



IT TAKES YOUR COMMUNITY

ALTARUM CENTER FOR ELDER CARE
AND ADVANCED ILLNESS SYMPOSIUM

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Washington, DC



SOLUTIONS THAT MATTER. HEALTH CARE THAT WORKS.

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This transcript has been edited for clarity and readability.

Cover photo of Zuni Elders provided by Karen Leekity and used with permission.

Opening: Communities and the “Age Wave”

Anne Montgomery

Deputy Director, Altarum Center for Elder Care & Advanced Illness

[View presentation slides: [Anne Montgomery slides \(PDF\)](#)]

Anne Montgomery: Good morning everyone and welcome. I’m Anne Montgomery, Deputy Director of the Center for Elder Care and Advanced Illness, and I’m seriously excited to be here this morning and have all of you here in this beautiful room and participating via webcast. And I know there are even some early risers out there on the west coast watching in their pajamas which is a wonderful thing. So welcome everybody.

Today we’re going to be taking a deep dive into the world of community care which I would argue is the most exciting place to look at and to jumpstart innovation in these fascinating and fast-moving times.

But before I do that I want to take a minute to thank Nelson Mullins for providing the venue for today’s conference and particularly my colleague Jennifer Pharaoh, a talented attorney and health policy expert I’ve known for quite some time. Jennifer, if you’re in the room, if you would wave. Ah, there she is. Thanks so much again. And endless thanks to my amazing colleagues at Altarum who I have the honor and privilege of working with on this symposium and many other initiatives.

A couple of quick words about Altarum. We’re a nonprofit health systems research and consulting organization and we focus on systems-based solutions that can overcome barriers which cause the healthcare system to become inefficient, ineffective or unsustainable.

Part of that involves recognizing that there is no single healthcare system—there are in fact many—given that healthcare is shaped by multiple factors that are constantly interacting and also constantly changing in the world of policy and financing.

An important question before us today is how can we improve what we already have and enable our programs—Medicare and Medicaid and the Older Americans Act—a whole host of additional programs that are funded at different levels of government along with private insurance and private savings to create a system that is much more efficient and reliable than what we have today. How can we pull it all together and create a more coherent elder care system for a long, live society?

To answer that we have to first back up and look at where we are. I know some of you have seen this slide before—we created it for the 50th anniversary of the Older Americans Act—it was published in *The New England Journal of Medicine*. It’s very revealing because it illustrates how we

invest our public dollars today: mainly on the medical side of the house and very little on the social services and supports side. Meanwhile we have a rapidly growing population of older adults—those are the green bars.

Why is this disparity of funding important and what do social services address? This slide provides the answer. They are essential to address the social determinants of health. The items here in red are those that are particularly salient for ensuring that older adults can thrive as they age in place in the community. Absent help in these areas, evidence shows that many older adults wind up in the hospital repeatedly and prematurely placed in nursing homes, driving up costs and causing them and their families to suffer adverse consequences.

The help afforded through adapted housing, through accessible door-to-door transportation, home delivered nutrition, personal care and respite for family caregivers, volunteers who can visit and reduce social isolation for those living alone, help with understanding complex medication regimes and medical appointments—these are among the services that are essential, not optional, for a successful aging.

So who's in charge of them? The answer is we are in charge: meaning that as the healthcare system increasingly shifts the focus of programs and systems toward outcomes it's up to us to step forward and do more to organize and improve the community-anchored services.

The pioneers in this room—all of you who we're about to hear from—have gone about doing exactly that. You'll hear how it's absolutely possible to build service hubs that work not just for a few elders, but for large numbers, as our population of older adults keeps growing.

As a quick overview, and to whet our appetites for more to come later, today here's the model of care that we have adapted at Altarum. We call it MediCaring Communities and it's tailored to meet the needs of a frail, elderly population that requires both ongoing medical care and long-term care: aka community-based supportive services.

In building out a community system, which can be done by adapting existing programs that have established financing mechanisms, we are really combining the best of what we have collectively learned that's in the literature. It's an absorptive model or framework that tries to array the core elements or building blocks of what is most needed to construct a reliable care system for older adults. Notice the word longitudinal for example. It's a system of care for elders that is designed to be in constant contact with them, monitoring their status, reaching out to them where they live and often delivering services to them at home. That's very different from the episodic acute care system that we have for younger people.

Note also that there is mention of a community board. For the most part we haven't thought much in the US about how helpful it would be to have communities with representatives including elders who have a role in shaping local services. But luckily there are those who are in the

vanguard—and Karen Leekity—on our panel that’s coming up—will talk about Zuni Pueblo, a tight knit community that has an organized committee that ways in on the needs of local elders and helps to shape decisions about services.

Finally, I want to throw out a quick reminder to all of the researchers and advocates out there that we need to dedicate a good amount of energy to analyzing and highlighting the savings that are possible to reap when the focus of care shifts to lower-cost upstream services that keep people out of medical crisis.

We’ll be talking a lot more about this and we want all of you out there to participate by submitting questions and raising your hand when it’s time for Q&A. This is meant to be a very interactive symposium. Okay, so now we’re going to go to the first panel and I move to introductions. So I would invite our panelists to walk around there and come to your seats. And I apologize for the brevity of the introductions, but the full bios of our participants are on our website. And we have a cool resource pod feature, which if you click on it you’ll find background materials including narratives on each of the three communities that we’re about to hear from.

Three Communities: What Are the Driving Factors?

Our first community star is Ken Genewick, Director of the Niagara County Office for the Aging in Western New York. Ken has been Director for the last six years and he has a rich and deep background in health and long-term care.

Our second community star Karen Leekity oversees all elderly services programs in the Pueblo of Zuni in New Mexico. She’s been with Zuni elder programs for 27 years and is remarkably creative in establishing programs that are funded on very lean budgets and pull from many sources.

And our third community star Connie Benton Wolfe is President and CEO of Aging and In-Home Services of Northeast Indiana. Connie wears an area agency on aging hat and an aging disability resource center hat and a few others. Like Ken she has created new entities in the course of expanding a portfolio of services in partnership with a range of healthcare organizations and she’s in the vanguard of pushing the aging network forward on information technology.

So we’ll start with Ken and then we’ll go to Karen and Connie.

WESTERN NEW YORK INTEGRATED CARE COLLABORATIVE

Ken Genewick, MBA

WNYICC Board President & Director of Niagara County Office for the Aging

[View presentation slides: [Ken Genewick slides \(PDF\)](#)]

Ken Genewick: That's great. Thank you. Good morning everyone. Appreciate the opportunity to be here today. As Anne mentioned my name's Ken Genewick, I'm the Director of the Niagara County Office for the Aging. But I'm here really as the President of the Western New York Integrated Care Collaborative which is a regional not-for-profit corporation that was formed in Western New York to regionalize some efforts that we are doing to help improve services for older adults.

For those of you who aren't familiar with us, we are at the westernmost tip of New York State. It's about as far as you can get from New York City. The major city in Niagara County is Niagara Falls and we are partnered with Erie County, whose major city is Buffalo, so we cover the Buffalo/Niagara Falls area.

The reason why we look for regional network development is pretty simple. We wanted regional economies of scale for services throughout our area. New York State has a very heavy county based triple-A model. Throughout New York State there are 59 different triple-A's or offices for the aging that deliver services so it's very county based and very territorial in the way a lot of these services are offered.

We started exploring the opportunity to regionalize some of our services while maintaining our county based identities. We wanted to expand our reach into all the communities throughout our counties –urban, suburban and rural. As mentioned, we have a few major cities in our two counties, but as we look to expand into eight, and then 16, counties of New York, it becomes increasingly rural, and there's a very broad mix.

We wanted to acquire technical and subject matter expertise through business acumen development. Fortunately, we were the early recipients of an ACL learning collaborative grant and so we're looking to be able to expand that learning across our region.

We wanted an adaptable and scalable service delivery model with a single point of contact for business development through contracts, revenue and expanded services for our partners. We really want to have a regional approach to our customers—or to patients and, clients in the community.

Our area is considered Western New York, so our media market and everything is just Western New York. There's no county boundaries, so we're looking at ways to build regionalized appeal and

service delivery to improve health outcomes. Very importantly, we are building a model that we want to see replicated not only in our region, but across our state. We hope that it's something that is replicable in other areas of the country as well.

So the history of the collaborative is that in 2013, Erie County Senior Services and our Niagara County Office for the Aging and a group of community-based organizations that we affectionately call our “coalition of the willing” put together an application to be part of ACL’s learning collaborative.

It’s been a wonderful experience. It really allowed us to take part in national learnings—the n4a [National Association of Area Agencies on Aging] conference and the pre-conference courses called intensives—which have been a great opportunity for us to learn about expanding the services and the best practices across the country.

Anne Montgomery: What is ACL?

Ken Genewick: The Administration for Community Living. That work led to our local health foundation of Western/Central New York awarding our group an exploration grant that allowed us to really shift focus from just learning what was out there to start to nail down what type of business would be most effective for us to really deliver services in a formal manner.

We have had several forays into regional grant partnerships. As a matter of fact, this learning grant really led us to participate in a seven-county regional Alzheimer’s caregiver partnership grant that regionally offers services to caregivers of individuals living with Alzheimer’s and dementia. However, it took a regional not-for-profit to really be the lead in that. But we really wanted to explore having that not-for-profit corporation for our region.

So we created our business in 2016 as a taxable not-for-profit, because it passed what we called our “speed test” that would allow us to have a not-for-profit to work to build an accredited diabetes model, which I will mention. And we will establish a 501(c)(3) by early next year.

Overall, we are focusing on regional health and wellness and evidence-based programs and services. And we’re really focusing on sustainable funding for an integrated care collaborative that generates revenue for all of our contracted partners.

Our first service focus—and this happened concurrently when we received our not-for-profit status—is that we received an accreditation in July 2016 from the American Association of Diabetes Educators—or the AADE—and that was a big step for us because both our counties offer the Stanford-based, chronic disease self-management and diabetes self-management models. Rather than looking to receive individual accreditations, we did that as a region which is now allowing us to explore business opportunities and set up a Medicare reimbursable model.

We are now in the middle of developing contracts locally and have opportunities with local managed care organizations.

So this all led to us receiving earlier this year a 30-month \$375,000 grant from the Health Foundation of Western and Central New York to formally kick start these efforts and really put our efforts in the fast lane. We hired a full-time director of business development, we signed a contract with Tim McNeal, whom I'm sure you all know—or many of you know in the room—to really help us nail down all of the nuts and bolts of our business to be able to move forward. And we established an aggressive four-month build-out for our diabetes self management program. That includes establishing a Medicare billing number to move ahead with an electronic health records system and to be able to develop formal contracts with our local managed care organizations and Medicare Advantage plans which we intend to do within the next two months.

Next steps for our future are to create that technological link from our programs and our client management system that we currently use with an electronic health record system, and partner with our Health Information Exchange for New York State, so that we can bring all of the data together.

We are partnering with several community-based organizations offering evidence-based programs. It's interesting because we're using a diabetes model that is evidence based, yet it looks very different across our two counties. However under the umbrella of our integrated care collaborative, it's allowing us to really to maintain our own identities, but also have a standard model.

We're also looking to expand those services. This really is the first program that we're looking to offer and we are in the process of evaluating our next programs. We can already say that it's going to focus on falls prevention as well as mental health, and we're looking at not just limiting it to diabetes self-management, but also to offer our national diabetes prevention program as a reimbursable model.

As well as expanding our network, I was telling Anne earlier about our business acumen build-out and I think so much about business acumen is not only learning the data, but when we talked about building our business, we literally had to find a building to rent from. We needed to purchase paper and post-it notes and all of that—so it's literally building a business, and now we're at a point where we have that stabilized and we'll look to expand our network membership. And that is what I wanted to present today and I would be happy to answer questions at the end of the panel.

Thank you.

Anne Montgomery: Thanks so much, Ken. Okay, we will go to Karen now.

ZUNI ELDERLY SERVICES PROGRAM

Karen Leekity

Directory of Elderly Services, Pueblo Zuni

[View presentation slides: [Karen Leekity Slides \(PDF\)](#)]

Karen Leekity: Good morning everyone. My name is Karen Leekity. I'm the Elderly Services Director in the Pueblo Zuni, New Mexico. Our reservation is located near the New Mexico/Arizona border and we are way out of mainstream America. That creates a dilemma for us at times because of even food can be hard to get. We don't get fresh fruits for our nutrition program or elderly services— Meals on Wheels.

That is also true for the caregiver program, the senior volunteer program –Foster Grandparents & Senior Companions—and our adult daycare program.

I have pictures that we have of what our elders do and I will report on some of these activities as I go along.

We have a population of over 10,600 people in the Zuni community. There's also over 11,000 that are off the reservation, and our elder population is growing fast. When I started it was in the 600's, and now we're serving over 1600 elders 55 and older.

We have very limited Federal funding and through state programs. So sometimes we have to look outside the box for funding and services for our elders.

We have an elderly services committee comprised of programs from social services, Indian Health Services (IHS), the police department, our tribal administrations, Zuni Housing, home healthcare agencies—and some of these programs tap into third-party reimbursement systems. But our elderly services do not, except for our adult daycare, which is a social model. A medical model is very costly in New Mexico, and there is not support for that.

Fortunately our elder programs really do serve a majority of our elders. Our community is afflicted with diabetes and end-stage renal disease and we are constantly receiving referrals from IHS Hospital, the dialysis center, and home healthcare agencies. We also receive referrals for meals. And the age is getting younger for our people to be on dialysis.

We look at everything for our elders. For example, our elders grew up not having fast foods: they grew their own crops to eat, and exercised a lot with traditional dances. Our community is primarily still active in their traditional ways and customs, and dancing is a part of that.

Our elders do not want to be sent off to a nursing care home that is probably 40 to over 150 miles away. When that has happened, our elders lasted only a week or so away from their home. So adult

daycare is providing a way to prevent them from being sent off the reservation. The nearest township is 40 miles away, which is Gallup, New Mexico, and the nearest large metropolitan area with an international airport is Albuquerque, New Mexico.

We have a lot of challenges, so while we do get funding from the federal and state governments, sometimes we have to look outside the box for resources. And in some of these pictures on the screen, you can see our elders are very active: they want to come to the senior center. They don't want to be home alone, isolated. We have intergenerational activities for children from the local schools and they come to the senior center. Other young people from out of state come and join our elders if they're preparing a traditional meal here.

As I said before gardening has traditionally been the tribe's primary way of getting food. And along with that come traditional dances in the fall. Our adult daycare has some box gardens, and sponsors other activities, so elders still have that voice in the community to participate.

One of the things to remember is that most of our community has Medicaid—more so than Medicare. Our Indian Health Service Hospital is in the community but it's just a hospital with outpatient limited services. They don't have a surgical unit so they have to fly out tribal members to other areas—Albuquerque and out-of-state for more specialized services. But they do have an elders' clinic.

The elderly services coordinating committee meets to discuss all of these programs. We have met since 1998 and we talk about how to fill gaps in the services that we have. We've filled some of them to where now we meet on a quarterly basis—we used to meet on a monthly basis. This is one good way of getting a community involved in elder care.

A lot of times, we coordinate with IHS referrals to other social services, such as for abuse situations. We have to do what is necessary to meet the needs of our elders.

One thing that is very beneficial for us is that we know our elders: what their needs are, and where we're going. We conduct surveys and get feedback from them; that's a part of why we've survived with very minimal funding. Our tribe does not have natural resources to bank on, and we do not have Indian gaming revenue. We have a lot of limitations. We're just now getting fiber optics in our community and that in itself is a barrier.

Basically what we do for our community is to discuss and address the various issues that our elders are facing through the committee and with Medicaid and Medicare dollars, work through referral processes to make our programs work as well as possible.

