



## VDA WEEKLY E-MAILING

October 1, 2013

### Table of Contents

[ACL and NASUAD Update Links](#)

[National Survey of Computer Usage at Senior Centers](#)

[Consumer Financial Protection Bureau Article](#)

[Training for Healthcare Professionals: Differentiating Depression and Dementia](#)

[Altarum Institute Webinar: "Advanced Old Age in America: What Can We Count On?"](#)

[Final Contract Year 2013 Financial Report & Service Report \(13 Month Report\)](#)

### ACL and NASUAD Update Links

*Cecily Slasor, Administrative Support*

Link to NASUAD Friday Updates

<http://archive.constantcontact.com/fs163/1109249143446/archive/1113206599203.html>

Link to ACL Update

[http://www.acl.gov/www.acl.gov/NewsRoom/eNewsletter/archive/enewsletter\\_archive.as](http://www.acl.gov/www.acl.gov/NewsRoom/eNewsletter/archive/enewsletter_archive.aspx)

[px](#)

Note: The web links in this document may change over time. DARS-VDA does not attempt to refresh the links once the week has passed. However, this document is maintained on the web for a period of time as a reference. Some links may require registration.



## National Survey of Computer Usage at Senior Centers

*Elaine S. Smith, MS, RD, Program Coordinator*

At the following link you will find a summary of the results of a survey of computer usage by Senior Centers with detailed comments from Directors sharing their experience. The summary and analysis can be seen at [www.seniordirector.org](http://www.seniordirector.org) (select national summary and comments from the menu at the top of the page). The summary and attached comments underscore the great variation between centers and in their readiness for the incoming surge of computer literate baby boomers. Please feel free to circulate this summary to Area Agencies and Directors of Senior Centers. If you would like to participate in the survey, please [contact Don Hutchinson at SeniorDirect@Verizon.net](mailto:SeniorDirect@Verizon.net).

## Consumer Financial Protection Bureau Article

*Gail S. Nardi, Director, Adult Protective Services Division*

Good afternoon,

Along with other federal regulators, today we clarified for banks and other financial institutions that they generally may report suspected elder financial exploitation to the appropriate authorities without running afoul of a federal privacy law.

**Read the blog:** <http://www.consumerfinance.gov/blog/banks-can-help-spot-elder-financial-exploitation-and-abuse>

Older Americans are often targeted by scam artists, family members, financial advisors, caregivers, home repair targets – you name it! Financial institutions often spot the red flags for abuse sooner than anyone else can, but their employees may be confused about whether privacy laws allow them to share information with authorities that can take action.

That's why we are telling banks and other financial services providers that reporting suspected elder financial abuse to the appropriate authorities generally will not violate the Gramm-Leach-Bliley Act. And it's the right thing to do.

[Read more about today's guidance and why we believe it is so important.](#)



We can only stop financial exploitation of older people through coordinated efforts at the community, state, and national levels.

Thank you,

Nora Eisenhower  
Office for Older Americans  
Consumer Financial Protection Bureau

## Training for Healthcare Professionals: Differentiating Depression and Dementia: Cognitive Considerations

*Tim Catherman, Director, Aging Operations*

### **Differentiating Depression and Dementia: Cognitive Considerations**

Please join the VCU Department of Gerontology, Piedmont Geriatric Hospital and Danville Parks and Recreation for this upcoming training for healthcare professionals.

Date: Tuesday, November 12, 2013

Time: 2:00 pm and 5:30 pm

Location: Ballou Recreation Center, 760 West Main Street, Danville, Va. 24541

Cost: \$10 (\$25 for Continuing Education Units)

This Geriatric Training and Education (GTE) funded project has been developed by the Virginia Commonwealth University Department of Gerontology. It features a 1.5 hour interactive training for healthcare professionals that is offered two times during one day.

It is facilitated by experts in the field of differentiating diagnoses between Depression and Dementia. Clinical Psychologist Dr. Andrew Heck and Gerontologist/Developmental Psychologist Dr. Tracey Gendron will be facilitating the training sessions at Ballou Recreation Center.

Participants will also be participating in a pre and post test to determine the efficacy of the training.

