Other hospitals will also make patients’ follow-up appointments with their primary care physicians in order to ensure that such visits take place within a reasonable period of time. To further safeguard patient health,

some hospitals call patients 72 hours after discharge — and in some cases every week for a month — to see how they are progressing and to intervene, if necessary, to prevent rehospitalization.

- **Working closely with post-acute providers.** Several Detroit CARR hospitals have developed working relationships with post-acute providers so that transitions to nursing homes are easier on patients. In one intervention, providers of post-acute care make hospital visits to patients who will be released to their facilities. This visit helps ease the transition for patients who may be frightened about the nursing home placement, gives the post-acute care provider a chance to talk to the hospital team about the patient’s case, and sets the stage for ongoing communication between the acute and post-acute settings. In addition, Detroit CARR hospitals have devised a two-page transition form that lists, in one place, the most critical information needed to care for that person. This standardized form travels with the patient between settings to ensure that all providers have the information they need to provide quality care.

Accomplishments

Working together, hospitals in the Detroit area have succeeded in reducing rehospitalizations for heart failure by up to 20 percent since the Detroit CARR initiative began. Overall, the rehospitalization rate in the city has decreased by five percent among adult patients.

Next Steps

A new cohort of 31 hospitals is now beginning the second phase of an effort to expand the MI STA*AR initiative statewide to 59 hospitals. In early 2011, the new members of the MI STA*AR initiative were busy creating their transition teams, interviewing patients that were readmitted to their facilities, and selecting the strategy on which they will focus their attention. Meanwhile, the five hospitals participating in Detroit CARR are gearing up to introduce additional interventions to reduce rehospitalizations. These include the development of a person-centered discharge planning initiative that will be implemented in partnership with the state Office of Services for the Aging.

Lessons learned



Patricia Sprigg and Heather Altman of Carol Woods, Nancy R. Eldridge of Cathedral Square Corporation, and Nancy Vecchioni of MPRO have learned many lessons since the day they decided to become catalysts for change within their communities. Here are a few of those lessons:

Identify a champion. It's important that every Innovative Community identify a change agent, early in the initiative, who can use his or her influence in the community to advance the collaborative's work. This should be someone whose opinions are widely respected and whose support for the initiative could open doors at the local and state levels. According to Heather Altman, Carol Woods has had such a champion, who helped the retirement community obtain its original Community Connections grant. Over time, Carol Woods took on the role of community change catalyst because it had proven itself as a neutral convener who, says Sprigg, "did not have a dog in the fight."

Make the case for change. Inspiring stories and convincing data are both powerful tools that Innovative Communities can use to convince partners that change is necessary. Nancy Vecchioni suggests that hearing stories about real patients who “fell through the cracks” can often convince partners to commit themselves to breaking down barriers that stand in the way of coordinated patient care. Personal stories about the successes of Innovative Communities can also help keep partners on track. For example, VNA and AAA executives strengthened their commitment to Vermont’s SASH program after hearing personal testimony about the value of the program from their nurses and case workers.

Learn about the health world. Cathedral Square staff learned about the Medicaid program in 2000 while developing a 28-unit assisted living community during the first round of the Assisted Living Conversion Program, sponsored by the U.S. Department of Housing and Urban Development. Those lessons came in very handy while Cathedral Square worked on the SASH initiative. “If you are going to do this kind of cross-sector work, you really must understand the sector you are planning to work with,” says Eldridge.

Bring consumers to the table. Older adults, adults with disabilities, and caregivers comprised one-third of the participants in the Community Engagement Event sponsored by Community Connections to map community services and identify pressing needs. Heather Altman said she recruited those consumers by identifying “connected” older people who had a strong social network upon which they could call. Consumers attending the event brought with

them powerful stories about how the health system worked for — and failed — them, as well as valuable insights into their concerns and preferences.

Don’t duplicate existing services. Vermont’s SASH organizers made a concerted effort to ensure that their partners in the primary, acute, and long-term care sectors were “operating at their highest and best use and that there was no duplication,” says Eldridge. “We knew that creating new services within the housing organization would not be a viable approach either from a financial or a political perspective.”

Focus on sustainability. Cathedral Square Corporation wasn’t interested in creating a “boutique” project that would work well only in Burlington. “We probably could have gotten the money to get all our sites up and running with SASH, but it would never have been sustainable financially,” says Eldridge. “Instead, we took a systems change approach that is doable in every corner of Vermont.”

