



COMMONWEALTH OF VIRGINIA
DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

JAMES A. ROTHROCK
Commissioner

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MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: James Rothrock

DATE: October 16, 2012

SUBJECT: Get out the Vote

The State Board of Elections and Virginia Board for People with Disabilities have collaborated to increase knowledge about voting accessibility for people with disabilities and the aging community. According to Donald Palmer, Secretary of the State Board of Elections, "we want to ensure all voters, regardless of their age or disability, are ready to vote." This new voting accessibility information is available through videos, Web sitepages, and print materials.

Four videos show voters how to register, apply for an absentee ballot or annual application, vote curbside, or utilize assistance at the polls when voting on Election Day. The videos are posted on YouTube via http://bit.ly/vote_12 and at www.vaBoard.org and at www.sbe.virginia.gov.

A new Web page for Voters With Special Needs has been added to the State Board of Elections Web Site. It contains information about polling accessibility, absentee ballots, curbside voting, voting rights and cognitive impairments, an accessibility brochure, and other useful information for DARS clients. The link <http://www.sbe.state.va.us/VoterWithSpecialNeeds.html> is also posted on the DRS VR Forms Cabinet.

Print materials are available through the State Board of Elections and Virginia Board for People with Disabilities, and on their agency Web sites. Publications are available in alternate formats upon request. If you wish to order a supply of the accessibility brochure "Accessibility: Exercising Your Right to Vote," please contact Terry Wagoner at 804-864-8937 or terry.wagoner@sbe.virginia.gov.



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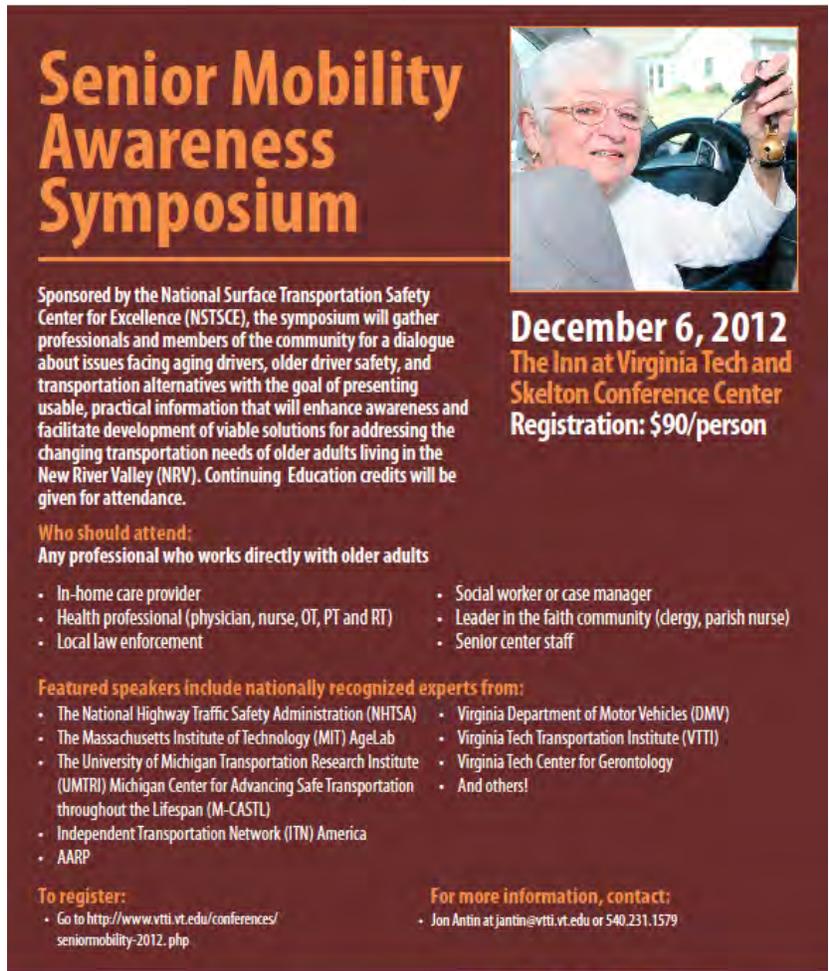
MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Nancy Lo

DATE: October 16, 2012

SUBJECT: Senior Mobility Awareness Symposium



Senior Mobility Awareness Symposium



Sponsored by the National Surface Transportation Safety Center for Excellence (NSTSCCE), the symposium will gather professionals and members of the community for a dialogue about issues facing aging drivers, older driver safety, and transportation alternatives with the goal of presenting usable, practical information that will enhance awareness and facilitate development of viable solutions for addressing the changing transportation needs of older adults living in the New River Valley (NRV). Continuing Education credits will be given for attendance.

December 6, 2012
The Inn at Virginia Tech and Skelton Conference Center
Registration: \$90/person

Who should attend:
Any professional who works directly with older adults

- In-home care provider
- Health professional (physician, nurse, OT, PT and RT)
- Local law enforcement
- Social worker or case manager
- Leader in the faith community (clergy, parish nurse)
- Senior center staff

Featured speakers include nationally recognized experts from:

- The National Highway Traffic Safety Administration (NHTSA)
- The Massachusetts Institute of Technology (MIT) AgeLab
- The University of Michigan Transportation Research Institute (UMTRI) Michigan Center for Advancing Safe Transportation throughout the Lifespan (M-CASTL)
- Independent Transportation Network (ITN) America
- AARP
- Virginia Department of Motor Vehicles (DMV)
- Virginia Tech Transportation Institute (VTTI)
- Virginia Tech Center for Gerontology
- And others!

To register:
• Go to <http://www.vtti.vt.edu/conferences/seniormobility-2012.php>

For more information, contact:
• Jon Antin at jantin@vtti.vt.edu or 540.231.1579



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MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Elaine Smith, Program Coordinator

DATE: October 23, 2012

SUBJECT: Evidence Based Programming Webinar October 25, 2012

AAA's who are seeking highest tier criteria evidence-based programming for the use of their Title III-D funding may be interested in the National Council on Aging's webinar on Thurs, Oct. 25 from 3-4:30 pm ET on "Addressing Depression in Older Adults through Evidence-based Programming."

Please join leaders from the aging network who will share evidence-based programs that empower older adults to manage their depression and improve their quality of life. Two programs that meet the Administration on Aging highest criteria for evidence-based programming will be highlighted—Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) and PEARLS (Program to Encourage Active, Rewarding Lives).

Speakers

- Lesley Steinman, PEARLS (Program to Encourage Active, Rewarding Lives), Seattle, Washington
- Esther Steinberg, Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), Houston, Texas
- Gordon Gibb, St Barnabas Senior Services, Los Angeles, California

You may register for the webinar by visiting <http://www.ncoa.org/calendar-of-events/addressing-depression-in.html>



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MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen Nau

DATE: October 16, 2012

SUBJECT: Caregiving and Lifespan Respite Information

Reports:

Home Alone: Family Caregivers Providing Complex Chronic Care recommends actions to assist the more than 42 million family caregivers in the U.S., including: encouraging health care professionals and providers to reassess the way they interact with caregivers, ensuring that caregivers are well trained and prepared to perform difficult tasks, revising how caregiving tasks are labeled and identified, and addressing family caregivers' needs in the development of new models of care. For the whole report, go to:
<http://www.uhfnyc.org/publications/880853>

Webinars:

National Spinal Cord Injury Association (NSCIA)

"Employment Etiquette: Resume Building and Job Interview Tips," will take place October 24 from 3-4 pm EDT. [Register for the webinars](#) You can access all of United Spinal's previous webinars by visiting its online webinar archive at <http://www.spinalcord.org/webinar-archive/>.