The State of New Mexico has an aging and long-term care services department which we work very closely with. There is an Indian Area Agency on Aging department, which serves the 19 Pueblo and the two Apache tribes in the state and they provide an all-inclusive services for our elders like

enhanced fitness and nutrition training, and working with staff from those two departments has really improved our services for our elders.

The one thing that I will recommend is that we need to get Medicare/Medicaid reimbursements for our senior center. At this point in time, we have no programs that we can charge to, so we work with those programs that administer Medicaid and that help both our elders and our children. Our children are more and more now afflicted with diabetes. We have a lot of work ahead of us to take care of those issues.

The adult daycare is helping our elders who need a lot of support. Some are isolated, some don't have families, but we take care of them on a daily basis. I will recommend knowing your elder population and knowing your elders well—what their needs are can—make a big difference in the way, an elderly program can manage. I think that we've come far in getting services to them. The state is now providing more support for our programs, including transportation.

In looking for other resources, we partnered with Jewish Family Services of Albuquerque. Whenever I do a presentation stating that we have a project with Jewish Families, I see eyebrows going up, because what Indian tribe has a Jewish Family Services nearby? It's great, because they have brought us a lot of things that our elders benefit from. For example brain fitness—our elders learned how to use chopsticks. They learned to prepare a Chinese meal. Jewish Family Services brought flutes or recorders and the elders blew into those recorders. Enhanced fitness was the first service. Our elders are willing to try everything. It's new to them, but they enjoy that. Although we consider them very traditional in their ways, when we bring new things with the help of others, it improves our care.

The way our elders keep strong is coming to the senior center for adult daycare; the exercises; nutritious meals; and seeing one another on a daily basis. Whenever the center is closed for the holidays or for meetings they want to know why they can't come.

All of these things I've reported really make our programs worthwhile. The Administration for Community Living provides funds under the Older American Act, yet they don't fund adult daycare. This is a challenge, and sometimes it's hard to work with our state and the tribal process. We're considered sovereign, and the regulations and the policies that the state has sometimes don't jive with ours, and that's a difficult challenge. Support from our state leaders—the Senators and the Representatives—comes in handy when I'm talking about these types of barriers.

Anne Montgomery: Well, thank you Karen, your creativity is unsurpassed and now we want to hear from Connie Benton Wolfe.

FORT WAYNE, IN

Connie Benton Wolfe

President & CEO, Aging & In-Home Services of Northeast Indiana, Inc.,
Preferred Community Health Partners, LLC

[View presentation slides: [Connie Benton Wolfe slides \(PDF\)](#)]

Connie Benton Wolfe: Thank you very much. It's a delight to be here today and I'd like to thank our friends from Altarum in terms of putting together this symposium and offering an opportunity for all of us to focus on the strength of community and how it plays into healthcare in our country.

Our organization is an Area Agency on Aging that is based in the northeast corner of Indiana. But we have found ourselves moving forward with a business model that has taken us beyond those traditional borders and those traditional programs to try to really carve out a space in terms of moving our mission toward, and interpreting it as something that is effectively dealing in the integrated care arena.

For most of the folks who think about this when they first meet us they hear our name and they think, "Well, you must just work with people who are over the age of 60." Obviously our core business is very much grounded in the Older Americans Act and the work that we're doing with older adults. But we also have a major role that we play in our communities in terms of serving people who are under the age of 60. In fact 45 percent of my clients, because of waiver programs that we do, are under the age of 60.

And so we put this slide up because we always like to quiz people and say, "Who do you think our client is?" And actually I will tell you both—both of them actually are. We have clients who are as young as a couple of months and as old as 102. So we're excited about that. A lot of the expertise that we've built in our Agency on Aging lends itself to expanding to deal with other individuals who have disabilities and now we're seeing that it really lends itself well to working with very complex patients.

About five years ago, our board of directors and executive leadership began to shift how we think about our business. And as the research became apparent in terms of social determinants of health and how those impact healthcare costs, one of the things that we realized is we are the resident experts on social determinants of health. We're a community-anchored organization that's committed to integrated care and sees the ability to address these. We looked at our very frail clients and thought, "What are their greatest challenges?" Quite frankly, it was trying to navigate through two very complex systems: the medical care system and the social services system. So our board felt very strongly that if we could find a way to integrate those two systems, we would be doing something that would be of great importance to the clients that we serve.

I think probably everybody's familiar at this point with what's included in social determinants of health—you know, it's the food people need, it's safe housing, it's transportation, it's community engagement—all of those things. But I think what sometimes isn't recognized is the impact that this has on healthcare spend. What we know from the research now is that only about 20 percent of the healthcare spend is tied to clinical factors. It's the psychosocial behavioral factors that are really driving healthcare costs in this country.

So what we have figured out, but what we've emphasized probably in the last few years of our business, is the fact that what we are good at is helping people stay at home, age in place and do it in a safe and effective manner. And when I say effective I mean not only for the individual but for society—society in general—because we really have been able to show an impact in terms of healthcare costs.

We have what we consider a pretty broad portfolio of things that we can bring to the table that are related to healthcare—certainly in terms of being able to be in the home and actually view what's going on there, and carry that information back not only to the social services world, but the medical world in general. And we've found that to be one of the most valuable pieces that we bring to the table. We have a very person-and-family-centered approach to the work that we do, so our goal is not to go in and just find what people are eligible for, but to go in and find out what their needs are and what their support systems are. Then we put together the package that makes the most sense for them and supports them in the greatest way.

We were very fortunate because we were part of CMS CCTP—Community-based Care Transitions Demonstration Project. That helped us significantly as an organization to change our business model and our culture so that we could more effectively work in tandem with the healthcare community, and we've continued on with our specialization in care transition support.

This care coordination for high-risk patients, we had been doing that for years with our Medicaid waiver population. And we knew from the work that we'd done with our Medicaid waiver population that we were able to keep people who were nursing home eligible out of higher-cost institutions for an average of over 3 years and 4 months. That was really significant. We'd never really counted up what the return on investment was on that particular service, but we're starting to do that now because when you start putting those numbers together they become very, very compelling.

We do some chronic disease management—like Ken, we're moving into the diabetes—we've just been accredited also in terms of diabetes self-management, and we have behavioral health support.

Probably one of our most important programs is that we provide support for family caregivers, who remain to this day in this country the bedrock of long-term care. The more we can do to

support the family caregiver, and to extend the time that an individual can reside in their home safely is critical. And we have a full array of long-term services and supports that we either provide or we have contractor relationships with other providers to provide.

We moved into this arena by, like I said, putting our toe in the water with care transitions, starting with a local health system that's, very community oriented—Parkview Health Systems—where we started a pilot program and figured out what it is that we could do and wanted to do. And then as I mentioned, we moved into the CMS demonstration project, and really moved and expanded the care transitions and care coordination work that we were doing.

From our initial nine county area we all of a sudden found ourselves doing care transitions in 30 different counties of Indiana, working with 10 hospitals under the CMS CCTP demonstration program. So we really stretched our wings and found that we had a lot to bring to the table. And we had some amazing results in terms of healthcare utilization being reduced.

We actually saw readmissions of high-risk Medicare patients in our 18-month experience with CCTP being reduced by 42 percent. And that was with a 30-day “Coleman model” intervention.

Let's talk about return on investment. We know that net CCTP savings just in our little part of the world for Medicare was \$5.5 million. We put together a coalition, because for those folks who were still engaged with care transitions under the CCTP demonstration—there were about 26 of us across the country who were working on care transitions at the end of that demonstration—we formed sort of a loosely knit coalition just to bolster each other and learn from one another, and then to try to put some data together.

This is not, you know, deep data but this is what we collected from 26 coalition members across the country. They had served a quarter-of-a-million people that were high-risk Medicare folks and we know that the documented net savings for Medicare, from those 26 coalition members, was over \$86 million. So we feel that there's a significant role for community-based organizations to play in terms of reducing healthcare spend.

One of our greatest challenges was in data transfer and management. We were very ill-equipped when we started all of this to try to figure out how we would accumulate data and how we would transfer any data to the medical community. We were very fortunate in that we linked arms with a company that was based in Indianapolis that had been working with Indiana University and the Regenstrief Institute, and we've built out a health IT platform called Population Health Logistics which is specifically designed for community-based organizations that deal with social determinants of health. We built it out with multiple capabilities, but one of the key things to note is that it is interoperable and we can communicate back and forth with the medical communities that we're working with, so that we can electronically share what we find in the home that's pertinent to the primary care doc or the healthcare system. We're able to track things, we're able

to measure things. We've tried to measure the outcomes of the work that we're doing, both with this program and our Older Americans Act programs.

The other thing that we've done is that we've fully aligned our system now with NCOA [National Committee for Quality Assurance], LTSS standards and I'm really proud to say that my team, in northeast Indiana was the first to get the new accreditation through NCOA for the LTSS standards. We decided to just go forward and see if we could make it happen and we did, and we're very, very proud of that and I'm proud of my team.

We also have analytics—pretty sophisticated analytics—that have been built into this system that we have access to, and that really take us beyond just data warehousing to being able to analyze. We have some predictive capabilities now that we can call into play and some risk stratification that we can do so that we can tier the interventions that we want to do with patients. We can also tie into the state Health Information Exchange so that we can get alerts if one of our clients is admitted to a hospital or transferred from a hospital to a nursing home. We can actually access that information—we have downloads every evening for that.

What we're finding with community-anchored healthcare is that the return on investment is really, really significant. Built into our data system is an ROI calculator that we were very fortunate to have access to. It was not something I could have ever created but it was created at Indiana University with Regenstrief and I think the Stevens Institute. It's a simulator that basically allows us to plug in what happens if...? So with a population panel of patients that have a certain diagnosis, it really is able to craft a history of healthcare utilization and then tell you what kind of return on investment that you're going to be able to get if you drop in an intervention.

Just to give you a real quick sense of the kind of numbers we're looking at, we've been looking at our panel of Medicaid waiver patients in our state. We have 18,000 Medicaid waiver patients that our Agencies on Aging manage and, within that patient panel alone, we were able to demonstrate if we dropped in something as simple as a 30-day care transition when somebody is discharged from a hospital if they're high-risk, we could show a return on investment in terms of the payer—the medical payer—of over \$50 million annually. It's big money if you begin to get community-based organizations involved.

Essentially, we have been able to move forward to begin to work with other payers because we've broken down some of the data barriers. So we have contracts now with private insurance and managed care organizations, and we've been able to get a Medicare provider number. We've also organized into a statewide network in Indiana so that we have one contracting entity for all of our Area Agencies on Aging. The managed care companies are much more likely to work with us because we've made it easy for them to contract with us. Also, because of the technology we have one place where we receive referrals and can quickly get them out to the appropriate Area

Agency on Aging. We get the intervention done and report back up as appropriate to the managed care organization. We also monitor quality and make sure that we are standardizing the intervention and getting the quality that each customer really wants to have.

I have this big vision and I know it's shared by others, so I shouldn't claim it, but I always worry that if I say this too loud somebody's going to say, "Well, what are you saying?" I'm saying this: that we have a community-anchored infrastructure in this country already, and it's a very strong infrastructure.

There are also other important community-based organizations, but the Aging Network is the one that I know about and that I have a lot of faith in. And it really does provide one of the potential answers for healthcare costs in America because of what we can deploy and how quickly we can deploy it.

If I were a [private] business and I walked into a managed care company or any other payer and I said, "These are my outlets. And I can reach virtually all of your patients, your complex patients, in every single county," you would be very excited to talk to me. But because we're human services, we haven't always packaged ourselves as a solution. Yet we really are a potential solution. We're in every state, we're in every community: we virtually can be in every home.

And that really is going to be I think the significant game changer for healthcare in the United States, which is why I'm so excited about community-anchored healthcare.

Q&A

Anne Montgomery: Thank you so much. These were three very different presentations and they were all incredibly illuminating. All of you touched on IT and since I'm very interested in information technology I wanted to take a moment to dive into that.

Ken and Connie, you talked about it in some depth and I wanted to alert the audience that there's now federal funding available on 90/10 matching basis—90 percent being the federal share and 10 percent being the state's share—that community-based organizations that are working in Medicaid can think about applying for through the HITECH act.

It's available on a rolling basis through 2021 and Altarum did a report on this—it's in the resource pod if you want to take a look at that—so it's good news that now we have federal funding that's available for IT development.

So here's the question. I'm wondering if you can talk a bit about the strategic vision that you have in mind for information technology in your expanding and evolving community systems. Kathy Kelly, of Family Caregiver Alliance, had a question a few days ago, and I think it's a really good one, on predictive analytics for population health, and the way she put it is this: "If you have a community of X square miles with X number of older adults stratified by age and overall health

statistics, are there IT systems that can tell you what is the optimal array and capacity of supportive services that are likely to be needed?" What do you think?

Connie Benton Wolfe: I think we are there or very close to being there. I mean what really strikes me in terms of the potential for technology in all of this—and it's vast—it's the fact that we're no longer looking at interventions on the social services side of things that are one-size-fits-all.

We actually can get to find the right intervention at the right time for where that individual is by using a risk stratification approach. We can also figure out with predictive analytics who may be at most risk for nursing home placement or potentially a re-hospitalization, and then wrap around additional services if that's what's needed to support them in that preferred setting—the one that is also a lower-cost setting for society.

So I think that the capabilities are absolutely there. There's so much more than—I'm certainly no expert when it comes to all of the detail when you go into big data and really start, moving in this, but I get to hang out with some of these people now, and it's amazing to me what we could do. It could entirely change our business model in terms of both human services and the medical component of things in this country if we really got smart with the data.

Anne Montgomery: Ken, what are your thoughts?

Ken Genewick: I think the important thing is the data is there. An exciting thing that happened in New York State is that the New York State Office for the Aging implemented a statewide data system, and so now all of our triple-A's across New York are collecting the same data. There is uniformity, and given the fact that we are administering Older Americans Act programming as well as a menu of different grants, all of the data we collect in case management, all of the demographics, everything we collect—it's all there.

The important thing is getting that data to communicate with other systems. So as we are building out our collaborative we are also now looking to implement an electronic health record and Meaningful Use Standards. Our data that we collect does not yet meet meaningful use standards. It's getting that electronic health record to communicate with our managed care organizations, and bridge that together.

We are also working with our state Health Information Exchange [HIE]. One of the things we are very excited about is our State Office for the Aging as well as our Association on Aging for New York State, which is our state triple-A coalition, are embarking on a multi-year business partnership. With n4a, we are looking to be at the forefront of that, with hopefully piloting an effort to be able to link our electronic health record with our client management software, as well as linking that up with our HIE.

So the data's all there: I think it's really getting it all to communicate across settings. It's not just about now but also about the future. The triple-A's really are literally in everyone's homes. We have that data, and not only the data: it's the human side of it. You know, we don't just have the hard value, it's the fact that we have volunteers going into people's homes. So we can collect data that others can't –but it's getting that to communicate with our managed care organizations, with our hospital systems and making it very seamless so that our workers can go into homes, do what we do best, but make sure that the data communicates effectively.

Anne Montgomery: Terrific. Karen, you talked a lot about the adult daycare center model that you've put in place. What are your hopes for that going forward? Do you want to build it out further? It sounds like it's the hub of a lot of the services that you organize.

Karen Leekity: Yes, our adult daycare is primarily for our elders who really need the daily care and services—especially for the caregivers –we provide respite for them. With adult daycare, it's keeping our elders at home and not being placed off the reservation. But we are looking further along that line by developing something like assisted living. We're looking at is an elder home where we can come up with a home to take care of our elders who are pending placement off the reservation. And it will be like assisted living 24/7 care because some of our elders are not taken care of very well in their own homes.

Anne Montgomery: Terrific. All right, I'd like to open it up to anybody in the audience. And I think we have roving mics so—Carolyn—Dr. Poplin.