#### **Learning Objectives:**

**At this end of this sessions, participants will able to:**

**- Review and understand similarities and differences between depression and dementia in older**



## adults

Certificates of Attendance will be provided to all participants. CEU's will be available for an additional processing fee of \$10.

Presentations will be made at 2:00 pm and 5:30 pm and will last one hour and thirty minutes.

Cost: \$10 (\$25 for continuing education units)

To register please contact Karen Hibbard at 434-799-5216 or email [hibbakm@ci.danville.va.us](mailto:hibbakm@ci.danville.va.us).

## Altarum Institute Webinar: "Advanced Old Age in America: What Can We Count On?"

*Amy Marschean, JD, Senior Policy Analyst*

On September 26, 2013, the Altarum Institute presented a very informative panel discussion on the topic, "Advanced Old Age in America: What Can We Count On?" For those unable to listen to the webcast, here is a two-page overview of the discussion with attachments. Further information is available on the Altarum Institute website: <http://altarum.org/research-centers/center-for-elder-care-and-advanced-illness> (Amy Marschean)

## Final Contract Year 2013 Financial and Service Report

*Marica B. Monroe, CPA, VCA, Financial Reporting & Accounting Manager*

Please read carefully and follow instructions.

The Contract Year 2013 Financial Report and Service Report (13<sup>th</sup> Month Report) should be completed and electronically submitted to the Department for Aging and Rehabilitative Services (DARS) by the close of business, **November 15, 2013**. This report is used by Area Agencies on Aging (AAAs) to report finalized annual performance, expenditures and receipts for the fiscal period October 1, 2012 through September 30, 2013. The following schedules must be submitted.

- **Final Contract Year 2013 Financial and Service Report:** This year the Aging Monthly Report (AMR) will be used to report compiled annual programmatic and financial information for the period October 1, 2012 to



September 30, 2013. When completing your report, select **Final (13<sup>th</sup> Mo)** from the month drop down menu on the payment worksheet. Please name your file, "Final PSA xx," when emailing your submission to [closeoutreports@dars.virginia.gov](mailto:closeoutreports@dars.virginia.gov) . Insert your PSA number in the characters denoted by xx.

Please make certain your Agency's AIM or PeerPlace data supports the AMR service data.

- **Final (13<sup>th</sup> Mo) – Schedules A, B, & C:** Schedules A, B, & C have been written in Excel and are available on the DARS website at <http://vda.virginia.gov/reportsandinstructions.asp>. The three schedules are tabbed as separate worksheets in the workbook. The workbook should be downloaded to your computer before completion. Please name the file, "ABC PSA xx," when emailing your submission to: [closeoutreports@dars.virginia.gov](mailto:closeoutreports@dars.virginia.gov) . Schedules A, B, & C are to be included in your audited financial statements as supplementary information and your audit firm is **required** to include these schedules in their audit opinion. Please ensure all funds received from DARS are included and that recorded amounts reconcile to the September 2013 remittance advice to be provided by DARS. **Please ensure that the agency submission and the schedules included by your auditor in the audit report are in the current format.**
  - **Schedule A, Status of Funds:** This schedule provides an accounting of grant funds on hand at the beginning of the period, and receipt and expenditures of grant funds during the period. Although general fund awards for the fiscal year ending on June 30, 2013 needed to be obligated by June 30, 2013, the recipient had until September 30, 2013 to liquidate the obligations. If a cash balance exists on September 30, 2013 from any general fund award for the Program Year (PY) ending on June 30, 2013, please refund the balance to DARS with a copy of Schedule A as your remittance advice.
  - **Schedule B, Costs by Program Activity:** This schedule accounts for the expenditure of funds by activity rather than grant. Please



ensure that Schedules A & B tie where appropriate. Again, Schedule B has been modified to correspond to the Aging Monthly Report. It now includes separate sections to report Title III activity (Except III-E) and a section to report III-E activity. If there are no audit adjustments, the data reported on your final AMR should be the same as reported on Schedule B.

- **Schedule C, Status of Inventories:** Tangible personal property purchased with funds from a Federal or State grant should be included. Generally, equipment or large quantities of food would be the main items reported. Equipment with a fair market value of less than \$5,000 per unit should not be reported.