Phone Conferences:

Quarterly Family Caregiving (National) Coalition Call

“Developing an Advocacy Agenda: How to get your coalition engaged in determining policy goals, securing membership buy-in, recruiting allies, and raising funds for your advocacy work” Call-in information: Access# 1-800-582-3014

Award!!!

Lory Phillippo, Director of Richmond’s Circle Center ADS Receives 2012 Ruth Von Behren Award

This award is named for Ruth Von Behren, a former NADSA Chair, internationally renowned for her pioneering work in California and throughout the country. Ms. Von Behren is an author, a long-time advisor to NADSA, and she played a major role in the development and implementation of the OnLok replication model, PACE, nationwide. Ruth Von Behren was the first recipient. The award was created in 1992 to recognize the personal achievements and commitment of individuals in the field of Adult Day Services who have had a national impact on Adult Day Services. It is given to an outstanding volunteer or employee of an organization that directly supports adult day services nationally. Ms. Phillippo is a member of the Virginia Caregiver Coalition.



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MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Tim Catherman

DATE: October 10, 2012

SUBJECT: N4A Receives ACL Funding for MLTSS

Press Release from N4A.

n4a and Partners Receive Funding to Assist the Aging and Disability Networks Build the Business Capacity for Their Involvement in Managed Long-Term Services and Supports
For Immediate Release 202.872.0888
October 11, 2012

Washington – In early October the U.S. Administration for Community Living (ACL) announced that the National Association of Area Agencies on Aging (n4a), together with its partners the National Disability Rights Network (NDRN), Health Management Associates (HMA), the National Senior Citizens Law Center (NSCLC) and the Disability Rights Education and Defense Fund (DREDF), have been awarded a \$250,000 grant focused on **Building the Business Capacity of the Aging and Disability Networks for Managed Long-Term Services and Supports (MLTSS)**. The goal of the project is to leverage the Aging and Disability Networks' extensive infrastructure, service capacity and expertise, to ensure the delivery of efficient, high-quality MLTSS to older adults and people with disabilities.

—We are thrilled that n4a will have this opportunity to work with our partners to help prepare the community-based Aging and Disability Networks for the many opportunities that come with Medicaid Managed Care,|| said Sandy Markwood, CEO, n4a. —This grant will help to ensure that Area Agencies on Aging and local disability organizations have the skills, knowledge and access they need to work with managed care organizations to ensure

that the health needs of the nation's growing population of older adults and people with disabilities are met.||

During this three-year project, n4a and its partners, will assess and measure progress on the Aging and Disability Networks' knowledge of and involvement in managed long-term services and supports. Additionally, the partnership team will provide training and technical assistance to ensure that the Aging and Disability Networks play a significant role in developing and implementing quality MLTSS programs.

This funding opportunity comes at a time when the entire health care delivery system, especially Medicaid, is undergoing a major transition. This transformation is and will continue to have profound effects on two of the major population groups that rely on Medicaid—older adults and people with disabilities. In FY 2009, older adults and people with disabilities represented 25 percent of all Medicaid beneficiaries, but drove 66 percent of total costs (\$230 billion out of \$346 billion). The aging of the U.S. population is creating a rise in demand for Medicaid acute and LTSS services, escalating Medicaid costs even as states are facing dwindling resources. To try to bend or flatten the cost curve in Medicaid, the vast majority of states are expanding use of managed care organizations (MCOs) to deliver Medicaid acute health care and many are moving quickly to incorporate managed LTSS into their Medicaid systems.

While MCOs have years of experience organizing acute health care delivery and its associated costs, most have little or no experience coordinating and delivering home and community-based services for older adults and people with disabilities. By contrast, the Aging and Disability Networks have a long history of assisting millions of older adults and people with disabilities by assessing and coordinating needs, and effectively delivering critical long-term services and supports in the least restrictive settings. Together, MLTSS poses an opportunity for MCOs and the Aging and Disability Networks to build on their complementary expertise to provide quality LTSS.

About n4a

The National Association of Area Agencies on Aging (n4a) is the leading voice on aging issues for Area Agencies on Aging (AAAs) and a champion for Title VI Native American aging programs. Through advocacy, training and technical assistance, we support the national network of 629 AAAs and 246 Title VI programs. AAAs and Title VI programs were established under the Older Americans Act to respond to the needs of Americans 60 and over in every local community. By providing a range of options that allow older adults to choose the home and community-based services and living arrangements that suit them best, AAAs and Title VI programs make it possible for older adults to remain in their homes and communities as long as possible.

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MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Tim Catherman

DATE: October 10, 2012

SUBJECT: Policy Update – Audit Due Date

Section 10.4 of the FY'13 Area Plan Contract on Audit due date has been modified. For the current year it reads,

For all Area Agencies on Aging (AAAs), the current year audit or agency-wide financial review shall be submitted to the State Agency no later than December 15 of each year. If, for reasons not within the control of the Area Agency, this report cannot be submitted by this time, the Area Agency shall make a written request for an extension of time. A justifiable extension for an audit or agency-wide financial review may be granted. **The request for an extension must be received by December 15.** Submission of an audit or review report beyond the granted extension or an audit report that does not meet specific state and federal requirements may result in withholding of payments until the audit or independently reviewed financial statements is received and found to be consistent with all requirements.

Prior year language allowed only one 30 day extension. The new language allows more flexibility. DARS-VDA encourages agencies to comply with the December 15 deadline. However, if that timeframe does not seem possible please submit a request prior to December 15 stating when the audit will be completed.

When making the request please be aware of the following:

- The [Federal Audit Clearinghouse](#) normal due date is to submit the audit within 30 days after receipt of the report or 9 months after the end of the fiscal year.

- DARS-VDA must receive the audit, review the report, examine the financial statements, and verify schedules A, B, and C. If there are discrepancies between our records and the report, DARS-VDA may ask for the audit to be corrected. This process takes time, often months. As stated in the contract above and the DARS-VDA regulations, payment may be withheld until the audit is received and found to be consistent with all requirements.
- Finally good accounting practices should ensure the agency's records are closed shortly after the year-end and the records provided to the auditor.

If you need to request an extension, please send your request to Marica Monroe at Marica.Monroe@dars.virginia.gov with a copy to Solomon Girmay at Solomon.Girmay@dars.virginia.gov prior December 15.



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MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: James Rothrock

DATE: October 16, 2012

SUBJECT: Governing Magazine articles on Aging

The October 2012 issue of Governing magazine contains several great articles on aging that I believe will be of interest to you. The articles range in subject from states efforts to help seniors remain at home, to end of life issues, Telehealth, and better exchanges of health data that may affect older patients.