Audience: Hi. I'm Dr. Carolyn Poplin. I'm a primary care physician, I'm also an attorney, and these days I work with a law firm that represents whistleblowers who allege Medicare and Medicaid fraud. You haven't really talked about people who are carrying out the services. I've seen two models: one when I practice—the Visiting Nurses Association—where people receive training, benefits, there was a skill ladder and possibility for promotion.

And I've seen others where someone puts—a business puts together a system where they pick up people with very little training—and sometimes very little English—and they pay them minimum wage or a little bit above, they offer no benefits, no possibility for—no training. They pay this small amount and then they charge \$30 or \$35 a day to the client.

Except for Karen, you haven't really talked about the people who are doing the work, and I'm concerned about that. I think that's important and I would be very distressed if it turned out you were using volunteers to offer services to managed care companies. It's nice to volunteer, but I don't think people should be asked to volunteer to work for or on behalf of a for-profit company.

Anne Montgomery: Okay. So a question on workforce. Connie or Ken, do you want to start?

Connie Benton Wolfe: I'll be happy to respond to that because I think you raise a really good question on a number of different levels. One is that I think in general we're only as good as the people that we send into the home and I think one of the things that we are very cognizant of, because we're community-based organizations, is the importance of that.

So from my organization all of the folks that we send into the home who are either care transitions coaches or case managers are all credentialed—accredited individuals—and they're employees of our organization who are salaried and have benefits, et cetera. And we think that that is really important. We also believe there's a role for community health workers in this and we're starting to take a look at that as an organization and figure out how we could work with them and do it with integrity and make it work for the clients that we serve. We're looking at it in two different ways. One is we want people to work to the extent of licensure that's required for the task but we also want to make certain that they are making a living wage and that they're well cared for at the same time—because we really believe that when you're dealing with very vulnerable people in their homes you can't be too careful.

We're not utilizing volunteers for any of our contracting purposes—that's not what we do as an organization. I think a lot of Area Agencies use them for friendly visiting and maybe meal delivery—those kinds of things—but when it comes to actually being in the home and coordinating care, and making certain that we're monitoring the quality of other care provided, we use credentialed individuals.

Anne Montgomery: Who want a career, not just a job.

Connie Benton Wolfe: Sure. I couldn't agree more.

Ken Genewick: If I could just add—I mean I think it's a very important consideration as we're looking to build out our regional model. I think one of the important things is that the work that we do, given that it must meet the requirements for our Older Americans Act funding and other programs—we certainly have standards that we do meet in all the work that we do. As we look to build out some of our programming—particularly focusing on the evidence-based national program models—this ensures a certain level of quality and data collection, and everything has been studied and proven. Particularly as we look at regionalizing this work and beyond we are looking at those models that have shown evidence of high-quality standards being met.

Anne Montgomery: Terrific. Another question.

Audience: Thank you so much for this opportunity. I wanted to ask you about your behavioral health. Are you able to support it? Also, if you could also talk about the role—and Karen forgive me for this question—the role of telemedicine. Thank you.

Connie Benton Wolfe: The work that we're doing in behavioral health really is right now more focused in on dementia and depression predominantly. We're starting to look at an opioid program but we're not all the way there yet. We are looking at how those behaviors are impacting care within the in-home setting.

So that's our sweet spot in terms of looking at behavioral health right now. We're finding that with my Medicaid waiver panel, 45 percent of the folks have some documented cognitive disability. We also screen for depression and find that depression is a huge factor for those folks who are dealing with multiple chronic illnesses and other psychosocial kinds of things. We're looking at expanding some of our work in the behavioral health category as we go forward because there's such a huge need within that arena. Again, it all ties back into what can happen in the community setting.

So we partner right now for some of that. For example, we have licensed social workers; we have a dementia specialist; and we have a program that actually was created at the Aging Brain Center that really is a community-anchored program that we're launching. We are very excited because we think that's going to be one of the things that is probably most impactful for our community and fits in with our area of specialization.

Anne Montgomery: Well, I think we are running slightly behind so please join me in thanking this wonderful panel of Karen, Connie and Ken. Thank you, and I'm sure they'll be around to talk to anybody who would like to follow up.

Okay, now we will call up our second panel of absolutely top-notch federal officials who are working not only to support and assist communities like those that we've just heard from, but also working to create new strategies and initiatives and paths forward that we can all benefit from.

I'm extremely honored to present to you these three folks. Mike Nardone, Director of the Disabled and Elderly Programs Group at the Center for Medicaid and CHIP Services. Mike joined CMCS in January of 2016. He has more than three decades of experience in health and human services including working at Health Management Associates as a managing principal and serving as Acting Secretary of the Pennsylvania Department of Public Welfare.

Mary Lazare is Principal Deputy Administrator at the Administration for Community Living and she comes to ACL from St. Louis, Missouri, where she served as Vice President for HCBS—Home and Community-based Services—for Lutheran Senior Services. Mary has degrees in both management and gerontology and knows the world of long-term care and community health operations extremely well.

And Marisa Scala-Foley is team lead for ACL's Business Acumen and Health Information Technology at ACL. She manages the agency's efforts to advise and build out the business capacity of state and community-based organizations to partner with and to contract with healthcare

organizations of many types. Marisa has also worked at the National Council on Aging, one of DC's top organizations in the aging space.

So we'll start with Mike and then we'll go to Mary and Marisa. And Vicki Gottlich of ACL was also scheduled to be with us today but she has a stress fracture so, Vicki, we miss you but we wish you a speedy recovery. All right.

The Role of the Federal Government in Supporting Community—Anchored Care

Mike Nardone

Director of the Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services

Mike Nardone: Good morning. Thank you very much. I'm Mike Nardone. I have been at the Disabled and Elderly Health Programs Group at CMS for close to two years. I'm a former Medicaid director from Pennsylvania, and also led some of our long-term services and supports efforts in the state as part of the administration that I worked in, and also prior to that time was in Philadelphia and headed up homeless services and special needs housing for the city. I come at this from a long history of working in and around this community space. I think just to maybe state more broadly the role of the federal government and how we support the efforts at the local community level, I think the main way we do that is through partnering with states in the provision of home and community-based services.

If you reflect back on the history of Medicaid, which funds a large proportion of long-term services and supports, that really is the major vehicle by which we support the work that happens in the community. Now historically, Medicaid funded institutionally-based care. Nursing facility care, is still a mandatory benefit under the Medicaid program, and has been since its inception. Around the late '70s or early '80s, a young lady who I remember, because I grew up during this time, was Katie Beckett. Some of the efforts of her parents to take care of her in the home really helped to spur a transformation in the way that we think about long-term services and supports.

In 2013 for the first time, the percentage of expenditures for long term services and supports funded in HCBS settings actually exceeded the funding that was provided in institutionally-based care. So that really was a watershed moment for how we fund services under Medicaid. Now having said that the significant percentage of funding that's now going to HCBS services is not equal across all populations: the percentage is higher for individuals who have developmental

disabilities versus people who are older Americans. For older Americans it's more in the neighborhood of 44 percent or 45 percent who are receiving services in HCBS.

So I don't know what the right percentage is, but we clearly have more to do in that area. Obviously, we work with states as our main partner; HCBS is an optional service and there is a great deal of flexibility that we provide to states in terms of how they establish HCBS settings. We do that within the federal parameters of various HCBS regulations.

I think what's clear though, and what certainly was one of the major conclusions around the Money Follows the Person initiative that came out of CMS—and I think we heard it from the first set of speakers—is that first of all HCBS is a very cost-effective way of providing care. And it sounds like a lot of the folks who preceded me relied on funding from our waivers for home and community-based services, or HCBS. I think that clearly the cost-effectiveness of home and community-based services is something that all states are aware of and I think there's also—and again this is another major finding—I don't think it's surprising, but the Money Follows the Person demonstration shows that individuals who reside in HCBS versus institutions are very satisfied with the care that they receive at home.

I think there's a dynamic in terms of HCBS in that I think it's to continue, and states will look to HCBS as the major vehicle to provide services to elders. We spend approximately in Medicaid about \$150 billion, which is a very big number, on LTSS, and as I said, more than half of that is for HCBS services.

One of the major trends that we are also clearly seeing and that I would expect to continue in addition to this move to home and community-based services is an increasing use of managed long-term services and supports. And I'm just listening to Connie talk about some of the work that she was doing in interacting with managed care. It is very similar to my experience in Pennsylvania in talking to the community-based organizations there when I was working in Health Management Associates: That is the recognition that in many states, they are looking to managed care as the vehicle for managing their long-term services and supports—both institution-based as well as HCBS.

In a well-run managed care program, there is an ability to align incentives, so that the entity that gets a payment for the provision of services, has an incentive to look at the most cost-effective services, as well as highest quality services. And potentially additional support, not only for individuals in home and community-based settings but for some other types of community-based services. There's more flexibility in the managed care system than sometimes there is in fee-for-service. But I started that by saying, "A well-run managed care program." One of the things that I've seen as I've looked at states—and I think you all have made a very convincing case—is that to the extent that a managed care plan can build on some of the community-based organizations that

already exist, that potentially provides the opportunity to have a much more robust system at the community-based level.

In listening to some of the presentations, I think those CBOs obviously did a very good job of making the value case to their managed care entities. For community-based organizations that's the challenge when dealing with managed care.

From our perspective, states increasingly are headed in this direction, whereas you know several years ago the number of states that were doing managed LTSS was more like 10; we now have close to 30 states that are doing some form of managed LTSS in one of their populations. There are roughly 20 states that do managed long-term services and supports for the elderly population. I would think that this trend also will continue going forward in terms of how Medicaid funding gets melded into HCBS services.

Our role at the federal government, in addition to providing matching funds for the services is to oversee the programs that get implemented at the state level. There is flexibility that's provided to the states. We just implemented a major managed care rule that puts in provisions around how states run their managed care programs but also their LTSS, and obviously we also have a framework within HCBS. So that's the role that we play at CMS. We also play, I think, an important role in terms of technical assistance and one of the major innovations that we've been involved in is the "Innovation Accelerator Program," and I mentioned at the outset that one of my experiences, was in the realm of special needs housing.

One of the real challenges, in addition to some of the other challenges I heard from the discussion in the last panel, is around housing and making sure that people who, in order to receive home and community-based services, have to have a place to live. Therefore, one of the things that we've done through the Innovation Accelerator Program—or as we call it, the IAP—is to provide technical assistance to states around interacting and working with their local communities, including their housing agencies, to try to build that infrastructure. One of the things that is really challenging in this work—and you see it on the ground—is that the folks from the housing agencies don't talk the language of Medicaid. And Medicaid doesn't talk the language of housing agencies, and so figuring out strategies to bring these two silos together is critical.

Our role here is really at the state level but one of the things I also have learned from my experience is that discussions have to happen at the local level. That involves a lot of complexities, but one of the things we've tried to work with the states on is how can we best marry resources at the state level between housing and Medicaid, so that we're able to ensure that we have a place for people with HCBS to go to receive services, or a place to receive their services.

So technical assistance is a major area of work for CMS. Another area where I heard some discussion from the last panel was around quality, and the reality is that we don't have a lot of good quality metrics in the area of long-term services and supports.

We've done some work at CMS in terms of developing through our TEFT demonstration [Testing Experience and Functional Tools]. Generally it is a quality metric tool that measures satisfaction in home and community-based settings. We have NCOA accreditation for that metric. It is only the tip of the iceberg, but it is a publicly available measure that managed care plans can use—and I would envision that as we're moving forward, that there'll be a lot more emphasis on what our outcome measures in the LTSS space are, so that we can look to see whether or not people are receiving services in LTSS, and that it's of high quality.

We already do that with our home and community-based services waiver programs. States have to report on certain quality metrics that relate to health and welfare. But most of those have tended to be process measures, um and I think that increasingly we're going to want to move to more outcome-based measures in terms of the services that people receive.

So I think the ability of CBOs to talk in terms of the overall quality of care that's provided to people on the ground will very much line up with the direction that we will be going at CMS.

I just want to conclude by saying that in addition to the technical assistance that we provide—we work very closely with my partners at ACL. In fact, I think tomorrow I'm helping to kick off a joint session with ACL up in Baltimore around thinking through what some of our priority issues need to be going forward.

Certainly, with regard to some of the initiatives, such as Money Follows the Person, the Balancing Incentive Program and the fostering of the “No Wrong Door” approach as well as some of the many initiatives that ACL is involved in, we are closely aligned. We work very closely together.

One of the major initiatives that has been a key focus of mine for the last two years at CMS is around what we call the settings rule. Basically that regulation was a first attempt to define what that is. What is it that makes something home and community-based and rather than institutional? That had never really been done before in regulation or in statute, and states are in the process of implementing the requirements. The folks at ACL have really been there from the beginning in terms of helping us implement that regulation, so it's a real pleasure to be with them on this panel and to turn it over to my colleagues. Thank you.

Anne Montgomery: All right, thank you, Mike. And Mary, if you could tell us a little bit about the mission of ACL and maybe from your perspective how you work with CMS and just sketch it out for the larger audience.

Mary Lazare

Principal Deputy Administrator, Administration for Community Living

Mary Lazare: Sure. Thank you. Well, as you heard, I was hatched in St. Louis, matched in St. Louis, and when I'm finished with this appointment, I will be dispatched back to St. Louis.

I want to share another little interesting observation for today—and thank you for having me here as part of this panel. We were preceded by Karen, Connie and Ken, and we're replaced by Mike, Mary and Marisa, so I don't know if this is purposeful or not, but lucky me—my name begins with “M” and I get to be here with these two great people.

So let me also just start off by saying that we are so happy to be able to work with CMS and this is an opportunity to be able to say, “Thank you, CMS,” because I used to be one of those people who was always knocking on the door saying, “We need more money. We need this. We need that.” You have to know that they do a fabulous job of trying to listen to everybody's needs, respond and spread their talent and the resources they have as far as they can. Tomorrow is a great opportunity for us. None of us accomplish anything in silos: we have to work together.

And so one of the things that ACL is about is not being in a silo. We have to work with other federal agencies, we want to work with other federal agencies, and we will do much better work when we collaborate with other federal departments, agencies, and community-based organizations –everyone that we can work with to create synergy, and expand the capacity and the ability of resources to meet needs.

The Administration for Community Living is about maximizing the independence of people—people with disabilities and older adults—helping them to be as participative and engaged in community life as possible for each of them. So when I talk about people with disabilities across the lifespan, we're addressing youth, children, babies and people who age with disabilities into older adulthood. We also have a particular focus through the Older Americans Act on older adults. By virtue of the Older Americans Act, which is defined as people who are 60 and over, we serve those older adults who have social and economic needs, who are most needy in those realms. Relative to tribes, they are able to identify their age eligibility so they are not restricted to 60 plus.

Within ACL, as part of HHS, we're part of three large initiatives that Health and Human Services has identified as priorities. One of those is childhood obesity. Another priority is around mental health-mental illness, severe mental illness. There are certainly people who are impacted by mental illness, depression and so forth, and so we engage in a lot of different programs—and I'm going to allow Marisa to mention some of those specific programs—but some have been discussed already in terms of disease self-management initiatives. We also are addressing the opioid crisis. The Administration has identified the opioid crisis as something on a national level that we all need to rally around and participate in.

In addition to those three initiatives ACL has also identified five pillars—initially it was four—and one of the pillars is around supporting families and caregivers. In particular we have, through the Older Americans Act, a national family and caregiver support program. I won't go into a lot of that right now, but what's vital to note is that when we hear—and I think someone on the previous panel gave a number to the value of caregiving in the home—informal caregiving by families and kin, neighbors, and friends exceeds \$200 billion.

The value of that is greater, as Mike addressed, than what's being spent for long-term care. And so that's a resource that we need to support so that we're not spending dollars in providing institutionalized or other types of care. So we recognize this as very important.