**Contractor Certification Form:** This form should be prepared on AAA letterhead and signed by the AAA Executive Director. The form is available on the [DARS/VDA website](#).

Please mail the Contractor Certification to:

Marica B. Monroe, Financial Reporting and Accounting Manager  
Department for Aging and Rehabilitative Services  
8004 Franklin Farms Drive  
Henrico, VA 23229

Your submission should include **all** contracts issued by DARS to support contract year 2013 operations. All funds received during the period, October 1, 2012 to September 30, 2013, should be accounted for and included. **As a reminder, your agency's audit report is due to DARS by December 15<sup>th</sup>.** One 30-day extension may be requested in writing, but the extension request must be received before December 15<sup>th</sup>.

# CERTIFICATION

I, (Insert Name)\_\_\_\_\_ certify that I am the  
Executive Director \_\_\_\_\_ of (Area Agency on  
Aging)\_\_\_\_\_.

I have reviewed the Final (13 Month) Aging Monthly Report (AMR) and Status of Funds, Costs by Program Activity, and Status of Inventories (Schedules A, B, & C) for contract year 2013. By submitting these reports, as required by the Department for Aging and Rehabilitative Services (DARS) Regulations, Section, 22 VAC 5-20-480 and Section 22 VAC 5-20-500, I certify, that to the best of my knowledge and belief, this information is a true, correct, and complete statement prepared from the books and records of the agency in accordance with applicable instructions, except as noted.

Further I certify that all costs and revenues reported are allowable as specified by the contracts issued with DARS. Any audit adjustments that occur subsequent to the filing of these documents, shall be promptly reported to DARS.

---

Executive Director

---

Date

**Contractor Certification Form:** This form should be prepared on AAA letterhead and signed by the AAA Executive Director.

Please mail the Contractor Certification to:

Marica B. Monroe  
Department for Aging and Rehabilitative Services  
8004 Franklin Farms Drive  
Henrico, VA 23229

Your submission should include all contracts issued by DARS to support contract year 2013 operations. All funds received during the period, October 1, 2012 to September 30, 2013, should be accounted for and included. **As a reminder, your agency's audit report is due to DARS by December 15<sup>th</sup>.** One 30-day extension may be requested in writing, but the extension request must be received before December 15<sup>th</sup>.