Stay at Home,

States are
searching for
affordable
ways to allow
seniors in
need of long-
term care to
remain in
their homes.

By Dylan Scott

Photographs by Krisilna Krug

After three years
in a nursing home,
Delores Powers
moved in with her
son and daughter-in-
law. Her caregiver,
Angie, helps her
around the house
five days a week.

Mom

For three years, Delores Powers languished in a nursing home. Already struggling with diabetes and early dementia, the 86-year-old Decherd, Tenn., resident landed in the hospital in 2008 after mismanaging the dozen or so medications she takes every day. Doctors told Delores' son David and his wife Dale that unless somebody could stay with her all day, she needed to live in a nursing home. Both David and Dale work full time, so staying home was not an option. Delores was moved to a nursing home, the default option for someone in her situation.

"She seemed to be going downhill, picking up speed," says Dale of how her mother-in-law handled the move. She recalls the conversations she and her husband had about what they could do. They talked about Dale quitting her job to stay home with Delores. "But we really couldn't afford that."

Then, a few years ago, Tennessee lawmakers approved a new program called CHOICES. Implemented in 2010, the program was conceived as a way to help seniors on Medicaid receive home- and community-based care instead of living in a nursing home. After an assessment of Delores' condition and finances, state officials approved her for the program.

This June, Delores came home. A caregiver named Angie, whose salary is paid by the state, comes from 7 to 5 every weekday. Angie gives her a bath, doles out her medications, checks her blood sugar, prepares lunch and takes Delores on walks outside. "You could say she does everything," Dale says. A physical therapist works with Delores at the house twice a week, and a registered nurse stops by once a week to check her vitals.

Today, Delores' life is getting back to normal. It's the little things: a shopping trip to Walmart, her first hair salon appointment in years, sitting on the porch in her small town of 2,200, waving as people walk by. In the afternoons, Angie hangs up a curtain in Delores' bedroom so she can watch movies late into the night, just as she likes.

The concept of managed care—the model that allows people like Delores to remain at home—has been around in health policy circles for years. But it's now gaining particular attention for seniors. The idea is that one company or organization oversees all of a patient's health-care needs. The company manages long-term aides and caseworker visits. If a patient ever needs more acute health care, such as a trip to her physician or specialist, the organization contracts with doctors, "managing" her care in a more holistic way than if she were left to navigate the system on her own.

Coordinating every aspect of one patient's health care is complicated enough. But when that care is paid for by the government, coordination can become next to impossible. Med-

icaid pays for almost all long-term care services for low-income patients. Medicare, the federal insurance program for individuals 65 and older, covers more acute care, such as emergency room visits and most prescriptions. Low-income seniors, such as Delores, are known as "dual eligibles." They qualify for both programs and are constantly bouncing back and forth between them—Medicare for an operation, Medicaid for long-term recovery. Sometimes, Medicaid pays part of a patient's out-of-pocket costs for Medicare premiums.

It's a maze.

As a result, reconciling the two programs can be a nightmare. Many primary care doctors who work under Medicare are not aware of their patients' options for long-term home- or

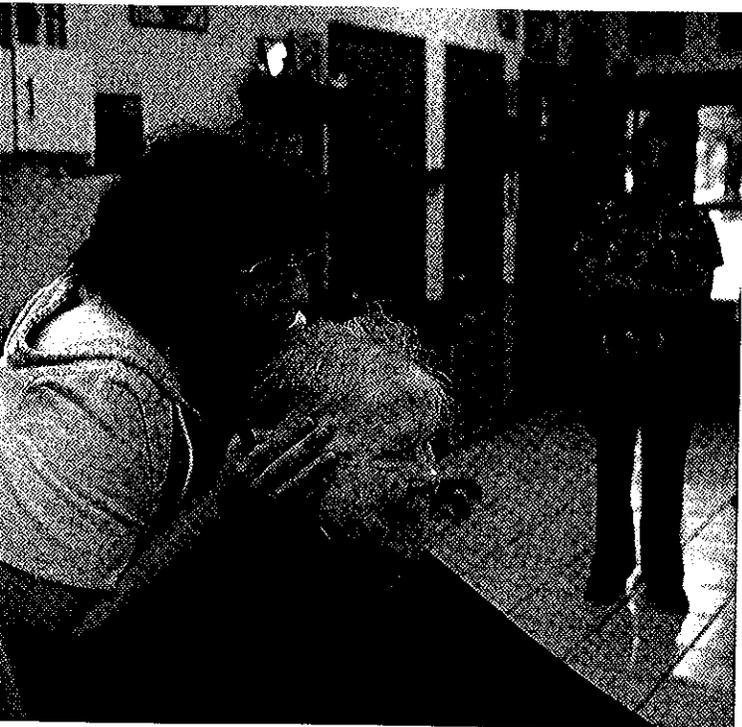


Under CHOICES, Angie's help allows Delores to remain as independent as she can. One recent afternoon, Angie took Delores to get her hair done for the first time since she came home.

community-based care under Medicaid. Everyone involved in health policy has heard horror stories of patients being stuck in a nursing home while the two programs bickered over which would pay for different services.

It's a piecemeal system and one that's unacceptable, says Matt Salo, executive director of the National Association of Medicaid Directors. Speaking at a Washington, D.C., conference this July, Salo called it "a national shame that we're subjecting the poorest and sickest among us to this fragmented care."

Dual eligibles can also be a major expense for states. They make up 15 percent of the 62 million Medicaid enrollees nationwide, but they account for nearly 40 percent of the program's costs. And roughly 70 percent of those costs are tied up in long-term care. Better management of long-term care for dual eligibles means a lower burden on state resources.



That's why a program such as CHOICES is so attractive to policymakers. A decade-long study published in *Health Affairs* in 2009 found that states with established home- and community-based care programs had cut their overall Medicaid long-term care spending by nearly 8 percent. States that instead relied on institutions like nursing homes saw their long-term costs increase by almost 9 percent. According to a 2011 report from the Bowles-Simpson presidential commission on fiscal reform, placing dual eligibles in Medicaid managed-care programs like CHOICES could save up to \$12 billion by 2020.

"As the population ages and more and more people need long-term care, if nursing homes are our default option, we're not going to be able to afford that," says Patti Killingsworth, chief of long-term services and supports at Tennessee's Medicaid office, which oversees CHOICES.

But improved coordination is not just about keeping costs down. It could also mean higher quality of care and a better patient experience. The federal Centers for Medicare & Medicaid Services (CMS) estimated in 2005 that 45 percent of hospitalizations for dual eligibles could have been avoided through better coordination between the two programs. Better coordination means greater independence for patients.



More than 80 percent of Americans over 50 say they want to remain in their home as they age, according to AARP. That includes Delores. “We didn’t want her to leave before her time, and we felt like it was getting to that point. We had to do something. This is the best thing that ever happened,” Dale says. “When they can come home, it changes everything. She’s happy, she’s going places, she’s doing things.”