Second, we need to pay more attention to access to information and resources. How many of you are caregivers in the room? And how many times have you said, "I didn't know that was available. I didn't know that service was out there. I wish I had known." We can't have that so we have to do all we can to dig in, dig deep, to find out and market better—I'm using that business term—we have to market, brand and identify our services and get them out there so that people are aware. We can't do that alone as ACL: we have to use our networks, our other agencies and so forth to be able to accomplish that monumental goal.

Third, elder justice. Protecting the rights of older adults as well as people with disabilities is very important. Lance Robertson, who serves as administrator for ACL by designation of the Secretary of Health and Human Services, coordinates and serves as the lead for the Elder Justice Coordinating Council.

We just had our first meeting, and I'm happy to report that all 12 agencies or departments were there in attendance, recognizing this is indeed a key issue. ACL will dedicate time, resources and talent to this pillar.

You've also heard a lot about business acumen—which means we are addressing and strengthening our networks. Mike described this, and others previously—Ken, Connie and Karen—they all were talking about their networks and the state units—all of this—and that it needs additional strength and support. Marisa will be able to talk more about business acumen, because this is one of the jewels, as Connie described, of how Area Agencies on Aging are building the sustainability of networks and the community-based organizations that are part of these networks. And when you hear about outcomes: ACL is focusing ever more on data outcomes, not just output—not only how many people did we serve, but how well did we serve them, and did we have the outcome that was expected. Because if we don't alter and develop programs—I think there was a quote up earlier from Buckminster Fuller to the effect that, if we have a model that's not working now—create a new model. So that's what we will be about.

A fifth pillar was added recently when we had National Disability Employment Awareness Month in October. We announced our fifth pillar around at that time—employment. It's not employment just for people with disabilities but also for older adults. We all know that many older adults like to work as they get older. And even though some of us are on Medicare, we're still working, and there are a lot of older adults who not only want to work but need to work. So how do we help open up opportunities and catalyze opportunities for older adults, as well people with disabilities so that employers understand the opportunities and create more intersections for them.

So these are some of our priorities relative to ACL.

Anne Montgomery: How wonderful. So Marisa, I know you are a business acumen expert, so if you could give us a little bit of the history on it—I think it started out as a public-private collaboration or it grew out of that—and maybe some of the leading lessons that we've learned and where we're going with that program.

Marisa Scala-Foley

Team Lead for Business Acumen and Health Information Technology, Administration for Community Living

Marisa Scala-Foley: Sure, thank you so much, Anne, for the opportunity to talk about that. And thank you too, Mary, and to Mike for the lead-in. There have been a number of hallmarks of the work that we have done at ACL in partnership with our national partners, as well as philanthropic partners, and organizations that represent the needs of older adults and persons with disabilities.

So the work began truthfully in concert about five years ago in 2012, after the Patient Protection and Affordable Care Act had passed. Community-based organizations were coming to ACL and saying, "Where do we fit in in terms of these delivery system reforms that are happening around the country?" Whether that's through managed long-term services and supports, Accountable Care Organizations or other kinds of changes to the health and long-term services and support systems that bring them closer together to address the needs of the whole person.

They were coming to us and saying, you know, "Where do we fit in in terms of some of this work?" So we started with some national grants to organizations like the National Association of Area Agencies on Aging, or n4a—and we'll hear from Sandy Markwood a little bit later—as well as NASUAD, the National Association of States United for Aging and Disabilities. We looked at broad-based technical assistance to prepare state and community-based organizations for changing roles in delivery system reform.

We quickly realized that while national perspective and national technical assistance was important, that a lot of this work was very community-driven. As you heard in a wonderful way from the first

panel, the needs of different communities can reflect not only the people in those communities, but the service systems in those communities.

So we recognized that not only did we need that national work, we needed much more targeted technical assistance addressing the needs of community-based organizations in partnership with state organizations around the country to address their specific needs when it came to building their business capacity.

We've done a couple of learning collaboratives which have been 18 months long—very intensive and involved work with community-based organizations around the country. We did two rounds of those and worked with 20 networks of community-based organizations around the country. You heard from two of them this morning and there are others here in the room—you'll hear from Sandy Atkins with Partners in Care Foundation which has been another—one of our community-based organization leaders in this work. These networks comprise hundreds of organizations around the country. And as I mentioned before, we work with national partners like n4a, and philanthropic partners most notably the John A. Hartford Foundation, the SCAN Foundation, the Gary and Mary West Foundation as well as two regional funders: the Colorado Health Foundation and Marin Community Foundation. They are supporting some of the next generation work in this area being done through n4a's Aging and Disability Business Institute, as well as other work to build that capacity to be good partners, and ultimately to hopefully contract with healthcare organizations. That's largely what this work is about: building those contracting skills and building more sustainable networks of community-based organizations.

A couple of you asked about lessons learned. Some really quick lessons that we learned from the outset: One is that culture change is critical. Culture change, I would add, encompasses thinking about how to market your services, how you build a value proposition that will encourage or entice a healthcare provider or payer to contract with for the kinds of services that you offer—whether those are care transition services, evidence-based programs, or other kinds of services.

Culture change on the part of community-based organizations is key, but culture change on the part of healthcare organizations is also very critical. For example, even things as basic as language play a role. Care management from a community-based organization perspective is a very different entity than what a managed care organization thinks about as care management. So bringing those systems together and helping them to align in order to meet the needs of the whole person and to really create a person-centered integrated system is a challenge.

Anne Montgomery: You know, I find it fascinating that you all are working with people of all ages. When you think about AOA [the Administration on Aging] you think 60 and older, but ACL has a lifelong mission and I guess I hadn't really fully appreciated that. That's incredible.

Q&A

I want to take a minute to ask you all to reflect on the Community-Based Care Transitions program. It was a groundbreaking demonstration of how communities, mainly led by Area Agencies on Aging, learned to work with hospitals on care transitions interventions and aimed to reduce readmissions of high-cost, high-risk patients.

That ended a couple of years ago, but the triple-A's that participated—and Connie talked a little bit about this—learned a lot in the process about how to package multi-component interventions, which in turn involved work to establish protocols for getting referrals, setting standards, response time, training staff on care transitions, working with hospital staff to coordinate their work with what the triple-A's do, post-discharge and a lot more. For the high-risk patients who participated, the major areas of assistance provided by triple-A's were help with understanding how to manage their medication regimens, help with maintaining a personal health record, help with tracking follow-up appointments, and information about how to watch for “red flag” indicators.

That's a very brief thumbnail. But from your perspective did the CCTP program tee up a lot of other work that's playing out in business acumen, HCBS waivers and more? If you could just reflect on that that would be great.

Mary Lazare: Sure, be happy to. One of the programs that we just highlighted last week is a program called veteran-directed home and community-based services. So let me describe for you—and the commercial break is that if you go to the White House Facebook page you'll see a two-minute video of the Acting Secretary for HHS visiting a veteran in their home. I think you'll find it very interesting.

This program touches on all of the things that you just mentioned. This is helpful for ACL to see, because we are basically working through the networks which are the skeleton, and we add capacity and build muscle around them. So the bones—the skeleton—of ACL is our networks that serve people with disabilities and older adults.

In this program particularly, we are serving veterans and their families and caregivers. We are working with the VHA—that's the Veterans Health Administration—and in particular Veteran Medical Centers to serve veterans who are nursing home eligible and who want to remain in the community. They are assessed and when found eligible they are connected to the Aging and Disability networks in their community—the Area Agencies on Aging—and assigned an options counselor. This is the “No Wrong Door” system. A counselor vets their needs in a person-centered way. It's “What do you need? What's the information we need to take in? Where can we refer you for additional support?”

Let me give you an idea of what I'm talking about so you get an idea of some of the flexibilities of this program. The veteran chooses who is going to provide services to them, and this works well in areas—particularly rural areas, where a wide variety of resources and services are not available. So we just had a visit with an older veteran on a panel, a 92-year-old veteran, who said, "I've hired my niece—someone I know and trust, someone who is reliable to come to my home and provide services for me. I pay my niece from my stipend." He is also assigned a financial counselor, who helps to manage not only that arena, but also all the tax implications of hiring people and so forth. And through this program, veterans have a lot of flexibility. They are able to hire a neighbor who can cook a meal and bring it over, a relative to serve as a caregiver. The program is also serving younger veterans—those with post-traumatic stress disorder and traumatic brain injury.

One veteran has hired a runner to run with him; this allows him to run and find his way home—which he could not do on his own—and it clears his head and helps him throughout the rest of the day. The flexibility in those programs allows the veteran to choose and tailor his services. So this is what we've all been talking about.

So in this program, ACL works with the VA, and with funding from the VA, we work to strengthen the networks, while they provide the stipends. The ACL networks are providing the options counselors, the financial counselors. It's up to the veteran to decide within the limits of their stipend "What do I need?" There are tremendous outcomes from this program.

In terms of this 92-year-old gentleman, he said, "I get to live at home with my wife. My niece provides care." And this has been going on now for many years. This is a veteran who would not be able to care for himself. Another veteran was a gentleman who had a stroke that impacted his left side. He's not able to care for himself without support. He hired a person he's known and met, someone he trusts, and she is able to provide the caregiving support that he needs.

So there are all different ways these programs work, but this is person-centered, home and community-based, with the excellent outcomes that we're looking to achieve in other programs. So I wanted to particularly highlight that one for you.

Anne Montgomery: Thank you.

Marisa Scala-Foley: If I can also build on what Mary's talking about in terms of linkages to home and community-based services, I think we learned a great deal as a Network in terms of the outcomes of the Community-Based Care Transition Program you mentioned earlier. It formed a foundation for some of the business acumen work, which is progressing at the community level and at the national level. That said, the program certainly had its ups and downs over the course of the several years that it ran. We were very heartened to see, however, the results from the final evaluation report released right before Thanksgiving. For those of you not familiar with the program—Anne mentioned a little bit about it—the leads for the CCTP sites were largely

community-based organizations, such as Area Agencies on Aging like Connie's, and other aging and disability organizations like the Partners in Care Foundation which was another CCTP site. There were 101 sites across the country. The final evaluation report showed that those sites were able to prevent over 12,000 Medicare readmissions to the hospital, and the savings that they estimated in the final report was over \$600 in Medicare A and B expenses per person served in the program.

Getting to the home and community connection that Mary mentioned, what they found was that it was not only the care transitions intervention that was used—there were different models of care transitions interventions that were used—but it was also the connection to home and community-based services, whether that was nutrition services or other kinds of personal care services, or transportation to get back to a followup doctor's appointment. One of the things that they felt was one of the most important learnings for those sites was that the connection to community services was incredibly important in terms of the prevention of those Medicare readmissions.

Mike Nardone: And I would just say that—it's interesting—I haven't read that report—it's interesting the conclusion that you're referencing because one of the highlights of the MFP evaluation was that connection to community-based services and connection to home and community-based services is one of the factors that enabled people to successfully transition out of institutions.

So to the extent that there was some connection with those services previously, I don't want to say it's a determinant—that's too strong a word—but it was basically an important factor for people who had been in institutions for a longer period of time. That was one of the factors that seems to have significantly related to their ability to transition out.

Obviously the Money Follows the Person initiative was also one that sought to build on transition services, and the availability of transition services to help long-term residents of institutional care transition out. It has demonstrated success with close to 70,000 people being transitioned out through that program.

Anne Montgomery: Thank you so much for your work on behalf of communities and people who are aging in place. This has been an incredible conversation and we will now join in thanking our panelists. Thank you.

[Break]

Panel Discussion: Drilling Down

Sarah Slocum

Health Policy Analyst, Center for Elder Care and Advanced Illness, Altarum

Sarah Slocum: Thanks everyone for coming back together so quickly. Welcome back. Good morning. My name is Sarah Slocum, I also work at Altarum in the Center for Elder Care and Advanced Illness with Anne. I'm in the Ann Arbor, Michigan office, however, so I'm just here for this wonderful forum and conversation today.

For this next session we're going to do a bit of analysis about what we've heard so far from the three star communities and from the key federal officials that we've heard from. So for this purpose we have three stellar and highly experienced people—all three with great expertise and insight, and I cannot possibly do them justice in these brief intros but you can read more about them on the event website.

First up, and participating remotely—so we'll be listening for—you know, if you remember Charlie's Angels, that voice that comes over the speaker—is Brenda Schmitthenner of the Gary and Mary West Health Institute. Prior to joining West in 2016, Brenda was the administrator for the largest Community-based Care Transition Program—CCTP—in the country, based in San Diego, California. She managed over \$20 million in aging grants, so we will be very pleased to hear from here in a few minutes.

Next we will hear from Jean Accius of AARP. He is Vice President of the Long-Term Services and Supports Group within the AARP Public Policy Institute. Jean has a broad base of experience, ranging from the State of Florida Department of Elder Affairs, to the federal level at CMS where he contributed greatly to their LTSS work.

And then last and certainly not least we will hear from Sandy Markwood, CEO of the National Association of Area Agencies on Aging since 2002. At n4a, Sandy takes on leadership on multiple fronts including policy strategy and building the grassroots and national leadership of the triple-A network.

I'd ask first that each of you, starting with Brenda, and then Jean and then Sandy, just give a few minutes of reflection about what you've heard so far, but also about yourselves and what draws you to this conversation about community-anchored care.

So Brenda, I'll ask you first to make a few comments.

Brenda Schmitthenner

Program Officer and Senior Director, Gary and Mary West Foundation

Brenda Schmitthenner: Thank you very much Sarah, and good afternoon everyone, it's really my pleasure to be able to join remotely from San Diego this afternoon. I'd like to kick off this panel discussion by really thanking Altarum for bringing us all together today, to think about and envision that new care delivery system that really is going to better address the needs of this growing population of older adults.

It's given us the opportunity to learn from trailblazing organizations as well as federal agencies that are doing tremendous work and supporting new models of care that we can look to replicate and scale in communities across this country. I'm preaching to the choir here, I'm sure, when I say that we've got a huge population shift coming soon. We've got 10,000 baby boomers who are turning 65 every day, and I don't know if there's anyone in the room that really thinks that our healthcare delivery system or even our long-term services and supports are really structured or scaled to meet that growing demand, or even the expectations of seniors, persons with disabilities, and their caregivers.

It is for exactly this reason that West Health has aligned medical research, policy and advocacy and outcome-based philanthropy together across just one singular mission: to enable older adults to age in place with access to high quality healthcare and supportive services. We're very fortunate because we have the opportunity to work with a wide range of healthcare providers, researchers, academics, advocates and community-based organizations to test and scale new models of care. Our research focuses on community-based healthcare delivery models and on long-term services and supports, and oral health, family caregivers, palliative care, geriatric emergency care, care coordination and health economics.

The cornerstone to our work is that we see that community-based organizations are uniquely positioned and qualified to identify changes and risks within the clients that they serve and to address the social determinants of health—which as you heard from Connie are the driver of significant unnecessary healthcare utilization and ultimately poor health outcomes.

I was really excited when I heard the three different community case studies, and it's clear that these organizations are generating the evidence that is needed for healthcare providers, policymakers and communities to make better and more informed decisions about how healthcare and community support services can be delivered locally to a growing and diverse population of seniors and persons with disabilities. I was also very excited to hear from Mary, Marisa and Mike about all of the support that these federal agencies have provided to advance new and innovative models of care. Their contribution just can't be understated.

You heard from Sarah that my prior role was with the County of San Diego's Aging and Independent Services Aging Program, where I served as Administrator for the largest Community-based Care Transition Program in the country. San Diego was also a recipient of an ACL business acumen learning collaborative grant, which helped to launch a successful population-centered health model.

You heard about CCTP and how it has generated new care models that are being scaled and replicated across the country. In San Diego I've got to say that it was CCTP—that partnership between the Area Agency on Aging and 16 hospitals that served over 57,000 Medicare beneficiaries—that brought the community together to think more holistically about care, and how to deliver person-centered care, which began at the point of admission and then continued well beyond the 30-days past that admission. So as we look to new care models, we look at West Health to support and advance those of you that are working in this field, and we just appreciate the opportunity to work in partnership with all of you.