**SCHEDULE A - STATUS OF FUNDS**  
From October 1, 2012 to September 30, 2013

FUND	UNENCUMBERED FUNDS ON HAND OCTOBER 1, 2012	TOTAL FUNDS RECEIVED DURING PERIOD	FUNDS REQUESTED BY SEPTEMBER 30, 2013 BUT NOT RECEIVED BY SEPTEMBER 30, 2013	TOTAL OF FUNDS AVAILABLE DURING PERIOD	ACCRUED COSTS TO CONTRACT PERIOD	UNENCUMBERED FUNDS ON HAND SEPTEMBER 30, 2013
<b>Older Americans Act</b>						
Title III-B				\$0	\$0	\$0
Title III-C(1)				\$0	\$0	\$0
Title III-C(2)				\$0	\$0	\$0
Title III-D				\$0	\$0	\$0
Title III-E				\$0	\$0	\$0
Title VII-Ombudsman				\$0	\$0	\$0
Title VII-Elder Abuse				\$0	\$0	\$0
Other				\$0	\$0	\$0
Other				\$0	\$0	\$0
Other				\$0	\$0	\$0
<b>Other Federal</b>						
Title V-(PY 06/30/12 Award)				\$0	\$0	\$0
Title V-(PY 06/30/13 Award)				\$0	\$0	\$0
Title V-(PY 06/30/14 Award)				\$0	\$0	\$0
NSIP				\$0	\$0	\$0
VICAP-(PY 03/31/11 Award)				\$0	\$0	\$0
VICAP-(PY 03/31/12 Award)				\$0	\$0	\$0
VICAP-(PY 03/31/13 Award)				\$0	\$0	\$0
VICAP-(PY 03/31/14 Award)				\$0	\$0	\$0
Alzheimer's Disease Grant				\$0	\$0	\$0
Aging & Disability Resource Center Navigate Health "A"				\$0	\$0	\$0
Aging & Disability Resource Center Options Counseling "B"				\$0	\$0	\$0
Aging & Disability Resource Center Expansion Funds "C"				\$0	\$0	\$0
Summer Cooling Assistance				\$0	\$0	\$0
Expanded Older Driver Rehab Project				\$0	\$0	\$0
DMAS Ombudsman FY 11				\$0	\$0	\$0
DMAS Ombudsman FY 12				\$0	\$0	\$0
DMAS Ombudsman FY 13				\$0	\$0	\$0
CLP2				\$0	\$0	\$0
MIPPA - AOA PRIORITY 1				\$0	\$0	\$0
MIPPA - AOA PRIORITY 2				\$0	\$0	\$0
MIPPA - AOA PRIORITY 3				\$0	\$0	\$0
Money Follows the Person				\$0	\$0	\$0
LifeSpan Respite				\$0	\$0	\$0
SNAP				\$0	\$0	\$0
Senior Farmers Market				\$0	\$0	\$0
CDSME				\$0	\$0	\$0
Other				\$0	\$0	\$0
Other				\$0	\$0	\$0
Other				\$0	\$0	\$0
Other				\$0	\$0	\$0
Other				\$0	\$0	\$0
Other				\$0	\$0	\$0
<b>General Funds</b>						
Title III Match-(PY 06/30/13)				\$0	\$0	\$0
Title III Match-(PY 06/30/14)				\$0	\$0	\$0
Community Based-(PY 06/30/13)				\$0	\$0	\$0
Community Based-(PY 06/30/14)				\$0	\$0	\$0
Spec. Transportation-(PY 06/30/13)				\$0	\$0	\$0
Spec. Transportation-(PY 06/30/14)				\$0	\$0	\$0
Home Delivered Meals-(PY 06/30/13)				\$0	\$0	\$0
Home Delivered Meals-(PY 06/30/14)				\$0	\$0	\$0
Ombudsman-(PY 06/30/13)				\$0	\$0	\$0
Ombudsman-(PY 06/30/14)				\$0	\$0	\$0
Care Coordination-(PY 06/30/13)				\$0	\$0	\$0
Care Coordination-(PY 06/30/14)				\$0	\$0	\$0

**SCHEDULE A - STATUS OF FUNDS**  
From October 1, 2012 to September 30, 2013

FUND	UNENCUMBERED FUNDS ON HAND OCTOBER 1, 2012	TOTAL FUNDS RECEIVED DURING PERIOD	FUNDS REQUESTED BY SEPTEMBER 30, 2013 BUT NOT RECEIVED BY SEPTEMBER 30, 2013	TOTAL OF FUNDS AVAILABLE DURING PERIOD	ACCRUED COSTS TO CONTRACT PERIOD	UNENCUMBERED FUNDS ON HAND SEPTEMBER 30, 2013
Respite Care-(PY 06/30/13)				\$0		\$0
Respite Care-(PY 06/30/14)				\$0		\$0
Guardianship-(PY 06/30/13)				\$0		\$0
Guardianship-(PY 06/30/14)				\$0		\$0
Transportation Services for the Elderly				\$0		\$0
Fan Care (Dominion Power)				\$0		\$0
Hold Harmless				\$0		\$0
Other				\$0		\$0
Other				\$0		\$0
Other				\$0		\$0
Other				\$0		\$0
Other				\$0		\$0
Other				\$0		\$0
Other				\$0		\$0
<b>*Note: PY means Program Year Ending</b>						
<b>GRAND TOTAL:</b>	<b>\$0.00</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

Revised 10/01/13

## Advanced Old Age in America: What Can We Count On?

### The Status Quo and Alternative Vision

- Senator Isakson and Senator Warner's aide discussed their bipartisan Care Planning Act of 2013. Information about the proposed legislation appears at the end of this document.
- Jennie Chin Hansen, CEO, American Geriatrics Society, spoke generally about quality of living for elderly frail and noted a new psychological measure of Days in Community v. Days in Hospital until Discharge to highlight the new focus on community living. She urged the system to be ready and noted there is money "sloshing" in the health care system to provide the best care. A best care example would be PACE where "everyone knows your name." She urged that the troops and tools needed to be ready to go with a prepared workforce for a frail population with dementia, just as there is a system in place for pediatric care. Health professionals should be prepared to hand off to the appropriate staff that is most competent. She made reference to the Bob Dylan/Pete Seger song with the lyric "Turn, Turn, Turn" and we should turn ultimately to palliative/hospice care. Life and dying transcends party affiliation.