Tennessee may seem an unlikely place to look for a national model of health-care reform. Before CHOICES passed in 2009, Tennessee had a poor record on long-term care. According to an AARP analysis, it had the nation’s lowest percentage of low-income seniors who received home- or community-based care. In 1999, less than 1 percent of Tennessee seniors on Medicaid received that kind of care. In 2009, as planning for CHOICES was under way, the share was still below 10 percent. “We really had nowhere to go but up,” says state Sen. Lowe Finney, who formed a study committee after taking office in 2006 to explore options for improving care for those individuals.

Tennessee’s Medicaid program, TennCare, has one of the most expansive managed-care systems in the country. Health-care providers are paid on a per-patient basis, rather than per procedure, as was the case in more traditional fee-for-service models. TennCare has been in place since 1994, but seniors hadn’t been integrated into the managed-care system. Instead, the default option for Medicaid-eligible seniors in need of long-term care was living in a nursing home.

In his 2008 State of the State address, then-Gov. Phil Bredesen made the CHOICES program the centerpiece of his plan for the state. “We need to make it easier to stay at home with more home- and community-based services. We need more residential alternatives to nursing homes,” Bredesen said in his speech. “If you want to stay in your home, if it makes sense to do so, this is the year we’re going to start making it easier.”

With that, planning for CHOICES accelerated. Finney’s study committee had found that 90 cents of every state dollar spent on long-term care went to nursing-home residency, the most expensive kind of care. So policymakers set dual goals: finding a more cost-effective solution and giving seniors a choice about what kind of care they would receive. Unsurprisingly, nursing homes were concerned that they would lose substantial amounts of revenue if more patients received at-home care. Lawmakers included provisions in the bill allowing nursing homes to provide additional services, such as adult day care, to make up for the reductions in permanent residents. The

CHOICES Act passed the state General Assembly in May 2008 without a single “no” vote. A federal Medicaid waiver, which was required to modify the state’s program, was granted in July 2009. “Everybody understood the goals we were trying to achieve,” says Tennessee’s Killingsworth, “and believed, based on everything we had studied and reviewed and analyzed, that this was the thing that was going to get us there.”

Of course Tennessee is not alone in searching for new approaches for its long-term care population. Oregon’s coordinated care organizations served as a model for Tennessee policymakers when they were designing CHOICES. Vermont had already implemented a tiered system similar to CHOICES, in which patients who didn’t require nursing-home care could opt to stay at home. Arizona and Texas have had managed long-term care systems in place for more than 10 years. At the federal level, the Affordable Care Act created the Medicare-Medicaid Coordination Office within CMS. Twenty-six states—including Tennessee—have told the new office they will develop dual-eligibles demonstration projects over the next few years to improve coordination.

But Tennessee did something those other states hadn’t. It integrated CHOICES into its overall managed-care program, rather than creating a separate entity for long-term care recipients. The idea was that it would be more efficient if that population could draw on the resources of the larger program. Since its implementation, Killingsworth says her office has fielded calls from more than 20 states about CHOICES. Other states’ officials involved with developing long-term care strategies have visited to see the program at work firsthand, as have officials from CMS.

Since Tennessee’s program took effect, the number of long-term care recipients who stayed in their homes or their community doubled from 17 percent in 2010 to 34 percent in 2012. The



state is seeing a financial benefit as well: Its Medicaid program's costs are projected to increase by half the national average in 2013.

Other states are now developing managed-care systems modeled on Tennessee's. When Kansas officials decided in 2010 to implement a managed-care program, including for long-term services, they spoke to Killingsworth and her office. "They've been there, done that, and they've been successful," says Susan Mosier, director of the Kansas Medicaid office, which is set to implement KanCare in January.

Similarly, New Jersey officials determined that they should adopt a managed long-term care system. (Like Tennessee prior to CHOICES, New Jersey has ranked near the bottom in terms of home- and community-care services.) Before filing a waiver application with CMS last September, New Jersey officials sent potential health-care providers on site visits to meet with their counterparts in Tennessee.

Valerie Harr, director of the New Jersey Medicaid office, says she regularly exchanges emails with Killingsworth about how Tennessee's experience could be translated to her state. "They're a model. You have to look to states that have been in the same situation," Harr says. "They've already asked all the questions that we're trying to answer."

Managed long-term care is the first step toward a coordinated approach on dual eligibles. Of the 26 states set to initiate dual-eligibles demonstration projects, 15 say they plan to move forward next year; the other 11 say they will to start theirs in 2014. Tennessee was one of 15 states to receive a \$1 million federal grant to plan its demonstration. The state plans to integrate Medicare benefits into its managed-care system. Patients would have a single insurance card and a single care management office to oversee their needs. Savings are expected for both Medicare and Medicaid within three years if the demonstration is successful.

That's just one of the myriad ways that states are proposing to improve coordination for dual eligibles. Generally, the plans fall into one of two categories: blended rate, which sets a single rate for health-care providers to offer both Medicare and Medicaid services; and state coordination, in which the state takes responsibility for integrating care and could qualify for financial bonuses if certain savings targets are met.

There's widespread agreement that dual eligibles and managed long-term care offer an important opportunity for policymakers. But there are challenges, to be sure. Dual eligibles are, almost by definition, a high-needs population. There are many questions about whether state-run managed-care systems are prepared to

handle those needs. And there's uncertainty about proper oversight and how to measure and maintain quality when health-care services are increasingly being delivered in individual patients' homes. Some patient advocates have already warned against rushing into Medicare-Medicaid coordination. "Part of our concern is that there is a lot of vagueness, a lot of unknowns," Patricia Nemore, senior policy attorney at the Center for Medicare Advocacy, told *Governing's* Health newsletter in July. "You can't talk about duals uniformly. You can't even talk about a state uniformly. The infrastructure is different in city versus rural, one part of a state versus another part."