Sarah Slocum: Thank you Brenda, that's a fantastic perspective. I'd like to hear next from Jean with some thoughts about this community activity and the federal role, and your perspectives on where these fit together.

Jean Accius

Vice President, Independent Living, AARP

Jean Accius: Sure. First of all I want to go ahead and just echo my thanks and gratitude for the opportunity to participate in this conversation this morning.

I think that the larger question we face—and Brenda alluded to this—is the fact that in light of the aging of the population with 10,000 people turning 65 each and every day—roughly about 8 seconds someone turning 65 on a day-to-day basis—is how can we promote their desire to live an independent and vibrant life for as long as possible in their homes and communities, which is where most people prefer to be an environment where there are some constraints in terms of funding?

What are the opportunities to innovate both at a local level, at a state level and broadly at a national level to foster the type of innovations that can meet the needs of a growing elderly population, and also a population that's living longer? Today, many people are living past 80, many are living past 90, and a lot of people are living past 100.

The other aspect of that question is not just how do we create a system that is really focused on the person, but more importantly, how do we create a system that's focused on the person and their families? I also want to acknowledge one of my colleagues within the AARP Public Policy Institute who has done a tremendous amount of work particularly in the field of family caregiving—

Lynn Feinberg—who is a trailblazer both internally within AARP, and clearly outside of the organization.

Going back to the larger question in terms of the aging of the population, the fact that people are living much longer, and they have a strong desire to stay in their homes and communities for as long as possible, what we know is the fact that many communities unfortunately are not prepared for this aging of the population. There is a gap between what people desire and what is available in their communities. That has significant implications, particularly for the conversation that we're having today. What does that actually look like? The importance of transportation and the importance of housing options are critical. One of the things that Mike touched upon was the Money Follows the Person rebalancing demonstration. What was so fascinating, and is still fascinating about this major demonstration from Medicaid, is that it actually raised a lot of the issues that we talk about now in terms of social determinants of health.

What we found through the Medicaid program, and particularly around MFP, was that it's very difficult to transition someone out of a nursing home if there's no place for them to go. Part of that also turns on what are the community features that allow people to age in their homes and communities for as long as possible? It could be access to transportation, it could be healthy food.

In 2015, our team created the "Livability Index" to spotlight community services. I don't know how many of you are familiar with this tool, but it really gets back to the theme of our session today: "It Takes Your Community." In order for you to make informed decisions, it's always important to have some data, some information, to help inform those decisions. More importantly, it has to be able to provide individuals across the range—whether it be a resident who lives in the local community or a local policymaker—with the tools that they need in order to really effect change.

So that's exactly what this tool does: it measures every neighborhood and community across the country based off of seven different areas of focus: housing, transportation, the neighborhood characteristics, health, economic opportunities, employment opportunities, and educational opportunities. Based off these seven different areas of focus, there are different ways in which we try to operationalize those areas. That can range from housing affordability and housing accessibility, to the extent to which individuals have access to local parks, or access to high-quality healthcare in their local community. Based off all of that information you actually get an overall score. And that tells you how livable your community is. And what we define as livable is what we heard from doing a survey with 4500 people, and how they defined livable.

If you step back and think about your own definition of livable, you will probably come up with something that's similar: You want a place where you can actually be active and engaged, and provide value, and one that promotes health—meaning your overall well-being. You want to be

able to walk in your neighborhood safely, and have access to high-quality care and also have access to the amenities that you desire.

An overall score tells you how livable your community is, but more importantly, it gives you information in terms of where there are opportunities to improve. So that is what's powerful about the Livability Index. When we come to think about the fact that it takes your community, that means it takes everyone in your community. How do you empower communities to really be prepared for aging and to think innovatively? We heard some examples today of how you can create some of those options to meet people where they are. So we're excited about this conversation.

Sarah Slocum: Great, thank you, Jean. Sandy?

Sandy Markwood

CEO, National Association of Area Agencies on Aging

Sandy Markwood: Well, I too want to echo my thanks for the forum and the discussion, because I think now is really the time when we need to start looking at new directions for how we bring together health and human services and how to bring it together at the community level. I really applaud AARP and the Livability Index, because I think it is bringing health and bringing all the community factors together with social services. Ultimately that will be a game changer as far as meeting the needs of people moving forward.

I know our panel doesn't start with all the same letters, but depending on what Brenda's middle name is, my middle name is Jean, so at least we have something going on here as far as keeping up with Anne's theme!

So that being said, as I reflect back on the wonderful discussions this morning, and look at it in the context of Area Agencies on Aging and the broader Aging Network; When I look back at how it was created—it was created to be boots on the ground; to be able to ensure that older adults' needs are met at the community level; and that there is someone who goes into the home. Our mission is to ensure that older adults can really live independently with dignity and respect and safely at the community level. The Older Americans Act is the foundation of that, and has been and will always be, I believe, the foundation of the Aging Network. But as the Aging Network has evolved, some really exciting things have happened, and I think we're about to see an acceleration of that. The Older Americans Act now is only 39 percent on average of an Area Agency on Aging's budget. The majority of funding has been shifting and diversifying, and much of that has been happening in the healthcare arena, with funding coming from Medicaid. Now, as you heard from the community panel discussions, Medicare is also entering into the realm of funding for Area Agencies on Aging.

The foundation for the social services are there, and they are now being recognized as important for addressing social determinants of health. That changes the dynamic. And what I see is the Aging Network being the bridge between the acute care health world and the world where most people live, which is in their home. As Connie was saying, that's really where our sweet spot is in the Aging Network—to be able to meet the needs of people where they are. And as Sandy Atkins and June Simmons would say, "We should own the home." We're invited into people's home. Community-based organizations are invited into the home to be able to provide services and supports.

In saying that, and in looking at the three wonderful examples from the community—Ken and Connie and Karen—what we heard is that there was not just one agency involved. It was about bringing everybody together to bring value and perspective on how you can garner help. In Zuni, you have done amazing things. But also in Connie and Ken's examples, they talked about leveraging the state and leveraging the healthcare resources to pull it together to make it work. That's not an easy task in any three of those cases.

I also want to recognize the leadership of ACL and the learning collaboratives that really spurred Connie and Ken's activities, and also for Tribes. I think that ACL leadership has been key, and is critical to looking at opportunities and also blessing those opportunities. ACL has been telling the Aging Network and states, regional offices and governance officials at the local level that it's okay to move in this direction of business acumen. Quite honestly when it first came out, you would often hear people say, "What are they talking about here?" Now, three to five-years later, one-third of Area Agencies on Aging either have a contract with a healthcare provider or are pursuing one.

So I'd say we are at a tipping point in looking at how we blend together social services and healthcare. It's happening quickly. It needs to happen quickly given the environment that we're living in. And I also want to recognize and thank the Hartford Foundation, the SCAN Foundation, the Mary and Gary West Foundation, and the Marin Family Foundation, because they have funded the Aging and Disability Business Institute. n4a is honored to be the lead in that but we have partners with Meals on Wheels, National Council on Aging, the American Society on Aging. This is an Aging Network tipping point of change that we are working together on to improve social services and healthcare and redefine what it is to age in America.

Thank you for having this discussion and dialogue to move these exciting developments forward.

Q&A

Sarah Slocum: Excellent, thank you all for those very pertinent and exciting comments. I'm hearing themes coming from all of you about the mix of medical care and long-term supports and services—the community-based/community- anchored care that has to happen. And I'm

wondering what your thoughts are about communities that are currently trying to define and serve particular populations of older adults, and the mix of course is going to vary. What are some projections for future demands? Some of you have mentioned data and using that data for really digging in and figuring out what communities will need to plan for.

Also, what do you see happening to move towards comprehensive care planning that can determine which services are going to be the most person-centered and the most effective for different people?

Sarah Slocum: Brenda, would you like respond?

Brenda Schmitthenner: Sure. I'm happy to weigh in. Thank you so much. So, you know, I think that there's significant evidence that the care models that have been the most successful are those that really are based on models that assess risk on the basis of both health and social factors, and then develop a shared person-centered plan of care that follows the individual across care settings and providers.

Having been in aging services for a very long time, it's really amazing and exhilarating to attend meetings and conferences with healthcare payers and providers and hear what their number one priority is—and that is engaging with a community to address the social determinants of health.

We have a long journey ahead of us but there are leaders and practitioners that have come to recognize that our healthcare system isn't sustainable, and that incentives and practice have to change. It is investments from foundations like the John A. Hartford and the Age-Friendly Health Systems Project that are improving the quality of care that older adults and persons with disabilities receive while lowering overall cost by better integrating those community-based supports and services within health systems across the care continuum.

Sarah Slocum: Great. Jean, did you want to add?

Jean Accius: Sure. So there's a couple of things. One is that from a systems standpoint, we know with the Livability Index that localities are actually utilizing this tool in order to really help to elevate the conversation more broadly. But how do they actually take their limited resources based off community need and align those in a way to really start making some incremental potential changes? Washington, D.C. is a perfect example of where they're utilizing the index to actually help inform their community planning and strategic plans moving forward.

More broadly, I'm thinking about some of the work that we've done around Medicaid managed long-term services and supports and family caregivers. I know this came up earlier in terms of Mike's conversation and discussions. Some states are actually already doing things to recognize and help support family caregivers. I think in South Carolina, Tennessee and Texas, for example,

they've created an independent assessment tool to identify what the needs of the caregiver are, and how best to support them.

I also know that in some localities like Santa Barbara County they're actually identifying the needs of family caregivers and trying to think about it more from a system perspective, with the idea that by supporting family caregivers you're also supporting the person that they're providing care to, and this has significant implications particularly both for navigating our complex, fragmented and often siloed systems of care.

Sandy Markwood: Adding to that—I think that Brenda and Jean have covered the issue, but I would add to that in looking at it from the perspective of the Aging Network, we look at it from a population perspective and the risk factors. Then we go in and develop that person-centered response which I think is really, really critical.

The one thing that I would also applaud in the managed long-term services and supports—the managed care world—is that they have also recognized the importance of caregivers and because of flexibility under MLTSS, have also started to incorporate some different types of responses—not only for the individual who may be the recipient, but also their caregiver. So looking at how we can blend this population model with a person-centered model is both art and magic.

Sarah Slocum: Excellent. That's a nice way to put it. Well, we heard in the previous panel the exciting news that tomorrow there's a meeting between CMS and ACL, so that prompts me to ask you all what you think about the federal government's role in all this. Do you think they're mainly a source of funding and infrastructure for these changes that we see coming forward, or a body that's going to provide quality oversight and accountability, or a leader in embracing novel models of how to carry out community-based care? Or some mix of all of these? What are your thoughts about the role of the federal government since they're going into this big meeting tomorrow?

Jean Accius: Having worked at CMS, I think that it's always great when agencies are coming together to collaborate and to have conversations. I will tell you that one of the first things I learned when I came to CMS, firsthand was the importance of having cross-cutting conversations, because oftentimes the definitions and what we might think is common language or common knowledge actually varies from one agency to the next. So to the extent we can continue to collaborate in a meaningful way and help to accelerate and pick up the pace and infuse some of these innovations, I think is critically important.

The other aspect of this—I think again of MFP, because the Money Follows the Person rebalancing demonstration is a good model in terms of actually bringing stakeholders together both at the federal level, at the state level and also at the community level. More importantly, consumers are represented in those conversations—not just as an end product but also during implementation and the design of services.

Another aspect of this is the fact that there's the component allowing states to utilize Money Follows the Person dollars to try some very innovative activities, and some strategies that I don't think would actually have been able to be executed otherwise.

Sarah Slocum: Yes, right. Sandy?

Sandy Markwood: Again, I applaud ACL and the conversations I know that they have continued to have over the years with CMS and other federal agencies that Mary alluded to that to, to keep this discussion of population health and social determinants of health moving forward. And they've done an incredible job, again, with the learning collaboratives, but also just in being a large megaphone for a small agency in pushing this idea.

I think that CMS continues now to put into different innovation announcements the need to coordinate with community-based organizations. The one thing that I would hope is that there would be money tied to that coordination, because as everyone in the Aging Network knows, it is a Network that does a lot with little. It's a Network that can do more with more, but we need to make sure that in aligning with healthcare, there are resources that go along with expectations.

Sarah Slocum: Great. Brenda?

Brenda Schmitthenner: Yes. Piggybacking on what Sandy just mentioned, I believe that one of the most important roles that the federal government can play is to strengthen communities to remove payment and other perceived barriers that really prevent healthcare payers and providers from financing long-term services and supports for targeted high-need, high-cost older adults and persons with disabilities. We have to recognize that these barriers exist within Medicare Advantage, within D-SNP plans, within Medicare Shared Savings Programs, Accountable Care Organizations, and even PACE programs. Making appropriate changes could go a long way in bringing the financing to support capacity building within the long-term services and supports network.

Sarah Slocum: Thank you. Excellent thoughts. I'm going to just take a few minutes to open up for questions because we want this to have some dialogue. So Connie, I think you had your hand up.

Connie Benton Wolfe: One of the things, as we've done all the work we've done, that we keep saying is that integrated care without integrated resources is just a nice concept. If we do not find a way to fund it—whether we redefine it as clinical or however we break down those barriers, integrated care will not happen unless the resources become integrated as well.

As we talk with managed care companies, we hear things like, "We tried to work with our Area Agency or our community-based organization but they don't have the capacity." Well, they don't have the capacity because they don't have the resources.

With the resources the Aging Network infrastructure is built: it's been invested in by the federal government for years, and it has shown itself to be capable of change and adapting to this new environment, and it holds the greatest promise for moving the dial on healthcare spend of anything else that's being tested. All we need to do is unleash it. So I just wanted to echo that.

Sarah Slocum: Thank you. Dr. Poplin?

Audience: This is Dr. Poplin. I'm concerned that the social determinants of health are being seen as part of the care program only after somebody's been in the hospital. I think that's a very narrow way of looking at it. My idea is that the social determinants of healthcare are what keep you out of the hospital in the first place.

People who can afford it move into retirement communities or assisted living, and I think it would be nice if they didn't have to do that because most people can't afford it. But some of the services that are provided in those places—like a place to eat or transportation—that's what we ought to be thinking about, not making contracts with managed care organizations, because they're only interested in their patients, their particular patients. And Medicare Advantage so much the more so.

Jean talked about a broader way of looking at communities and the social determinants of health. My question is how do you determine what a community is? For the Zuni that was not so difficult, and they provide other services besides transitions. But what do you do in a place like Montgomery County? Where is the community?

Sarah Slocum: Okay.

Sandy Markwood: If I could respond and then Jean and Brenda. I don't want to leave you with the impression that the only thing that Area Agencies on Aging do—and I know that a lot of the discussions earlier this morning had more of a healthcare focus—but this is based on the foundation of Older Americans Act Services, which include home-delivered meals and congregate meals, evidence-based health promotion programs, in-home support, housing rehabilitation and modification—a whole range of supportive services.

Area Agencies on average provide 22 services to keep people in their home and the community. So when you're talking about the social determinants, it comes into play with the CCTP program, or Money Follows the Person. Those services are there today in every community. But at this point they are not funded through healthcare unless you have that contractual partnership, they're funded by the Older Americans Act, which is 0.04 percent of the federal budget.

Audience: But people could pay, privately.

Sandy Markwood: Yes, I think from an Area Agency on Aging perspective, as we look at the aging population dynamics we face, there will continue to be traditional federal government funding—

through the Older Americans Act—which will be targeted probably to those most in need, most low-income. But there is another bucket of funding through healthcare which potentially provides a broader base of funding—again, for those social determinants. Another bucket that is starting to be discussed is a private pay bucket, to coordinate services for those who have the means to be able to pay.