Celebrate small victories. Go for the low-hanging fruit first, says Vecchioni. “Get those wins right away and show them to the community,” she says. “Then you can plan out how you will meet your longer range goals over time.” Sprigg agrees. “Long-term processes will easily turn into apathy if you’re not showing and celebrating the small victories and successes along the way,” she says.

Get people talking. When a hospital complained to Nancy Vecchioni that a chronic ventilator patient was continually bouncing back to the hospital from a local nursing home, Vecchioni recommended a simple, but revolutionary

solution. At her suggestion, hospital staff visited the nursing home to see how they could help make the patient's transition easier. The visit resulted in better training for nursing home staff and a hospital-facilitated upgrade for the nursing home's ventilator unit. "It's all about working together," says Vecchioni. "We need to talk to one another and go on site visits. We really encourage our partners to do that because it really opens their eyes."

Don't forget about the workforce. Even the most coordinated and integrated system of services and supports will fail if there aren't an adequate number of qualified frontline workers to deliver those services, says Sprigg. That's why Carol Woods included a workforce component in its Community Connections initiative. The initiative supported over 132 internships and stipends for students in aging services, including those

studying to be Certified Nursing Assistants. It also provided funds to educate 95 graduate students in falls prevention and to offer programs on aging and ageism to 621 high school and middle school students.

Be patient. Innovative Communities don't happen overnight. They often take years to take root. Many organizations find change difficult and often are afraid of it. Others need time to get used to interacting and working with partners with whom they have never worked, have had past disagreements, or view as competitors. A few organizations will need to be convinced, in a non-threatening way, that their processes are not working as well as they think. "It's a 'ah-ha' moment when these organizations realize that they aren't connected with other providers and that they need to change for the good of the patient," says Nancy Vecchioni.

a vision for the future

Participants in the LTQA Innovative Communities Summit were invited to create a common vision for a more collaborative future for those who provide care and services to older people and persons with disabilities. That vision included these features:

Consumer empowerment. Every consumer will have an individual, coordinated life-care plan that is person-centered and developed with the involvement of family. Consumers will be empowered through a money-follows-the-person approach that puts them in control of their acute care and long-term services and supports and allows them to receive care at home, if that is their preference. Consumers and their families will be encouraged to become “better activists for better health care.”

Team mentality. Participants in Innovative Communities will understand what each partner brings to the table and will have a clear idea of their own incentives for participating. These partners will work hard to develop a “team mentality” in order to widen the availability of services to the local population. Innovative Community partnerships will be broad-based and will include primary, acute, and post-acute providers, in addition to “nontraditional partners” like providers of transportation and other community-based services, health plans, housing organizations, universities, disability organizations, and others. Consumers will be at the center of collaborative, not just “token” participants.

Equal partners. All stakeholders — including providers of long-term services and supports — will be welcomed as equal partners in local health initiatives, including Accountable Care Organizations. Innovative Community partners will have common goals and will use common metrics and common terminology. They will also share evaluation and measurement tools that focus on community outcomes.

Independent and invested leadership. The Innovative Community will be led by a local champion who is viewed as a neutral party and who is deeply committed to the good of the community. This leader should be able to build bridges among partners and motivate them to work together toward common goals.

Free-flowing information. Innovative Community partners will freely share models and tools about successful strategies for improving care transitions and providing coordinated care. Partners will have access to a database of evidence-based interventions that they can match to their community’s needs and resources. Innovative Communities will also have access to a toolbox of models for developing the leadership skills of its partners, since good leadership skills are critical to the success of cross-sector collaborations.

Aligned incentives and flexible funding streams. Hospitals, physicians, and providers of long-term services and supports will be rewarded for working together to keep consumers healthy

and independent. Funding streams will foster cross-sector collaborations and partners will have the freedom to spend funds for the best and highest use. Providers will not need special waivers to carry out interventions that have been proven successful in other locales. Block grants will allow local stakeholders to engage in a collaborative process to determine how funds could be used locally to improve the quality of care and quality of life of consumers. Innovative strategies to keep consumers healthy will also be rewarded and encouraged.

Reinvestment of savings. Savings that result from innovative and collaborative approaches to reduce rehospitalizations will be reinvested in services and supports so the aging network can respond to the anticipated demand for its services as more older people age in place. The regulatory and enforcement system will be attuned to consumer preferences and will serve as a partner with health and service providers, rather than an advisory.