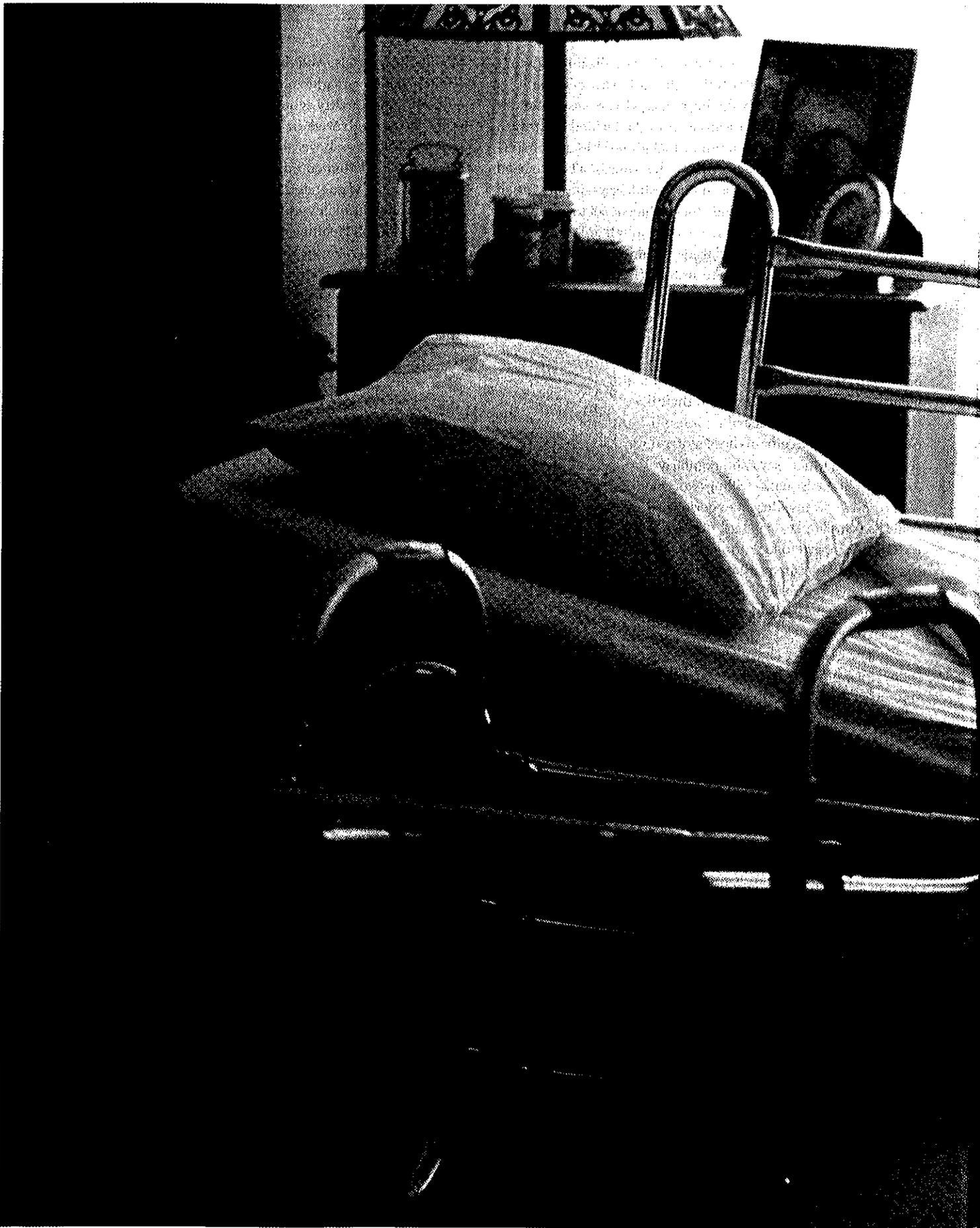
Since 2010, CHOICES has doubled the number of seniors like Delores who receive home-based long-term care. A regular exercise routine, overseen by Angie, ensures Delores is as healthy as possible.

But federal officials say the best option available is to let states experiment with different approaches. "There's not one model that would work in every case," says Alper Ozinal, a CMS spokesman. "We need to be flexible enough to recognize that states have different strengths and delivery systems to build around."

Now is the time to act, say advocates of dual-eligible reform. With a rapidly aging population, they say, states must be as proactive as possible. "You have two options," says Killingsworth. "You can either plan now or you can wait till it gets here. The only way we're going to be ready is if the planning occurs now and these kind of decisions are made now rather than later." **G**

Email dscott@governing.com

More stories on aging at governing.com/generations



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Last Rights

Aging baby boomers want control of their end-of-life care.

By Jonathan Walters

Assisted suicide. Euthanasia. Death panels. Rationed health care. There's nothing like a well-chosen phrase to inflame talk about end-of-life care—how the health-care system cares for those who are in the last stages of a terminal illness and how much control patients and their families have over that process. It can be an emotional and divisive issue, and for lawmakers, a dangerous business. That's certainly something President Obama quickly learned when a provision in the Affordable Care Act (ACA) that encouraged doctors to engage patients in discussions about end-of-life care quickly deteriorated into a nationwide war of words over whether such one-on-one discussions between patient and physician would result in "death panels" determining who should receive care.

But with America rapidly aging, the subject of end-of-life care isn't going to go away. It has the attention of any legislator or government official trying to make sense of health-care budgets in general and Medicare expenditures in particular. That's because in their last year of life, older adults consume more than a quarter of Medicare's expenditures, costing more than six times as much as other beneficiaries. It also has the attention of hospital officials. Under the ACA, hospitals will be penalized by Medicare for high readmission rates. That means there will be more focus on avoiding the ping-ponging of terminally ill patients that often takes place between nursing homes and hospitals as people near the end of their lives.

Meanwhile, an increasing percentage of Americans say they want more control over how they will be treated should they become terminally ill. Faced with

the mechanistic environment of hospital intensive care units, many older patients say they prefer to die at home, surrounded not by machines but by their family. Others want every option explored, every high-tech trick tried to prolong their lives, even if they are unconscious.

Today, the discussion over end-of-life care is alive and well—but not on a national level. “It’s pretty quiet right now, and has been since 2009 and the whole death panel debate,” says John Carney, president and CEO of the Center for Practical Bioethics, formed in 1984 to parse out complicated ethical issues around medicine and medical research, including issues like end-of-life care. Rather, the debate and press toward a political solution are currently taking place at the state level. There, policymakers and advocacy groups are managing to defuse the raw emotional responses that national, partisan-fueled battles elicited when the ACA was being debated.

The reason for that is straightforward. Rather than pursuing the “death with dignity” approach to end-of-life decisions—which immediately inflames the right-to-life lobby—a low-key movement has evolved in the states. This movement is focused on giving patients facing tough decisions about end-of-life care more say in what medicine and medical procedures they want or don’t want.

If advocates for more rational and patient-centered end-of-life care can avoid the specter of death panels and health-care rationing, there’s the real possibility of progress. Dr. Susan Tolle, who practices general medicine in Oregon and serves as director of the Center for Ethics in Health Care at the Oregon Health & Sciences University (OHSU), says, “When people are using language like ‘death panels,’ there’s more emotion and fear than if you say you want to honor the wishes of this individual.”

One tack that end-of-life care activists are taking is to push state legislation requiring health-care professionals to counsel terminally ill patients and their families on medical choices and palliative care, which is an area of health care that focuses on relieving and preventing the suffering of patients. Such initiatives have not triggered a negative response with right-to-life interests. But that doesn’t mean it has been easy to pass such laws.

According to the national chapter of Compassion & Choices, which is dedicated to advocating for more open discussion around alternatives to intensive and intrusive end-of-life interventions, only California and New York have counseling laws on the books. In New York, it was the Medical Society of the State of New York that came out strongly against the Palliative Care Information Act. Doctors there argued that it inserts the state into what should be private physician-patient relationships. That argument didn’t get far in Albany; the law passed in 2010.

Last year, New York took that approach one step further. The Legislature passed the Palliative Care Access Act, which requires institutions like hospitals, nursing homes and other long-term care facilities to offer end-of-life and palliative care counseling. This step is more significant than the Palliative Care Information Act. According to Kathy A. McMahon, president and CEO of

the Hospice and Palliative Care Association of New York State, it has led to a statewide coalition of all the health-care organizations that represent institutions like hospitals and nursing homes and gotten them to pull in the same direction on end-of-life care counseling. “The way to get real change,” McMahon says, “is to get the groups representing the facilities that are required to do this to buy in.”