Sarah Slocum: Right. I think that's an excellent point, that there's a whole variety of things going on and different ways to look at this. I appreciate your comment about how does a community define itself? Some of that's going to be a very local proposition, where communities will use some of the tools that have been talked about in this panel—some of the data that comes into the picture from services already provided—and what that predicts for the future. So we're gathering all these learnings: it's not really just a one-way street and I think that was a very excellent point.

Jean, go ahead.

Jean Accius: I want to just add one thing to that. With the index, you have an opportunity to assign different weights to different categories. So depending on the community, it's going to vary from one community to the next. We saw that when we surveyed 4500 people, which is why we created the framework that we did. It's about empowering communities to make the choices that are in their best interest and to give them tools in order to do that at a local level. So whether you're a policymaker or a resident in your local neighborhood who wants to impact change, it's meant to provide the type of information that is most helpful for you.

This way it gives communities an opportunity to provide different weights to what they consider to be important. So you have a national tool, but you also have a way to customize it.

Sarah Slocum: Okay, thank you very much. I think actually we could go on for a very long time with the amount of expertise we have on this panel, but in honor of time—we all bow to time—I'm going to ask us now to close this one out and thank our panelists very much for sharing with us.

[Break]

Anne Montgomery: All right, I'm going to summon you all back to our fourth panel. Welcome back. You guys are having a great time networking and having lunch—and hello to the webcast audience. This is a very lively series of discussions that we're having.

It's now my great pleasure to introduce Antonia Bernhardt, current a Presidential Management Fellow at the San Francisco VA; and Jim Lee, Vice President and Director of Altarum's System Research and Initiatives Group. They're over to my right. They're going to talk about how all of you watching and listening here and online can think about how to assemble a willing coalition of healthcare providers and social services providers, advocates, experts and anyone else who is interested in building a community anchored elder care system in your own community.

To get almost anything done and to begin to make concrete plans you have to think in budgetary terms, right? So that's exactly what we're going to do. We're going to walk you through how you can think about financially modeling a community managed system for older people in your area that will need a mix of healthcare and long-term care services. And as mentioned earlier we call the model that puts all these elements together MediCaring Communities.

So to create a financial simulation model we reached out to four communities—Akron, Ohio; Queens, New York; a suburban area of Portland, Oregon, called Milwaukie; and a community outside of Williamsburg in southern Virginia.

The reason that we chose these communities is that we had relationships with the providers there—doctors and hospitals and community services agencies—and we knew that they were interested in getting a handle on how to create a community-managed care system for older adults.

We also knew they'd be willing to share some data to help us do some modeling. The financial simulation that Jim and Antonia—or Oona, as we call her—are going to go through in a minute has been published in the Milbank Quarterly in September 2016, and so for the nitty-gritty details you can find that full piece if you like in our resource pod link. We're pleased to say that we had it reviewed by top-notch actuaries at Ernst & Young, who verified it.

By way of backdrop here are the six key elements that undergird the model and the simulation that we're going to hear about. First, you have to have providers in the community who want to take the reins to create change and reform. Second, they need to be able to generate methods of identifying and enrolling elders in the local area—we talked a lot about community in our last session and how you can think defining or scoping that. Third, they need to construct baseline cost estimates for each major service area, plus utilization. Fourth, they need to establish estimates of projected savings that can be reaped as care patterns shift to emphasize supportive services. And these estimates must be grounded in the medical literature and reflect expected enrollment. Fifth, you need to estimate administrative startup costs, which include provider training, marketing, outreach, and development of standards and operating protocols. And sixth, you need to track saving from the service delivery reforms as they are implemented. I want to emphasize that the savings that we're going to be talking about this afternoon will be from changes in utilization of certain services, not from changes in prices.

So I want to thank Jim and Oona and I'm going to turn the clicker over to them and they will walk you through this. Thanks so much.

Financing Projections by Communities and Getting a Handle on Services and Costs: How You Can Approach This as a Community Planning Initiative

Jim Lee

Vice President and Director, Systems Research & Initiatives Group, Altarum

[View presentation slides: [Jim Lee and Antonia Bernhardt \(PPTX\)](#)]

Jim Lee: So the financial simulation that we did—and if you're interested in all the economic and calculation details we have a Milbank Quarterly 20-plus page paper, I'd be happy some evening, when you're struggling to fall asleep, to walk you through it.

But the overview is that looking at four rather distinct communities—Akron, Ohio; Milwaukie, Oregon, outside Portland; Queens, New York—where in Queens you had relatively high utilization of hospitals and relatively low utilization of community-based services, versus Milwaukie, which had somewhat the reverse; and then lastly Williamsburg, Virginia, which while not particularly rural, still, a couple of those communities certainly did not have the kinds of resources that you would have in large urban areas—all of them achieved a positive return on investment.

The return is lower at the beginning, in part because you're making some investments to develop the programs. In part, we also assume that the benefit of the interventions is less in those first couple of years—it takes a while for communities to learn, to get up and running, et cetera. Eventually, all of them achieve relatively substantial savings, in year three.

The financing simulation starts with some things that have nothing to do with numbers, and that is cultivating the desire for change and reform. How does one target the programs that you have, that you're leveraging and that you're going to maybe create from anew? Then the numbers folks come in and help with what are some potential baseline estimates: how might one project savings, and then most importantly, from my perspective, how to track these relatively quickly over time, so you can see where you're on target, and where you might be off target.

You only have three years, so you can't wait two years to get data to see if things are going well—so how does one do rapid cycle improvement in this type of program? That is part of cultivating the desire for change and reform, which we have been talking about a lot today. It involves

figuring out, how do we recognize a special population that has particular needs and how are we going to meet those needs and priorities?

Each community is a little bit different. I've often been asked, "So how many primary care physicians do we need?" Well, how many nurse practitioners, PAs [Physician's Assistants] and others with geriatric specialization do you have? How many internal medicine physicians and others do you have who may be very interested in serving this population? Many of these things can well substitute. Also, what we have clearly demonstrated is that social supports can reduce the demand for some of this clinical care. So it's very difficult to say exactly. Certain other priorities within a community may also come into play, so having good local management and using some of these savings to support local development is essential.

It is also essential that you get buy-in from long-term services and supports providers, and from a broader community of people—particularly caregivers. I've been one three times now. Your local officials too, who are probably asking: "How might we be able to support a transportation system that can serve a multitude of people, as opposed to just one population?"

Working with these factors, we then compare, contrast—maybe with some other communities—and work to find what are the first things we want to work on. Then we work to target the population of interest. And sometimes that may be over 65, but we've also seen that often many of these services can be useful for a broader population.

One of the things that I've certainly seen is that it's possible to be over-optimistic about enrollment. That's a problem if you start building a program quickly, hiring people, et cetera, and then the enrollment doesn't come, because then the savings don't come, which are essential. So starting with a program that already exists may be easier, which already has a population base. In Akron, that was the local triple-A. It's nice to be in a group where that means not the American Automobile Association! The other piece to consider is that to what degree can you have an expectation of providers and others seeing people promptly? It's one thing to enroll 100 or 200 people, but if it's a three-month queue to do initial assessments and provide essential services—again, you won't achieve savings. And that's where business operation folks like Oona can help you a great deal.

Antonia Bernhardt

Presidential Management Fellow, U.S. Department of Veterans Affairs

Antonia Bernhardt: To build on what Jim is saying, once you have your population estimates, that's when you can really get down to calculating your baseline estimates. Again, an ever-reoccurring theme with this whole discussion here today is the necessity of working closely with your community partners.

You're going to really rely on your community partners first in identifying your startup and administrative costs—things like the cost of building any technical infrastructure. IT [information technology] has come up many times today as a theme. It's no different in this model. You're also going to need to develop a legal framework. You'll need education materials and training for your administrators and providers—the people who you're really going to need buy-in from—in order to implement any work that you propose.

Once that is accomplished, then you can look at your medical costs and service utilization estimates. Most of this you can find in CMS's hospital referral region public use files. Anything that you don't find there you can look at getting from your community partners. When we did this, we adjusted many of the estimates that we got using the PACE Frailty Index. That's a good way of calibrating some of these bigger estimates and tailoring them to a frail population that you and your community are serving.

We also extrapolated Medicare data to calculate costs for populations paying out-of-pocket. We did that so that we could calculate co-pays and deductibles. Generally speaking, these estimates probably aren't surprising for most people in this room. You can see the majority of the spend projected is in-patient hospitalization. Other categories, like out-patient hospitalization, primary care and SNF [Skilled Nursing Facility] days making up the rest of these high-cost categories.

Jim Lee: One additional point: We assumed that one would not be able to negotiate any discounts in these prices. We have found that in some communities, Medicare Advantage plans, PACE programs, et cetera, have been able to negotiate relatively substantial discounts, and in other places, not. So that's one place where we were a bit conservative in our assumptions.

Antonia Bernhardt: From this point, you can project your savings estimates. And again, work with your community partners to identify how you might generate those estimates. For savings estimates, we started—and you all can start too—with a literature review, and you're more than welcome to reference the review that we did in the Milbank article as a good starting point. Estimates from academic literature vary, so be prepared for that. And be sure to cross-reference those estimates with estimates from your communities: Really get a sense of how a particular group of estimates might vary based on your community's unique needs.

Jim Lee: One thing that public use files provide is—if you're familiar with the hospital referral regions—you can do a comparison, let's say, of a county or group of counties, to a state and a national benchmark for a variety of types of services. That gives you a sense that if costs are particularly skinny in several service areas, one can't expect a substantial reduction in spending on those services. In other service areas, spending may be higher, for example, in the ER [emergency room].

And frankly, in talking with folks like Connie and the folks in San Diego with their care transitions program experience, that's real on-the-ground experience. Knowing how quickly did they start achieving some of those kinds of reductions in readmissions and why, et cetera—allows you to prepare estimates that are grounded in reality.

Antonia Bernhardt: One other thing I'll add before we move on is that most of the estimates that we used were intended to be conservative. We tried really hard in the model to go for the conservative approach rather than the most ambitious approach. The logic behind that was that we wanted to make sure, to Jim's earlier point, that we were realistic in what we could project. It's always better to be pleasantly surprised.

So with that we can move to the next slide. You'll see in the first column—the service category—looks very similar to the last table that we looked over. Of the categories that we looked at—probably no surprise to the people in this room—in-patient hospital expenditures were projected to decline the most. However, for professional primary care, we projected this to increase. We see that as reflecting the benefits of the MediCaring model shifting the mix of services to a more geriatrically focused model of care, and really meeting people before they need to go to the hospital.

An important caveat here is that when we built out these estimates, we did this with a 30-month deadline to achieve a steady state. This doesn't have to be the case in your community. Your community can use a longer timeline, a shorter timeline—whatever you think is appropriate—but what we're showing here is that it is possible to achieve a steady state, and it is possible to see savings in that period. These are some of the big ticket items that we anticipated to generate the bulk of those savings.

Finally, as Jim mentioned, it is crucial—critical—to track changes. A good way to do this through a dashboard. We've seen international examples of dashboards, and I know that we've talked a good bit today about measures and the importance of tracking progress.

Earlier in this presentation, Jim described the importance of generating local buy-in. A dashboard is a really good way to do this. Measurement tracking in general is a good way of making sure that even as leadership might change, even as your community partners might change, that there's continuity of information as you continue to work on building out your system and your effort in this area. It's a way to hone a sense of local accountability.

This is what we ended up with on return on investment. It's important to note here this does not include startup costs. It does include operating costs in year one, two and three. Most of the change that you see across the three years have to do with enrollment expanding.

So again, to Jim's point earlier, you really need to make sure that enrollment is in place. Without rising enrollment you won't get the savings you're looking for. But you can see that even though

we've got really diverse communities, we're able to achieve positive return on investment in the third year in all four. All show substantial returns on investment. The smallest ROI over three years was in Milwaukie, Oregon; it was 165 percent in Akron. We projected that after year three and four, the communities that we surveyed and worked with would be able to achieve a steady state of return on investment.

Jim Lee: This was done a few years ago now. Since then, there is more and more evidence of programs that have been able to achieve savings like this or greater. And so I'm confident that a community that plans this well—and that does take some time –and which has the ability to adapt their program as they move forward, will achieve savings like this.

Three or four years ago I would have said, "Be careful, this is a simulation." But now I can say that many have done things like this and achieved the kinds of savings that we projected.

Q&A

Anne Montgomery: Great. Okay, so now we want to hear from you. We've walked you through the simulation and wonder what you think of it, and whether you think you could tackle it. Essentially what we did, just to summarize, is that we identified a population—one needing both medical and long-term care services; we costed out what those services are at baseline; we assumed based on the literature and geriatricizing services and providing more upstream low-cost social supports and services, that you could reduce the spend at baseline by a significant margin—roughly 20 percent overall—and we proposed to use the savings to operate a community-anchored system and to buttress underfunded social supports and services.

So that's essentially what we did. And what we hope is that you will think of it as an exercise that you could go through with providers in your community, willing healthcare providers, willing social services and supports folks, actuaries, researchers, interested others, and actually run your own numbers.

Now we'd like to open it up for discussion and hear what you have to say, and what you think.

Audience: Thanks. I'm Mike Miller. This is fascinating, and Jim I'm glad you made that comment at the end about actual communities that have implemented things like this and found savings. Because the work I've done at the state level with Governors and health secretaries, program directors or communities—they're going to go, "That's great. Looks great but has it actually worked? Can you show me where it is?"

Have you been able to reflect on your model based upon what communities have actually done, and/or have those actual communities been published? Or could you share more information, not necessarily now, but later through the Altarum website or something? Because that actual

implementation and experience I think can help drive decision makers more than just the really good modeling. Thank you.

Jim Lee: So there have been some additional reports—both academic and "grey literature." Did the care transitions program report ever come out?

Anne Montgomery: The final evaluation came out just before Thanksgiving.

Jim Lee: Yes. So, there we are. That is a good source of information as well. You know that was a rather rigorous study of the different care transition communities and you can see the variation in their success and the degree to which they varied.

Audience: My name is Patrick Killeen and I'm a volunteer with AARP. I'm on the Commission on Aging in the City of Alexandria, and we've already been named an "age-friendly" community by AARP nationally, and by the World Health Organization. We're now actively involved in taking this to the next level; we've got to keep going. Can't stop!

One of the things that I would be very interested in is where you get data and how you approach the population that's not covered by Medicare and Medicaid. That's a very definable subset of any community and certainly is in Alexandria. I worked in the "Family Care" program in Wisconsin 10 years ago, and we had a good model and we made it work and we saved money for the Medicaid population. The PACE program, of course, has led the way in combining Medicare and Medicaid payment for the dual eligibles. But then you get into the rest of the population—most of whom don't have long-term care insurance—but they have some resources. I'm not sure, can you even measure that well and build that into your model?

Jim Lee: That would be a particularly challenging population to identify. Maybe they're relying on a Community Health Center for their care; perhaps a Federally Qualified Health Center. Most of the people you're describing would be, I presume, uninsured, because if they're at that level of care they're unlikely to be employed with health insurance. They might be employed for different jobs but without health insurance. Or they may be relying on a state exchange for health insurance.

The challenge with this is that you'll find it's—you know, 8 here and 12 here, and that type of thing. And when you look for funds to get started most payers are much more interested in hearing, "Well, here's a group of 100 that I have." So that's one where I would look to a local community foundation or someone who could help you fund a small study—this doesn't need to be extensive—to get a sense of how are these people paying for the care they're getting, et cetera.

Audience: Have you been able to see anybody use their Affordable Care Act-mandated CHSRs as a way to get started, since that is already a convening body?

Anne Montgomery: You're going to have to define CHSR.

Audience: Oh, sorry. Community health survey results-the reports. The three-year annual for the region.

Anne Montgomery: I think that's a great place to start for many communities. We didn't actually start there, we sat down with actual healthcare providers, social services providers and created our own analyses of enrollment, target population and Medicare data, other sources of data around numbers—but however it is done, you should map your community's assets and that's a great place to start.