Cutting-edge technology. Innovative Communities will explore the ways in which care and service providers can use interoperable technology — such as electronic health records, remote monitoring, and telehealth — to move care into the home and help larger groups of consumers and their caregivers manage health their health conditions, exercise control over their health care, and remain independent for as long as possible.

A robust workforce. Innovative Communities will take steps to strengthen the workforce in acute, post-acute, and community-based care settings. All levels of staff working in the home care field will receive enhanced training around the challenges that patients face after leaving the hospital and will be educated about the long-term services and supports available to ease those transitions.

A strong volunteer network. All citizens will be encouraged to participate in the work of Innovative Communities by volunteering their time so that service organizations can reach more consumers at a lower cost.

Public education. A national campaign will educate the general public about the options available to help people with chronic disease and other illnesses manage their conditions while living in the community. The campaign will also address the challenges that hospital patients encounter when transitioning from hospital to home, and the resources available to ease that transition. At the local level, consumers will have access to all the information they need to make informed decisions about long-term and post-acute care. The Innovative Community will provide easy-to-navigate Web sites and databases that include information on how and where to access services and supports. An information database with a single-point-of-entry will ensure that every consumer knows where to begin the search for needed services and supports.

a role for LTQA

Participants in the LTQA Innovative Communities Summit welcomed the opportunity to collaborate with other stakeholders at the local level to improve care transitions and reduce avoidable hospitalizations. They also called for the establishment of a similar collaborative at the national level that would provide a forum where fledgling Innovative Communities could learn from organizations that were already involved in successful local collaboratives.

Participants identified several major roles for LTQA in promoting and encouraging the creation of multi-sector Innovative Communities around the country. They encouraged LTQA to:

- **Serve as a repository for information** that could help local stakeholders create and support Innovative Communities at the local level. In particular, Summit participants called for the development of a database of evidence-based best practices, interventions, and toolkits — from the U.S. and abroad — which Innovative Communities could adapt to their local needs and resources. To supplement this database, LTQA could create templates that Innovative Communities could use to replicate those practices and interventions.
- **Develop and promote a common language** that multi-sector collaborators could use to communicate better with each other and with consumers.
- **Serve as a cheerleader for Innovative Communities** by coaching fledgling communities and convening regular meetings where Innovative Community partners could share ideas and best practices.
- **Help Innovative Communities identify federal and state sources of funding** and advise them on ways to access that funding.
- **Launch a national public relations campaign** designed to educate consumers about the challenges associated with hospital-to-home transitions and the community resources available to ease those transitions.
- **Educate government agency staff, legislators, and policy makers** about Innovative Communities so they understand the nature of this transformative movement, the components of the model, its benefits, and intended outcomes.
- **Advocate at the national level for public policies, regulations, and funding changes** that encourage flexibility, innovation, and cross-sector collaboration in acute, post-acute, and community-based care. These advocacy efforts should include an emphasis on integrating multi-sector collaborations into the fabric of federal health programs so that waivers become a thing of the past.
- **Identify federal regulations that serve as barriers to collaboration and cooperation** across sectors. LTQA should work closely with government agencies, including the U.S. departments of Labor and Health and Human Services, to find ways to eliminate those barriers.

appendices



INNOVATIVE COMMUNITIES SUMMIT participant list

This list includes the names of individuals who pre-registered for the LTQA Innovative Communities Summit, held at Georgetown University Conference Center in Washington, D.C., on December 10, 2010. LTQA apologizes in advance if the names of participants who registered on-site are not included here.

Darcey Adams | Director of Community Programs
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Tom Akins | President and CEO
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Heather Altman | Project Director, Community Connections
Carol Woods Retirement Community | Chapel Hill, NC

Maya Altman | CEO
Health Plan of San Mateo | San Francisco, CA

Kathy Anderson | President and CEO
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Department of Vermont Health Access | Williston, VT

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LTQA: INNOVATIVE COMMUNITIES SUMMIT
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Total Longterm Care | Denver, CO

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America's Health Insurance Plans | Washington, D.C.

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Damien Doyle | CP Medical Affairs/Medical Director
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LTQA: INNOVATIVE COMMUNITIES SUMMIT
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(continued on next page)

LTQA: INNOVATIVE COMMUNITIES SUMMIT
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