But working through health-care professionals and health-care facilities to promote end-of-life care counseling is not getting a huge amount of traction in other states. More promising is a rapidly growing end-of-life care phenomenon known as “physician orders for life-sustaining treatment,” or POLST.

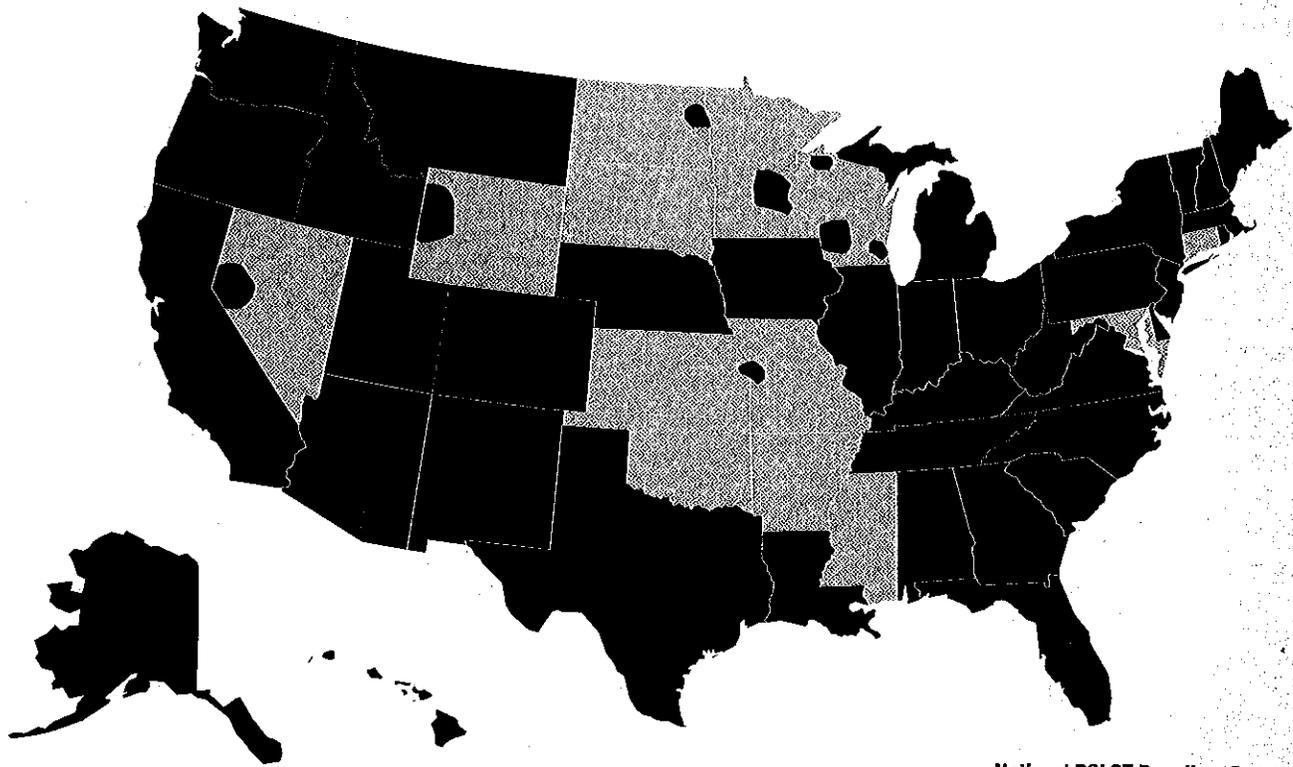
The basic idea behind POLST is to give anyone who is judged to have less than a year to live the chance to set out very detailed directions about what sort of care they want or don’t want. “It’s basically a DNR on steroids,” says Carney of the Center for Practical Bioethics. But unlike a “do not resuscitate” order, or an advance directive, POLST forms are formal physician’s orders worked out in advance with a patient or a patient’s advocate. “We have found POLST to be a very successful way to convey immediately actionable medical care based on patients’ wishes,” says Dr. Alvin Moss, director of the Bioethics Program at the West Virginia University School of Medicine.

The other advantage of POLST, at least when done thoroughly, is that it is instantly accessible to everyone from EMTs in an ambulance to doctors in an emergency room. That’s the case in Oregon, where the state maintains a rapidly expanding registry of more than 100,000 POLSTs available online 24 hours a day, seven days a week. There are currently five states with POLST registries, although as electronic medical records systems evolve and grow, POLSTs are likely to become part of any patient’s instantly accessible online record.

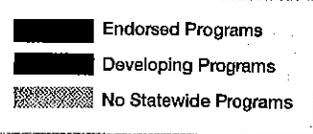
Given the registry and general knowledge of POLSTs in Oregon (the state implemented its POLST program way back in 1995), there’s been a significant shift in the behavior of both patients and health-care professionals. “There is a huge amount of public empowerment in this,” says Tolle of OHSU, which hosts the Oregon POLST registry. “We’ve seen a major transformation from ‘We didn’t ask, we just intubated,’ to [medical personnel] asking if someone has a POLST form.”

As for the politics of POLST, the death panel insinuation has not materialized. That may be because health professionals involved in the movement learned their lesson during the ACA fight. Now, when a state legislature is considering a POLST bill, there is a concerted effort to get all interests to the table at the very start, including right-to-life and disability rights groups.

In West Virginia, the key to successfully establishing its POLST program was to send a clear message that POLST wasn’t about helping or even coercing patients to forgo care. It’s about patient choice, says Moss, who also serves on a national POLST task force. The right-to-life lobby agreed to stay neutral on the bill, he says, because they understood that POLSTs were optional. “If