We want you guys to all do this and then come back to us, and say, "Yeah, this works." Or, "Well, we had somewhat different results," because it will differ depending on what community and what population you're talking about.

Jim Lee: Some communities have had varying and higher degrees of success when their nonprofit hospitals or health plans put together their reports to go beyond the usual focus populations. I care as much about maternal and child health as anyone else, but a report on babies and moms that of course is very attractive to many often doesn't get at the populations that, frankly cost \$40,000 to \$50,000 a year easily.

So I don't know the degree to which some states and others have been able to get a broader perspective on those reports. Unless the Area Agency on Aging is doing something, it's often very hard to find a good report on communities over age 60. I know when we approached our local health department because a community foundation was offering grants they said, "Well, that's just not the population we serve."

Audience: Is that the Healthy Population 2020 report you're referring to?

Jim Lee: This was a community foundation offering funds to study what are the needs of the existing uninsured population in those essentially age 60 and over. But because the CDC [Centers for Disease Control & Prevention] doesn't fund work on this population, the health department frankly just didn't care. Yes?

Audience: I have a technical definition question. How do the CHSRs differ from a nonprofit hospital's community benefit plan? Are they the same thing?

Audience: The woman in front of me is saying that the community health survey report is the evaluation that the nonprofit hospital does based upon their community benefit plan.

Okay, thanks.

Audience: Robert Jenkins with the National Cooperative Bank. I would be curious in the work that you've done with the communities you've engaged with, what are the resources that the communities need to pull together to provide the network of care that you all think should be

there that they just don't have, or can't find, or are not present and need to be developed? Is there any common thread across those communities?

Anne Montgomery: I think we've heard a lot of that today. It seems like we have a common theme developing and there needs to be IT infrastructure, there needs to be a way to measure what we're doing, measure our progress. Sometimes the measures are available and sometimes they're somewhat limited. Sometimes they don't exist.

I think those are good places to start: really making sure that you have ways to continuously evaluate what you're looking at, continuously evaluate the programs that have been implemented and work to improve feedback and communication structures—particularly for stakeholders that might not be particularly well-integrated going into this kind of an endeavor.

Jim Lee: I think of three things. One, on information technology: When Health Information Exchanges were established, they tended to focus on how do we integrate public health data and how do we integrate certain simple things like enrollment and payment. Now when you say, "I'd like a longitudinal care plan that follows this patient from care setting to care setting," many people say, "Whew, that's tough." So that's certainly an element of infrastructure that we need to work harder on. And how one pays for that, such that it is sustainable, is a challenge.

Secondly—and we heard a lot about this—is workforce. When the economy is particularly good—and this is the economist speaking—it's difficult to find somebody who wants to do a difficult job in healthcare or long term care for \$9.00 an hour when there are other jobs out there. So one needs a way of doing this that is long-term sustainable for the workforce.

And then lastly—no disrespect to any hospital chief financial officers—you need somebody who will go beyond, "How does this reduce my admissions and how much is a return going to hurt me?" Literally we have heard executives saying, "Yes, but my job is to make sure that hospital has maximum—if it's a nonprofit—net revenue," and not go any further. Because that's a difficult conversation to have, and what you need is a CEO and a board to say, "That is not our short-term, and that is not our long-term objective. We want to diversify our portfolio, understanding that a population that's aging is still going to need the hospital but in a very different way than 5, 10 years ago."

How a hospital can get through such a period, especially in a small, rural community, is very different than in, say, a university health system.

Anne Montgomery: Go ahead. Peter.

Audience: Peter Fitzgerald with the National PACE Association. And I just want to say a lot of the challenges that we're discussing are challenges that I think the PACE program has largely resolved. The issue has been really, how do we scale up the PACE program and how can more organizations

participate in it? There are some new opportunities for that as states increasingly look at capitated models for managed long-term services and supports and community-based providers become more comfortable with the idea of bearing risk, which many in the audience today have discussed.

I'm not sure everybody knows that the PACE model, originally coming out of San Francisco, came out of an aging center. It was founded by a social worker and a dentist, so it's really grounded in this broader view of what somebody's healthcare needs are and what allows them to live in the community. And there are two PACE organizations that are sponsored by Area Agencies on Aging. They're both in Virginia—they're in rural Virginia—where those Area Agencies on Aging saw a gap, a real lack of an effective model to help people age at home. So if you haven't taken a look at the PACE model in your Area Agency on Aging, I encourage you to do it.

To your point Jim, it is a sustainable model—it's a long-term sustainable model—and it's been replicated and proven its ability to do that. There are also seven PACE organizations that are sponsored and run by Community Health Centers. So it is a model for community-based organizations that are interested in integrative financing, bringing the resources together so that you can bring the care together. It's structured to do that. I think that it's a good fit for the intervention you would need to achieve the savings that are in your financial model.

Jim Lee: That's an excellent point, and thank you for raising it. In fact the first place that we're doing a full demonstration is with a PACE program in Michigan, and I have been pleasantly surprised at their financial savvy combined with how well they can operate efficiently in a care model that is ripe for expansion. It needs to be modulated—you know, these are not things that you franchise out like a fast-food restaurant—yet you're absolutely right. So we are working with CMS and the State of Michigan Medicaid program to address some of the regulatory irregularities in regard to Medicare Part D and a few other things, so that those programs can serve a broader population. In this Administration when you go in and say, "All I need is some deregulation; I don't need funding," people will listen.

Anne Montgomery: Okay, one more question.

Audience: Ditto on the PACE program. One issue, Jim, and I think you briefly alluded to it, which really has not been addressed here is the future of the long-term care workforce.

We know today that the population is getting older and all of that. We know what the resources are going to be out there. But when I was running one of those pilot programs under Family Care in Wisconsin—we were one of the programs for Medicaid and we were funded on a per capita basis and we had a lot of flexibility in what we could do, including how much we paid providers—I had nursing homes, home healthcare agencies coming and begging me, "Could you pay us more? We cannot attract and retain the workforce that we need." That was 10 years ago. Since then, the increasingly elderly population has been growing. In the meantime, Medicaid is being driven by

long-term care. Medicaid is squeezing out other needs like infrastructure and education in state budgets. I don't think anybody wants to raise taxes—not anybody who wants to run for office these days. I call this the perfect storm.

Are you at least measuring what this might do and offer thoughts of how this fits in to the overall conceptual scheme? Thank you.

Anne Montgomery: That's a great question and we have some workforce experts in the room like Daniel Wilson right here at PHI in the front row. We do need to shift to a workforce that's much more focused on long-term care, there's no doubt about it—community-based long-term care. That's what we're talking about in large measure here, and we have to pay more attention to what that workforce looks like in a given area.

Is it adequate? Is it not adequate? And if it isn't adequate then how do we move things around so that we have more home health aides or more personal care aides? This is not an easy thing to do on a population health basis but essentially the model that we've laid out here starts down that road. It asks you to look beyond the HMO or beyond a single provider entity and look at the entire population and its needs—map your community assets, see where the gaps are—and when you do, you will find that there are lots of gaps.

To Robert's point, there are waiting lists for all kinds of services on the social supports and services side of the house, and those are the things that we have to reconcile. Fortunately there is a huge spend on the medical side, which is what we were trying to point out in financial simulation. We're medicalizing a lot of the social supports and services needs that an older population has, by seeing them in and out of the hospital over and over again, or prematurely placing them in long-stay nursing homes when they don't necessarily need to be there. So if we can capture some of those savings and reallocate them, it's to the benefit of the community and the population that lives there. And so that's the main message that we have. That doesn't fully answer your question, but we hope this tool is useful in helping you figure out how to do this work in your own area.

Jim Lee: Just real quickly, and this is a minor political statement—but the number one thing I think we can do to help the workforce is reduce our reliance on employer-based health insurance. It's very difficult to consider hiring somebody if you know that it's potentially \$10 to \$12 an hour just for the health insurance that they're purchasing. And while it's difficult to raise taxes in this environment, if you go talk to an employer about how, if we could reduce your healthcare costs by \$8 an hour in exchange for Medicaid expansion, some of them might actually listen. So, that's my political statement for the day.

Anne Montgomery: Thank you all. And thank you to Jim and Oona.

Where Can Communities Go to Find Some Money to Get Started?

Sarah Slocum: I see our next panel is assembling, so we're excited to keep forging ahead here. So we have now arrived at the point where we have hopefully convinced you that it is entirely possible to build a community elder care system, that there are lots of great reasons to do this and that there are programs to help, experts to assist and a way to model it all out financially. We've come to the part where we're going to hear about where you can go to get some funding to stand up such a system. For this we are turning to some of the best and brightest people anywhere—who not only know and understand financing, how to raise money for growing networks and operations and IT and more—but who also love communities.

I'm going to briefly introduce each panelist and then I'll start each of you off with a question and then from there we'll go on into our continuing discussion. First we'll be hearing from Robert Jenkins, Senior Vice President and Director of Social Impact Initiatives at National Cooperative Bank here in Washington, DC. Robert is a long-term care expert, having led the Greenhouse Project for NCB Capital Impact for some years. Greenhouse is an innovative skilled nursing facility based project that's now expanding into other venues—a very exciting piece of work in long-term care—and he's an expert in assisted living and community development.

Karen Kali is an operations specialist at the National Community Reinvestment Coalition, and she focuses on affordable housing, which we've been hearing about earlier today, and community development. She also did a stint at the NCB Capital Impact, the Center for Community Change, and led the Reinvestment Coalition's "National Neighbors Silver Campaign," which we look forward to hearing about.

Sandy Atkins comes to us from Partners in Care Foundation in California, where she is a Vice President of Strategic Initiatives. Sandy has worked at Partners for 13 years, and for those of you who follow the transformation of Area Agencies on Aging, you know that Partners is leading the charge to create networks of service providers in multiple communities. I highly recommend taking a look at their website, it's very inspiring. Thank you Sandy.

And we have Abigail Suarez, a senior business development officer at Capital Impact Partners. Abby knows everything we all want to know about loans and business development, and she's an expert on community development projects, including those that improve the quality of life for low-income communities. So we're hoping that Abby will say a word or two about the "Age Strong" project.

So Robert, first let's open with you. It would be great for this audience—and for me personally—to hear more about financial programs you run and how you approach thinking about how to lend as we move into financing of all these different types of arrangements we've been talking about. Hearing about how you approach this at National Cooperative Bank would be tremendous. It would also be great to have you reflect on what you've heard today so far in discussions we've been having and some of the threads that you may think are important to draw out. So, that was a big, long question, but go for it Robert.

Robert Jenkins

Senior Vice President and Director of Social Impact Initiatives, National Cooperative Bank

Robert Jenkins: Well great, thank you. And, thanks to everyone for being here today. I think the only way we'll solve these issues are to think about it together.

So what I'd like to do quickly is just give a little bit of an overview of how financing is generally approached, particularly for projects that serve low-income people, low income communities. That's the role for a mission-focused bank like the National Cooperative Bank where I work, the role for CDFIs [community development financial institutions] where Abby works, the role of foundations and other financing initiatives, reinvestment initiatives, et cetera.

To get to scale, my career has been mostly around trying to help models that serve low-income communities get to scale—so new models, expansions of models. In my opinion, the very best way to help those models to get to scale is to utilize the current and conventional financing systems. We have those systems in place; they're very prevalent, and they have plenty of capital. The challenge is, of course, that many of the programs and the models that we care about are either underfunded or not funded, or they're new enough that they're considered higher risk. So within the efforts to get new projects or expansions off the ground you really need a coalition of many pieces. You need foundations to take some of the risk in financing and starting up new organizations. You need non-traditional lenders, such as community development financial institutions and others to pick up the riskier pieces of the projects—either the earlier stages, or perhaps the part of the project that's not covered easily through some of the regulated institutions that adhere to typical ratios around loan to value and debt coverage ratios.

And then you very much need willing conventional banks—conventional commercial banks—because they have the resources to do the majority of the lending that they consider to be the safer lending.

So this panel—and we'll each get a chance to weigh in on our piece of it—will really talk about what are our roles, and how can we work together? But the thing I think I would like to say first and

foremost is we don't have all the answers and we don't have all the answers to the new models. To get to those answers, I think we all have to sit down as stakeholders—including the banks.

I think the banks and lenders are often not at the table with those promoting new models. Together we have to figure out what do the reimbursement streams need to look like? At what level do they have to be? If they are at a level that's too low to fund through a conventional approach, who will pick up the additional pieces? Are there enough foundation dollars to do that? Are there enough charitable dollars in the community to fill the gaps? Are there other ways to approach that through government guarantee programs? Can we use some of the existing guarantee programs? Do we need new programs? Or can we use some of the programs that—I'm sure Abby will touch on this—like the New Markets tax credit programs and the low-income housing tax credit programs that bring in a sort of private/public partnership?

To speak specifically about the work that the National Cooperative Bank does in this area, my role is to help bring gaps in access to financing to the attention of the bank, and to work with all of the different aspects of a traditional bank, including the credit officers, including the leadership, including the social impact pieces, to identify what we can do and how much we can do as a regulated commercial bank to bring innovative models to the fore.

A good example is a partnership we have with Peter and the National PACE Association. We have thought very highly of the PACE program—Program for All-Inclusive Care for the Elderly—for many, many years. And we've wondered why it hasn't been able to grow faster. One of the issues that Peter and Shawn Bloom and others involved with PACE identified is that for many organizations, it's very hard to get access to capital for a model that is perceived to have additional risk because of the capitated payment. Many PACE programs have been self-funded, with many funded by organizations that started them out of their resources. But if you really want to get to scale you need to get lenders to use their lending for PACE programs.

And so we have worked with Peter and Shawn for the last several years to work with their members who wanted to start or expand PACE programs to get our credit committee very familiar with the model, and to show approaches on how you can lend to those programs.

I think that type of partnership—in addition to having the providers, the national associations, and the regulators on board are really what we need moving forward to craft lending financing programs that work for each new model. Each will need to be slightly different.

So NCB's role—the National Cooperative Bank's role in this—is to invest the time and energy because of our mission to try to sort out some of those pieces, to help establish the lending market and then hopefully to exit that market once traditional commercial banks are willing to fill our role in that.

So let me stop there and others will talk about the other elements between foundations and non-traditional lenders.

Sarah Slocum: Okay, excellent. I'm going to go to Karen next. Karen, if you could talk some about your outstanding report called *Staying at Home: The Role of Financial Services in Promoting Aging and Community*. One of the striking things in that report is that it notes "There are often numerous barriers and threats to aging in community because many communities lack a comprehensive community model." Could you talk some about those threats that you see, and how banks and financial institutions can be partners with communities?

Karen Kali

Operations Specialist, National Community Reinvestment Coalition

[View presentation slide: [Karen Kali slide \(PPTX\)](#)]

Karen Kali: Definitely. I do actually have a copy of the paper. It's available online—I brought a couple copies with me that I'm happy to hand out afterwards, but it's available online, and I'm happy to send the link. This is a paper that I wrote with Robert Zdenek in 2016 and which was published by the San Francisco Federal Reserve Bank. What you're seeing up here is actually our model of aging and community. I should step back and say NCRC stands for the National Community Reinvestment Coalition; we've been around for about 25 years. We're a grassroots membership organization and we focus on creating opportunities to build wealth for all people.

Under the umbrella of NCRC is the National "Neighbor Silver" program that specifically focuses on economic security of older adults. We were launched about six-and-a-half years ago, and our main project at the time was, and still is, age-friendly banking. Within age-friendly banking there are six principles. One of those principles is aging and community: Specifically, how can banks and financial institutions facilitate aging and community? What is their role in ensuring that older adults can age well in the community that they choose to be in?

This focus on aging and community stems from our age-friendly banking work. When we started thinking about aging and community a couple of years ago, we particularly wanted to be able to provide thought leadership and support for our local partners on the ground that are doing this work. We wanted to take a look at some of the prevailing models around aging and community.