### Current Policy Plans and Proposals

- Joe Antos, American Enterprise Institute: Congressional Budget Office (CBO) is looking at the community "formal" care employed v. the majority of unpaid services supplied by family and friends which is a very important care component. However, it is a challenge to fund long-term care (LTC) because this unpaid factor is hard to account for in any budgetary analysis. Medicare covers post-acute care and not LTC. CBO analysis is that a LTC demographic analysis predicts growth of 1.3% GDP paid services growing to 3% so there would be a doubling of resources going into this area. With recession, no one is willing to look to NEW programs and health reform continues to overlook financial aspects and fails to coordinate medical and LTC services.
- John Rother, National Coalition on Health Care: Elderly want to be at home and not institutionalized. Paradox is that while people are living longer and also frail longer, we really should be looking to find ways to be healthy longer. Also, there is a great deal of money in the health system. The private insurance system has failed, so we need to look to a different system of care. **He believes that LTC is not a health problem but more of a disability issue. But although disability, we will take cash from the health care system:**  
ACA promotes person-centered medical home and promotes team for good outcomes and supports quality of life for enrollees. We need to build an incentive system based on outcomes and reward care coordination.

Solutions:      OnLok for post-acute care (LTC)-good model of private managed care  
<http://www.onlok.org/>  
Liberalizing disability for pre-Social Security—disability insurance for LTC population is less expensive than third party payor system  
Provide cash and counseling in community as cheaper option for LTC

LTC in institutions is predominately for dementia, incontinence and broken hips(mobility) so must find ways to limit/prevent. Research needs to be targeted at these three conditions

Standard benefit in ACA—while broad, needs to be broader for frail and those with LTC service needs. Repurpose dollars in system from institutional to home and community based care

- LTC Insurance—people don't buy because likelihood of LTC not immediate and most in denial. Asked whether public sector should promote and Mr. Rother disagreed that private insurance is a suitable solution. Insurers are trying to combine LTC insurance with life annuity to make more attractive and Mr. Antos commented that is like "putting lipstick on a pig." Insurance pools are down, so premiums are skyrocketing. It is hard to make a bet on costs 20-30 years out.
- LTC is needed for younger persons so Mr. Rother would push for more of a disability approach.
- Primary medical home model—doesn't treat whole person. Need new attitude from M.D.s and need person centered care across continuum.
- Prices should not be a "given" for medical care, but if government were to order prices down need to consider also that resources may dry up.
- A lot of dollars in medical sector and should have a medical home where *medical* not necessarily the focus. Focus should be on caregiver and should be providing dollars for them.
- **Change reimbursement so that not paying fee for service and move from volume to value**

Community Level Change—community issue and need community health teams with political leadership engaged

- Mimi Toomey, ACL—HHS focus on Prevention and noting that lack of social supports in community is problem
- John Feather, Grantmakers in Aging—Age friendly communities and promoting living well
- Suzanne Burke, CEO, Council on Aging of Southwestern OH—Cincinnati positive results—**use Property Tax Levies for Social Supports in Community** and this is popular in this community. Cincinnati allows for Co-pay of up to 100%.
- Joanne Lynn, Altarum Institute Center for Elder Care and Advanced Illness (worked with Dr. Allen on the Medicaring 4Life Grant with CMMI(abstract attached) Take funds from the medical side and move to social services---e.g., instead of doing 5 MRIs, use less costly X-ray and take savings for social services. Break up old model using Medicaring 4Life model with an ACO (Accountable Care Organization)
- Need to bring in architecture schools and local government planners to assist with housing for elderly frail—Livable Communities, Urban Planning and Universal Design
- Need multigenerational strategies for planning; young need to engage with elders. This issue needs to engage both 24 year old and 85 year old because the economic engine for the future must support people not financially giving back
- Religious organizations are definitely part of community social services efforts—essential to bring in all community leaders.