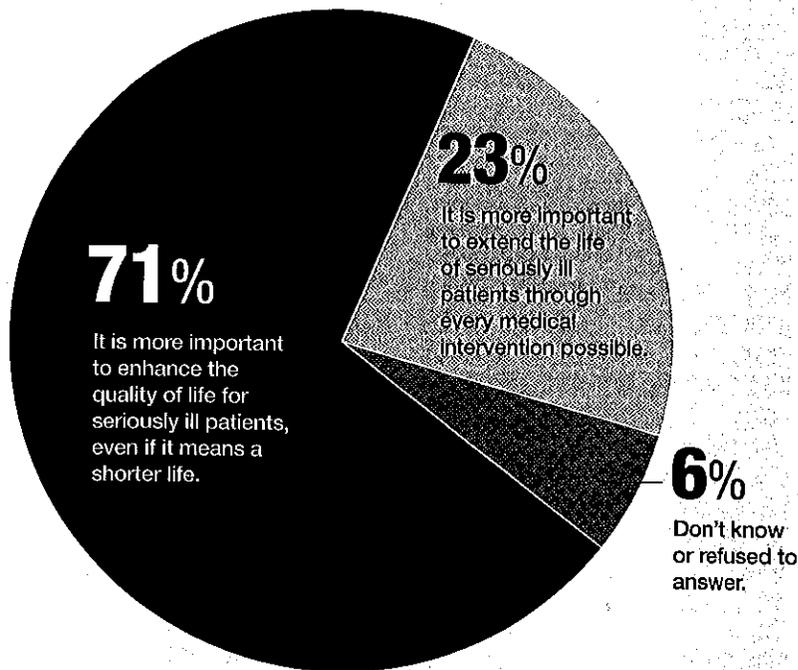
National POLST Paradigm Programs



* AS OF SEPTEMBER 2012

Let's Talk About the End

Talking about death isn't easy for anyone. But when the conversation goes public, it can become so politically charged that it simply deteriorates into a war of words. Since about 25 percent of all Medicare spending is on end-of-life care, the conversation is a vital one. A February 2011 *National Journal* and Regence Foundation poll asked which of the statements to the right most closely reflected respondents' beliefs. While talk of death panels has put the end-of-life care discussion on hold at the national level, states have quietly picked up the torch. "Physician orders for life-sustaining treatment," or POLST programs, are now in 14 states. These initiatives give people the chance to define clearly what kind of treatment they want or don't want at the end of their lives.



SOURCES: NATIONAL POLST PARADIGM TASK FORCE (MAP); REGENCE FOUNDATION/NATIONAL JOURNAL POLL, CONDUCTED FEBRUARY 2011 (CHART)

Dying at Home State by State, 2005-2009

Percentage of Total Deaths Reported in Home



SOURCE: CDC AND THE NATIONAL CENTER FOR HEALTH STATISTICS; UNDERLYING CAUSE OF DEATH; DATA OBTAINED FROM CDC WONDER ONLINE DATABASE

THE PLACE OF DEATH IS OBTAINED FROM DEATH CERTIFICATES AND REFERS TO WHERE A DEATH IS PRONOUNCED. INDIVIDUALS WHO PASS AWAY IN THEIR HOMES, BUT ARE TRANSPORTED TO HOSPITALS, WILL NOT BE RECORDED AS DYING AT HOME. FIGURES ARE FOR NON-INJURY RELATED DEATHS.

a person does want to fill one out, they can say they want CPR, they want a feeding tube. They can have all that.”

The notion of patient control and choice and its two-way nature seems to be fundamental to why POLST has not been as controversial as other laws related to end-of-life care.

Working in its favor, says West Virginia state Sen. Ron Stollings, is the simple reality that it’s directly in line with patients’ wishes. “It’s what my patients want,” says Stollings, a general practice physician who sees a large percentage of elderly clients. “They want high-touch, low-tech. They want meals on wheels and in-home services. They want to get out to the grocery store if they can. They don’t want CAT scans and MRIs.”

More than 14 states now have some form of a POLST system in place, with another 25 states considering programs. Typically, POLST laws and regulations also include language granting caregivers immunity if they follow a POLST form. In registering, POLST participants almost uniformly agree that the form be accessible to all health-care providers, which gets around the privacy concerns of Health Insurance Portability and Accountability Act regulations.

But POLST’s low profile cuts both ways. While it is off the radar of the political social wars, the lack of awareness of or information about POLST is considerable, which means in some states it is nowhere near to living up to its potential. “The process is a slow one,” says David Leven with Compassion & Choices of New York (the state passed a POLST law in 2009). “That’s unfortunate because studies show that when there is a POLST document it’s much more likely that a patient’s wishes will be honored and they will have less aggressive interventions, which makes for a higher quality of life. Right now there’s a major deficit in knowledge.”

The steep learning curve aside, the ultimate promise of POLST is significant. So far, the programs haven’t elicited the strong opposition that arrives with assisted suicide bills. That difference is on full display right now in Massachusetts. There, a bitter, high-profile battle is raging over a ballot initiative to allow terminally ill patients to give themselves a lethal dose of drugs. (Three other states have such laws in place: Montana, Oregon and Washington.)

Meanwhile, Massachusetts is also pursuing a POLST initiative. As long as it hews to hospice and palliative care discussions and doesn’t wander into the territory of assisted suicide, it isn’t a problem with right-to-life interests in the state, says Anne Fox, president of Massachusetts Citizens for Life.

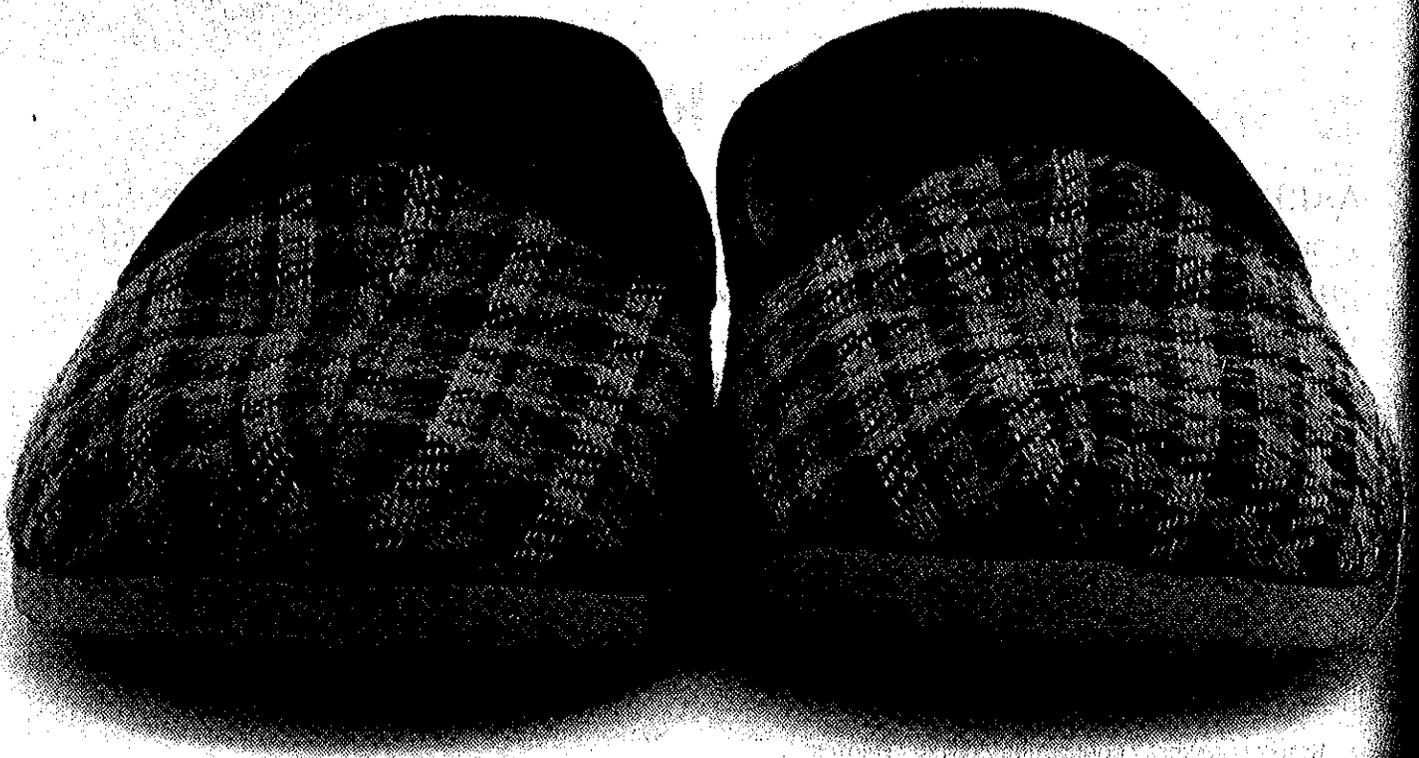
The end-of-life care movement is clearly gathering steam. Public officials and the medical community alike are discussing the topic in growing numbers. With good reason: An aging baby boom cohort and their families are much more tuned in to the subject than previous generations.