What we found was the models were great, but they focused on things like housing and transportation, health services—all important, all really relevant to the aging and community model. However, we thought when you want to be completely comprehensive, when you want to be able to, as a local CBO [community-based organization] to create a coalition or a task force within your community that focuses on the various issues within aging and community, you've got to have a lot of partners to bring to the table. You don't want to forget your banks and financial

institutions as well as in-home and physical supports, the housing and the transportation and the healthcare—all of those great things.

Our focus is on banks and financial institutions. Today I particularly wanted to talk about one of the partners that we focused on in the publication. And that's ESOP, which stands for Empowering and Strengthening Ohio's People—they're based in Cleveland, Ohio. They actually just merged with the Benjamin Rose Institute of Aging out in Cleveland. Both are fabulous organizations. When the foreclosure crisis happened decade ago, one of the things that ESOP found was that a number of their older adults were losing their homes or their homes were being foreclosed on because of simple things like property tax delinquency. These are a missed bill of perhaps \$500, a very minimal amount of money. It's an unfortunate circumstance to see an older adult who's owned their home for X number of years to then lose it to such a small amount of money.

Research also suggests that cognitive decline often begins around age 60 average, that doesn't mean everyone of course, but one of the first things that is affected is your ability to manage your finances and understand your finances.

So in 2015, ESOP partnered with Third Federal Savings and Loan. They were able to provide \$200,000 in working capital. They had also partnered with United Community Credit Union. ESOP's role is to provide outreach underwriting in the context of mandatory financial counseling to perspective borrowers. They also offer free financial services to address the problems that cause tax delinquency in the first place. The size of the loans range from anything as small as \$500 up to about \$6500. They've provided so far 23 loans, and financial counseling is also part of the process. It's a revolving loan fund, which means when it's repaid, the money just goes on in, circles around and is available to help other older adults who need that support as well.

As a direct result of the program and the enhanced collaboration, the county made it easier for older adults with delinquent property taxes to potentially enter into zero percent interest repayment plans via the county's already existing delinquency tax repayment plan. Additionally, the county committed funds to housing counseling agencies, specifically around real estate tax counseling. It was the first time that they'd done that, and funding for that comes from delinquency collections.

ESOP is a great example of a local organization that just reaches out and partners as best they can. In exciting news, they're in the process right now of expanding that small dollar loan program to home modification specifically. As part of the expansion they're looking to other banks and financial institutions in the area, and hoping that they can add some funds to their pool from them as well. They're also exploring the possibility of layering grant money. So, possibly if you have an older adult who has not missed a payment in X number of years—say, two years—then they may be

able to forgive a portion of the balance. This shows that a lot of really great things are going on with our local partners. It is one example.

Sarah Slocum: Excellent. Thank you very much. Next we'll go to Sandy at Partners in Care. You've done a wondrous job and we also want to acknowledge your colleague and CEO June Simmons, who is an incredible force in the world of community service delivery. You all have been working to develop a powerful network in the State of California. Can you give us a sense of some of the challenges and barriers that you've overcome or that you're still working on? Within that realm. Can you reflect on the role that finding funds plays in all this? Foundation grants and other sources of funding that you've tapped into along the way and your observations on that.

Sandy Atkins

Vice President, Strategic Initiatives, Partners in Care Foundation

Abigail Suarez: Wonderful. So just a tiny little bit of background: Partners in Care Foundation evolved out of the sale of the Visiting Nurse Association of Los Angeles. And lest you think that the "foundation" part means we have money, the total conversion fund was \$80,000 and pension liability for about a thousand nurses. So we're definitely money seekers and not money givers.

Occasionally, I've been accused when talking about business acumen and contracting and money, that it sounds like we're losing sight of people. And I consider it a great sign of success that actually at one talk that I gave, it was a doctor who said "it sounds like you're over-medicalizing social services," and so I was like, "Yes. We have arrived. Totally."

What we've been doing, like a lot of the other talks today, is thinking about and working on systemic approaches. I also have to say that everything we do is sort of responsive: We see a need, we fill a need. But everything we do is also in the service of a larger vision of integration—more virtual integration, because I know for sure California is not ready for full integration of Medicare, Medicaid, private funding, long-term services and supports, medical care and home and community-based services; it's just not ready. We do everything we can to create virtual integration around any population in need.

So when we talk about aging, it's not just a Medicaid problem, it's not only a rich people problem, and it's not only a middle-income problems. Everybody has the same challenges. So we believe that by opening up beyond just Medicaid, we can serve a lot of people who are otherwise left completely out. That's why we want to work with health plans and physician groups—because they have direct contact with the people that we want to serve. In order to get there, we have to talk about the business case, the return on investment and all of that, and get to a point where we have enough support to do that.

Our history with doing that started around 2010. What happened in California was that the aged and blind, disabled or seniors and persons with disabilities—depending on how you name that group—were finally mandated into Medicaid. Then you had managed care. All of these managed care plans who'd been serving women and children suddenly had seniors and persons with disabilities, and they didn't know what they were doing. Luckily, we had a contact, and we started partnering with some of the Medicaid health plans to help them make that transition using a Health Risk Assessment tool. We started helping them, using the Health Risk Assessment, actually find people—because in Medicaid finding folks is one of the most difficult things. People change cell phones, use throw-away phones, all of that kind of thing. So we had to chase them down.

Then we moved into care transitions, because we saw that need and we had a health plan that really wanted to improve their readmission rate and decrease what they were spending on that. We did some measurement on that. Every time we have the opportunity, we try to measure so that we can say to the next partner, "We reduced readmissions in this Medicaid population by 24 percent," which is about what I think it was.

Then the Community-based Care Transitions Program opportunity came along, and we wound up with three contracts for three different sub-geographies. But you know, the scale of California is hard to imagine: There are more dual-eligibles in LA County than there are seniors in New England.

We got involved with all kinds of health care organizations, we recruited healthcare people onto our board, and we developed contracts one by one for a needed service for a needed population. And it turns out that everybody has a pain point—a hospital's pain point is completely different from that of another organization. For example, a hospital winds up with people with mental health conditions that need to be discharged. But they can't get out of the hospital because they don't have a home.

Regarding Medicaid, a Medicaid waiver pays for stuff that Medicaid doesn't usually pay for in order to help somebody remain at home or return home after they've been in an institution. Things like a mattress if you're incontinent, an air conditioner if you're hot—services that wrap around the person. Health plans don't know what a waiver is, so we took it and split it up into little pieces. We do an intake, we do an assessment, we put together a care plan, and then while we're in the home we look at advanced directives. We look at all of these different things—not just the medical things that a physician group or a health plan would look at. We split it all up, made it a menu of services, and then that helped translate –we wanted risk tiers—so then we did risk tiers to show how this could be reconstructed in different ways for different payers.

We did this in a lot of our contracts. We had a wonderful huge grant from the John A. Hartford Foundation to do our local work, and then to bring that local work to the rest of the country. They

were matched by the Archstone Foundation and the Parsons Foundation. We had local funders and a big national grant to support the infrastructure work.

Then we were talking to our fellow community agencies about how we need a network so that we can—these are huge health plans and huge geographies and nobody can do it all—we need each other to accomplish this. And everybody that was doing that was participating in the Community-Based Care Transitions Program in southern California. So we started talking about how we could do things together. Lo and behold, soon we had a contract with Blue Shield of California, and we became a network. We were talking and working out details right up until there was a contract. And I think it's important to know that you can plan a lot, but I think it was John Lennon who said, "Life's what happens while you're busy planning." So we were doing the planning, but then suddenly we had a contract and we just had to work on it.

It's a wonderful honor to have Blue Shield of California, which has 2 million members, say, "We want services." So we put together the network and boy, did we have lessons learned. First of all, you never give a health plan or a physician group a price until you see their contract. We had to triple our insurance, we had to get IT infrastructure that we never had before, and we had to pay an outside company to do patient satisfaction surveys: We had a lot of infrastructure work to do. Luckily, we had a grant that we could call upon. Then they said, "Oh, and the Department of Managed Health Care in California says you have to be NCQA [National Committee for Quality Assurance]-accredited in order for us to delegate to you."

So that cost us about \$66,000 to get the NCQA health plan complex case management accreditation. Again, luckily we had a grant. But if other funding mechanisms were available, that would be wonderful, because you could say, "What are the barriers? What do you need to buy in order to get started?" Instead, we built it a piece at a time.

We had one contract that paid us the first three months up front, so that we had a drawdown fund for staff and software. There's all kinds of expenses to get your organization ready for contracting in general, and then we had other expenses to get ready for this particular contract. Each contract has a cost, and the organization readiness and going through culture changing and all of that has an impact.

When we did CCTP with the hospitals in the Bakersfield /Kern County area, they actually each contributed to a fund to help us start up. It was a loan, and when the program was over we said, "We think it would be good if you convert your loan into a donation and we'll continue to provide these services when CMS withdraws them." That's what happened.

We basically have had to be creative problem solvers. Sometimes I hear people talk about out-of-the-box thinking: I don't even know what a box looks like, you know? That's pretty much what I have to say. Thank you.

Sarah Slocum: I think that's actually a great context for the next question which is going to be for Abby. It's amazing listening to the creativity and the ebb and flow that communities and community organizations by necessity have to go through as they're growing and developing. As an experienced loan officer there must be a set of criteria that you're thinking of, and that you start from, when you're looking at an organization, or a partnership of organizations, that have come together in some configuration—whether it's an LLC or a taxable nonprofit or a 501(c)(3). But can you tell us something about what you're looking for in terms of financial stability within this whole world of evolution and growth and how you assess that? If an organization is found somehow wanting in an area, what are some key pieces that you typically see and how do you help fix those?

Abigail Suarez

Business Development Officer, Capital Impact Partners

Abigail Suarez: Sure. Just to give a brief background, Capital Impact Partners is a mission-driven lender. We care about addressing systemic poverty, building equitable opportunities, creating healthy communities, and ensuring inclusive growth. We see our investments around sectors. Healthcare is by far our biggest investment. We've invested about \$800 million in Federally Qualified Health Centers across the United States. We also work in housing. We work in healthy foods and we work in education, targeting those social determinants of health from an investment perspective.

We have two cross-sector initiatives: One is a place-based strategy in Detroit, and the other one is the "Age Strong" Fund which I can elaborate a little bit on. We have a history of working in the aging field and, trying to help communities and seniors age in place. I think three out of the four panelists here today have passed through Capital Impact Partners at some point, so that just sort of highlights our commitment.

One of the interesting things I do now is that I help manage the "Age Strong" Fund. Investors are the AARP Foundation and Calvert Foundation, and we also provide some of the support and capital. For the past two years, I've been really in charge of finding projects that would fit the fund's mission, and make investments across those sectors.

We've been extremely successful. We've made investments in every single one of the sectors. We did that in the first year, and they all look very different. We've used different tools too. Robert mentioned the New Market Tax Credit Program—we don't have nearly enough time for me to talk about that—but it's a wonderful tool that has helped us to be very innovative in this program.

We've worked with PACE programs. For example, using New Market Tax Credits, we've worked with Federally Qualified Health Centers that have a high population of seniors. Generally what

we're looking for is—I love Connie's approach and what she said—is that we need integrated care with integrated resources. That's really what the goal is; we see ourselves as looking at programs that are starting, that might not have all of those integrated resources and that are sort of putting them together. Because we're mission-driven, we're more flexible about how we look at things. We call it a transactional project or an organization—and we try to be very creative around what solutions we have. Does the organization need to go into debt? We like making those connections. One of the big things that we see is how, for example—I speak with Federally Qualified Health Centers a ton, and when I'm talking around aging my number one message to them is, "Work with your CBOs. Work on prevention. Let's get everybody supportive services before you need to get to a place where you need long-term care."

We usually typically work with organizations that have at least a three-year track record. We've done projects and funded initiatives that are more startup, but usually they're backed by an organization that has a [financial track] record. But we're very comfortable with different sources of funding, which I think is what makes us a good partner.

Sarah Slocum: Thank you all. So for any of the panelists—picking up on the comment about the fact that some projects and partnerships are more at a beginning stage, and some are sort of piggybacking onto a more established structure, like a PACE organization or a Federally Qualified Health Center, or some other type of provider—perhaps a senior center or even a housing provider—what do you advise for a community that's just starting to look at "how do we pull ourselves together and create an eldercare community?"

Robert Jenkins: Two comments. One is we've just closed, or are about to close, on financing for a new PACE center. The sponsor is the county nursing home in the community. So it's a big, big step for the county nursing home, but as Abby said, they have a very significant track record as a successful operator within long-term care—we know they can manage Medicaid and Medicare reimbursements—so we were able to get comfortable with that. The PACE model has very high startup costs, which you don't start to earn back until well into the second or the third year, typically. But then you have a very healthy operating margin and you can afford to pay back the debt.

So like Capital Impact Partners, we've been very interested in helping PACE programs get through that startup period with our financing so they can launch. And that's I think an example of what I was mentioning earlier about helping successful models scale. Once they've been proven, once we have a track record—as Abby says, we know it is an organization that has some capacity.

I also wanted to use Sandy's initiative as an example. So when I heard you talking about your startup and the funding that you receive from foundations, and now there is a desire to have that replicated in other communities, we would look at that and say: "We have the experience. Your

organization has the experience. We have the financials. We would trust and expect you to make projections for the next community." Based on those projections, if the margin was healthy enough to sustain, payments in, say, year two, three or four, and they could pay back the startup costs for years one and two, then we would be comfortable making a loan to them.

That's the role of financial institutions. You had to depend on foundations, government grants and other sources to get your model off the ground. But the sooner we can come in as a conventional lender, or Abby can come in as a community development financial institution, the further we can spread those very limited grant and public resources.

Abigail Suarez: That's exciting.

Abigail Suarez: The other thought is, I don't think that it's too early for [a startup] to engage a lender like Capital Impact Partners. If you're thinking about a strategy, if you're thinking that you have a model that you'd like to replicate: You never know whether, number one, maybe you are ready, and we can help walk you through that process; or two, because we are working nationwide, a lot of other people are talking to us—and another big part of what we do is make connections. So for example, it could happen that we used to talk to this person over here—and we know they're thinking about the same thing and this is how they've done it. This also allows me to engage your financial institutions—especially ones that are mission-driven, or have a long history of investing in this sector. I don't think it's too early.

Leveraging Action

Sarah Slocum: I think that's a perfect wrap-up for this extremely rich panel: There's so much expertise, I'd love to pick your brains for a really long time, but unfortunately we are at the end of our time. So I'd like us to thank this fabulous panel.

I have just a couple of things to say in closing, and first of all, I'd like us again to thank all of our panelists. We've had many fabulous experts talking with us today and so thank you so much to all our panelists.

They were very patient with us on all our timelines. And a special thank you to my superb colleague Anne Montgomery, who's really the driving force and pulled this conversation together. And I hope that Abby's last comment about staying connected and talking with each other is the thing that you leave here with, because that I think is one of the most valuable things out of this session—just meeting each other and staying in contact.

We've heard from community leaders, from federal government leaders, from some of our organizations that lead at the national level. We've heard about a financial simulation for a model called MediCaring Communities, we've heard about return on investment, and making sure that

you are looking at all possible realms, and getting educated about different ways to find financing that maybe nonprofits haven't had front-of-mind in the past.

We're hoping this pulls together for those of you who attended here in person, and on the web, and inspires you to really go forward at your community level and start building your eldercare community. We hope you will contact us. There's help, there are connections to be made. Altarum would love to hear from you about starting up a MediCaring Community and working with you to keep that going.

There is also a resource pod for this Symposium that you are invited to please go and look at, the recording of the session will be available later in December [2017] on the website, along with an edited transcript. With that, we thank you all and appreciate so much you spending your time with us.

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[Transcript finalized, January 2018]