**Aug 01 2013**

**[Sens. Warner & Isakson Introduce Bipartisan Care Planning Act of 2013](#)**

**Allows those with advanced illness to align care they get with care they want**

**Contact: Kevin Hall - (202) 228-6884**

WASHINGTON – U.S. Sens. Mark R. Warner (D-VA) and Johnny Isakson (R-GA) introduced legislation today designed to give people with serious illness the freedom to make more informed choices about their care, and the power to have those choices honored. The Care Planning Act of 2013 creates a Medicare and Medicaid benefit for patient-centered care planning for people with serious illness. It will reimburse a team of healthcare professionals for providing a voluntary, structured discussion about the patient's goals, illness, and treatment options. A written plan will reflect the informed choices made by patients in consultation with their health care team, faith leaders, family members and friends. The Care Planning Act also provides resources for public and professional education materials about care planning.

“When faced with a serious illness, you want the freedom to control how you will live. The Care Planning Act will help align the care you receive with the care you want – no more, no less,” Sen. Warner said. “People don't like to talk about sickness or death, and families tend to put off confronting what might happen if individuals become seriously ill or unable to make decisions about their own medical care. This patient-centered approach will help your doctors and your hospital know about the choices that you and your loved ones have made. If a patient prefers to explore every possible treatment option, that choice should be respected. And if an individual prefers a different approach after informed consultations with their health team, their family and others, those choices should be documented and honored, too.”

“I'm proud to join Sen. Warner in introducing the Care Planning Act today because it gives people who have been diagnosed with a serious illness, and their loved ones, an opportunity to have face-to-face conversations with their doctors, nurses and/or religious leaders to develop a care plan,” Sen. Isakson said. “I know from my own family's experience that having a plan makes a world of difference in ensuring a high quality of life during a loved one's last days. I encourage my colleagues to support this legislation because it will go a long way in honoring patients' wishes and empowering people to take charge of their own health care.”

The Care Planning Act:

- Establishes Medicare and Medicaid reimbursement for healthcare professionals to provide a voluntary and structured discussion about the goals and treatment options for individuals with serious illness, resulting in a documented care plan that reflects the informed choices made by patients in consultation with members of their health care team, faith leaders, family members and friends.
- Tests new models for more intensive services for those with advanced illness, and provides funding to support the development of a public information campaign to encourage effective care planning. It also provides grants to develop materials and maintain a web site with information about advanced care planning, portable treatment orders, palliative care, hospice, and planning services, and directs the U.S. Dept. of Health & Human Services (HHS) to include information about advanced care planning in the official Medicare & You handbook.
- Puts structures in place to focus providers on evidence of patient preferences, such as directives from other states or past discussions about treatment goals, and requires documentation of plans made

prior to discharge from health facilities to assure that care plans travel with patients after discharge.

- Directs the HHS to develop quality metrics that will measure synchronicity among the individual's stated goals, values, and preferences with documented care plans, the treatment that is delivered, and the outcome of treatment.
- Creates a Senior Navigation Advisory Board, comprised of a diverse range of individuals including faith leaders, health care professionals and patient advocates, which will monitor and advise HHS throughout implementation of the Act.
- Explicitly prohibits the use of funds in violation of the Assisted Suicide Funding Restriction Act of 1997, and further requires that all services be free from discrimination based on advanced age, disability status, or the presence of advanced illness.

"I have been interested in having an intelligent conversation about advanced care planning for many years, both as a policymaker and as a son whose mother suffered from Alzheimer's and could not communicate with our family during her final decade of life," Sen. Warner said. "Grappling with her health care challenges was much more difficult because we did not take the opportunity to talk with her in a frank and fully informed way when she was first diagnosed and capable of expressing her wishes. I regret that we never discussed with her the full array of care options available to her."

The Care Planning Act of 2013 has been endorsed by a broad range of health care, health provider, senior and patient advocacy organizations.