Ultimately, the drive toward a more rational, reasoned and patient-centered approach to dying is pretty straightforward. “We are,” says West Virginia’s Moss, “spending lots of money on people who die within a year, in settings they don’t like, getting treatments they don’t want.” **G**

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These Slippers Could Save

Telehealth will revolutionize health care for aging patients – if states can get out of the way.



ers Your Life!

By Dylan Scott

This exists: a pair of house shoes, equipped with pressure sensors and a special pedometer, that can sense when the wearer is about to stumble and send out an instant message to that person's doctor. Developed by AT&T in 2009, the slippers monitor the gait of the person wearing them and can alert a physician if there's anything unusual. That early notification might prevent a dangerous fall and a costly trip to the emergency room.

Seem crazy? How about a doctor's visit that takes place entirely through video conferencing? Or an in-home blood-pressure monitor that instantly relays a patient's stats to her doctor's office? Or glucose meters that constantly upload information to a password-protected website, allowing a diabetic patient's daughter to track her mom's health online?

It still sounds a little like science fiction for senior health care: Jetsons Age technology for a generation that grew up on "The Jetsons." But it's part of the very real, very rapidly growing telehealth industry, which is expected to triple in size to \$27.3 billion by 2016, according to projections by BCC Research, a market research firm.

It could be a cost-saver too. Some industry analysts have said remote monitoring could lead to savings of 20 to 40 percent by reducing unnecessary hospitalizations and catching chronic problems early. Others have cited pending doctor shortages—a national gap expected to reach 130,000 by 2025, as the baby boomer retirement wave crests—as reason to embrace remote health-care technology.

But state policies must first catch up.

Regulations set by state medical boards can make it difficult for doctors to practice telemedicine, Gary Capistrant, senior director of public policy at the American Telemedicine Association, told *Kaiser Health News* in May. State boards often require an existing doctor-

patient relationship or a prior in-person exam—severely limiting for an industry that frequently crosses state lines. Just two years ago, in a ruling that was decried by telehealth advocates, the Texas Medical Board expressly prohibited physicians from treating new patients virtually without an initial face-to-face exam (or a referral from another doctor who had met with the patient in person).

The national Federation of State Medical Boards convened in March 2011 to examine the relationship between regulation and telemedicine. Members voiced concerns over maintaining quality of care and providing adequate tech training for physicians. But there was an acknowledgment that telemedicine offers an important opportunity. "We have scarce resources, and there is recognition that life has changed when it comes to how best to ensure access to medical care for those in need," Dena Puskin, a senior adviser at the federal Human Resources and Services Administration, told the group.

Some states are embracing telehealth. The New Mexico Medical Board, for example, will issue a telemedicine license to any health-care provider outside the state who is licensed in any other state or territory in the United States. At least nine other state boards have modified their licensing requirements to allow some kind of telehealth practices across state lines. But with the other 40 states maintaining in-state licensing requirements, telehealth advocates say more action is needed.

"The best thing we could do is get rid of the term 'telemedicine,'" said Jay Sanders, president and CEO of the Global Telemedicine Group, at the 2011 conference. "When we started using CAT scans we didn't call it 'CAT-scan medicine,' and when ultrasounds came in we didn't call it 'ultrasound medicine.' It's medicine, period." **G**

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Information, Please!

Better exchanges of health data could fundamentally change the nation's health-care systems, especially for older patients.

By Dylan Scott

In the ongoing effort to rein in health-care costs, many policymakers and health workers view data and information as a crucial next frontier. The increasing expenses of health care, the thinking goes, are often a symptom of poor coordination and communication, a problem that could be remedied if health-care providers and governments were better equipped to share data.

"More and more innovation is happening with more and more data being made available," U.S. Chief Technology Officer Todd Park said at the 2012 Health Datapalooza in Washington, D.C., in June. "Health data is no longer a government initiative. It is an American initiative."

Seniors—and specifically dual eligibles [see "Stay at Home, Mom," page 32]—could benefit the most. With the dual-eligible demonstration projects created by the Affordable Care Act, intended to improve coordination between state-run Medicaid and federally run Medicare for the nine million people under both, states are gaining access to Medicare data for the first time.

Some state officials are almost giddy at the prospect. "We had a huge void because we didn't have access to that data," says Denise Levis, director of clinical programs and quality improvement at Community Care of North Carolina, the organization overseeing that state's demonstration. "Now that we do, it should have a huge impact."

North Carolina is one of 26 states developing dual-eligibles demonstrations under the health-care reform law. It has already begun integrating Medicare data into its existing health information exchange, an online warehouse that collects information from several state agencies and now the Centers for Medicare & Medicaid Services (CMS). In March, the exchange received Medicare data on hospital and primary care claims for the first time. The state is currently negotiating with CMS to access its prescription data as well.

Once it has as much federal data as it can get its hands on, North Carolina will run the information through algorithms to identify dual eligibles with the highest risks. Those individuals can then be targeted for disease management and medication management to make sure they are controlling their conditions as best they can. That should lead to lower costs. State officials project they'll see savings within the first 12 to 18 months if all goes according to plan.

More than 250 health information exchanges like the one at work in North Carolina are operating across the country. Some are government-run; others are run by insurance companies or health-care providers. They allow patient data to be shared electronically across providers and government agencies, giving doctors and hospitals a more complete picture of the people they're treating. For a high-needs population like dual eligibles, who typically have a history of health issues, that information can be invaluable.

Many analysts have extremely high hopes for these information exchanges. A recent survey of senior health IT specialists found that 40 percent believe that health information exchanges, more than anything else, "can have the most impact on patient care by improving clinical and quality outcomes."

Obstacles remain. Maintaining these exchanges requires funding, and it can be difficult to facilitate trust among the health-care providers involved. Overcoming those challenges is important, advocates say, because of the potential for data exchanges to revolutionize the health-care industry. "Electronic health information exchange addresses a critical need in the U.S. health-care system to have information follow patients to support patient care," wrote officials with the federal Office of the National Coordinator for Health Information Technology in *Health Affairs* this March. "Today little information is shared electronically, leaving doctors without the information they need to provide the best care. ... The demand for health information exchange is poised to grow." **G**

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