- "AARP recognizes the importance of care planning, advance care planning and making sure individuals have options and resources to plan for their future and have their wishes respected," said Joyce Rogers, AARP senior vice president for government affairs. "The Care Planning Act of 2013 recognizes the important role family caregivers play in supporting individuals as they age and we're happy to support this bipartisan legislation."
- "Sen. Warner has brought faith leaders into this discussion. As Christians, we should affirm efforts that are directed toward honoring the dignity of individuals and their families by giving them what they need to make the end of life decisions that honor their lives," said Rev. Jim Wallis, president of Sojourners.
- "The Care Planning Act would ensure that patients and families are able to navigate the journey at the end of life with the necessary information and support that will bring dignity, quality care, and hope when they are most needed," said J. Donald Schumacher, president and CEO of the National Hospice and Palliative Care Organization. "For more than 30 years, hospices have been providing high-quality, coordinated interdisciplinary care to people at one of life's most challenging times. The Planning Services benefit and the Advanced Illness Coordination Services demonstration project proposed in The Care Planning Act, in particular, use the knowledge and expertise of the hospice and palliative care community in valuable new ways. We could not be more excited about the potential of this legislation," added Schumacher.

In addition, the legislation has been endorsed by the American Association for Long-Term Care Nursing, ARCH National Respite Coalition, Critical Care Roundtable, Gundersen Lutheran Health System, and Well Spouse Association. In Virginia, the Act has been endorsed by The Virginia Hospital and Healthcare Association, the University of Virginia Medical Center and Virginia Commonwealth University Health System.

- Permalink: <http://www.warner.senate.gov/public/index.cfm/2013/8/sens-warner-isakson-introduce-bipartisan-care-planning-act-of-2013>

**MediCaring4LIFE (Local Improvements for Frail Elders)** aims to make dramatic improvements in trustworthiness, individualization, and efficiency of services for frail elderly people in four geographically-defined communities: Akron, OH; northeastern Queens, NY; Milwaukie, OR; and James City County, VA. Each site will enroll progressively disabled elderly residents (generally, dependent in 2 or more activities of daily living, requiring constant supervision, or expected to become this disabled within a year or so) and implement a set of evidence-based improvement activities that assure comprehensive assessment and individualized planning, ready availability of critical services at home (including medical, nursing, housing, transportation, caregiver support, and nutrition), and reliable care-plan-directed services across all settings. Also, each community will generate local coalitions and leadership capable of taking on appropriate responsibility for monitoring and managing the area's service production arrangements into the future. One of the sites is led by an Area Agency on Aging, and all have clinical leaders, community-based organizations, state Medicaid offices, local managed care entities (including the new managed long-term care companies), and community leaders involved.

At the start, funding will be through conventional payment, waivers of obstructing rules, and supplemental award funding. In the third year, the project's financial evidence will anchor development of a shared savings model for geographic special-purpose Accountable Care Organizations as the enduring financing and delivery model for serving the needs of frail elderly people into the future. This project most firmly fits the CMMI Initiative aim to improve care for populations with specialized needs: persons requiring long-term support and services. However, it also addresses the other three aims by rapidly reducing Medicare/Medicaid costs in non-hospital settings, transforming the financial and clinical models for clinicians serving frail elderly persons, and improving the health of this population by preventing falls and linking clinical care with community-based interventions.

The project budget is [~\$30 million] for about 14,861 enrollees across four communities, yielding net savings of \$30 million on their total cost of care. More than half of the funding (\$17 million) goes directly to patient care and one-third (\$10 million?) supports starting up and monitoring to enable the shift to shared savings. Ongoing operations cost less than \$1million per community, so we can confidently predict that Medicare shared savings will cover the added supportive services, customized patient care, and ongoing continuous improvement.

Altarum Institute's Center for Elder Care will coordinate the initiative, providing overall organization and project management as well as coaching and collaboration (with the Institute for Healthcare Improvement), quality measurement and monitoring (with National Committee for Quality Assurance), clinical and ethical standards development (American Geriatrics Society), financial monitoring and modeling (Dobson/DaVanzo), attention to anti-trust concerns (EpsteinBeckerGreen), support for information technology (GrowthHouse, Inc.), support for community building (Community Catalyst) and for enabling customer involvement in transformation and governance (Consumer Voice), and access to other experts and resources.

We will deliver a fully developed financial plan for geographic service delivery on a shared savings model that will sustain the improved experience of the frail period of elderly persons' lives and the improvements for family and caregivers, as well as decreasing both the expenditures of Medicare and Medicaid and the total costs of care now borne also by families, communities, states, philanthropies, and Older Americans Act services.