Welcome and Purpose of Meeting

W. DAVID HELMS, PhD: Good morning. I'm David Helms. And this is my first official duty at this year's AcademyHealth Annual Research Meeting and that's to welcome you to "Building Bridges: Making a Difference in Long-Term Care."

And I'm going to, in one minute, introduce Karen Davis, but with a point of personal privilege, I would like to tell you that, when I was a young man thinking that I could provide the intellectual and planning assistance to help this country lead a national health system, I decided that I would write a dissertation on just how much ambulatory care this country would need. After all, Karen Davis was down there in Washington and, very soon, they would be passing a new national health plan.

So I was busy up there at the Maxwell School at Syracuse University trying to figure out just how much ambulatory care this country would need and I wandered into a local health planning agency to see if I could get data on the number of physicians and number of primary care services and I met a lifelong friend, Monsignor Charles

Fahey, and I just wanted to acknowledge this fellowship and to acknowledge his being with us today. [APPLAUSE] All of you know him as the leader he is in long-term care.

But, now, I'll introduce Karen Davis. She's president of the Commonwealth Fund, a nationally recognized economist, a distinguished career in public policy and research. She was chairman of the Department of Health Policy and Management at Johns Hopkins School of Public Health. She was, as I said, the assistant secretary for healthy policy in the Department of Health and Human Services, making her the first woman to head a public health service agency. And, of all of the honors that I could cite about Karen, I'm especially pleased this morning to say that AcademyHealth will be honoring Karen at this year's meeting with our distinguished investigator award.

So now I can introduce -- [APPLAUSE] Karen Davis as a truly distinguished investigator in health services research.

KAREN DAVIS: Well, thank you, David, for those lovely remarks and also for the award, which I'm looking forward to. But particular thanks to David and AcademyHealth for putting on this session today and, in fact, providing an opportunity for those of us with a passion for the issue of

long-term care to get together and learn from each other and share experiences.

As David mentioned, I'm trained as an economist and I used to go to the annual meeting that's at the American Economic Association and they exceeded about 10,000 people and one felt a little lost at those meetings. So, when what was known as AHSR met for the first time in Chicago with 300 people, I thought, "I have found my professional home. I have found a group of people, intimate, but sharing the same passions and same interest."

And then, under the leadership of Alice Hersh and David Helms, it grew and grew and grew. So it doesn't have the attendance of the American Economic Association, but it's several thousand. And so it is harder to find those who are sharing exactly one's interest, so to have an opportunity like today's session on long-term care, the others that are happening in other rooms on children's health services, state health policy, I think is a very important innovation in the AcademyHealth meetings and do provide an intimate gathering.

So, thanks to all of you for being here. Some of you weathered the weather from the East Coast to make it hear today. Others are still in route, I'm afraid, but it's

great to have you hear and particular thanks to Penny Feldman and to Peter Kemper and the planning committee for putting on what I think is going to be a great day today.

Secondly, I just wanted to thank a number of you for your help with the Commonwealth Fund's review of our program on the quality of care of frail elders. I know some of you undoubtedly got surveys or questions about the program. We did commission Health Policy Alternatives to conduct an independent review for our board, which we do with all of our programs every five or six years. So I thought I would just take a minute, for those of you involved in that process, to share the results.

The number-one conclusion was that we are fortunate to have stellar leadership of the program in Dr. Mary Jane Koren. [APPLAUSE] The review also felt that the fund occupies an important niche in funding research on quality of care of frail elders and that we should very much stay the course and continue with this important focus.

The one weakness or area they ask us to strengthen was to ramp up our dissemination efforts and to really make the whole issue of culture change, resident-centered care, quality of care for frail elders much more visible and the information much more known to particularly those in a

position to effect change, those in policy-making positions, those who are on the front lines of care really trying to provide services to this very important population group. So I think that means, Mary Jane, that we should continue our support of this colloquium as a wonderful opportunity to reach a number of people and bridge -- building bridges between the research community and those in a position to effect change.

Finally, I just wanted to share with you another activity of the Commonwealth Fund. A year ago, we established a commission on a high-performance health system. This is chaired by Dr. James Mongan, president and CEO of the Partners Healthcare System in Boston, but has many leaders from both the healthcare delivery, the research and policy worlds. The executive director is Dr. Steve Schoenbaum, our executive vice president. And, as the commission has met over the last years, they've decided that our basic goals for the health system and, therefore, for the commission are to ensure that all Americans have an opportunity for a healthy and productive life. And, to do that, we need to be simultaneously concerned with achieving better access, improved quality and greater efficiency and

that, to do that, we need to enhance the capacity of this health system to innovate and to continuously improve.

So one of our first efforts will be the release of a scorecard on the performance of the U.S. health system, Cathy Schoen, our senior vice president for research and evaluation, has spearheaded that effort. But, you know, it's the first year and we'll continue to do it and she has tried to pull together the data that we have, but I must say, particularly in the long-term care area but in other areas as well, we really still don't have all of the kinds of information we'd really like to look at the performance of the healthcare system.

Vince Mor has been wonderful at Brown at running us some very interesting data and a scorecard on variations in, for example, hospitalization rates of nursing home residents. And when you see, even at the state level, twofold variations in the rates of use of acute care among nursing home residents, you get a sense that we don't have kind of best practice everywhere. We have variable practice everywhere.

So a lot of the thrust of that scorecard work is to show that, if we can bring all parts of the U.S. up to the best-performing parts of the U.S., we could make

substantial gains on each of those dimensions of care. But, for this audience, particularly, to be thinking about how we improve measures on the different dimensions of quality, safety, effectiveness, coordination of care, patient-centered care, access affordability, that certainly, I think, will be very important to move that work forward.

Obviously, within the quality of care -- within the high-performance health system and the various dimensions, too, that are particularly relevant in long-term care are care coordination and patient-centered care. So we talked about patient-centered care, we talked about family-centered care, we talked about resident-centered care. At some point, we're going to have to talk about people-centered care. But how we can, in fact, have best practices that lead to greater dignity, greater responsiveness to what those needing care most prefer.

As part of that effort, Mary Jane is heading up a project to do a national survey of culture change in nursing homes, so we hope to have that kind of information that's input into future efforts of the commission.

We're also very interested in care coordination. I mentioned Vince Mor's work suggesting that there's

variability in how well acute and long-term care are coordinated, but we're very pleased to be supporting the world of Mary Naylor, who you'll hear from today, Eric Coleman and others looking generally at this issue of care coordination.

I met yesterday with folks at the Group Health Cooperative here in Seattle and it's so wonderful to see a model of care that has long believed in care coordination, but, you know, even within systems like that, they struggle to make sure that all of that is pulled together and best-serves their members. But I shared with them some early results of a poll that we've done on public views of health system performance and the theme that comes through from that survey, which we hope to release in a couple of weeks, is how much the American public wants better care coordination.

You know, high percents of them are struggling with coordinating care for a family member who requires long-term care and other services, but, in general, they want all -- someone in the healthcare system to know their entire health record and to have that information available to the people who are seeing them when they seek care. They're very interested in having direct access to that

information themselves. They're very interested in team approaches to care.

So, anyway, there's a lot of work coming, but I look forward to learning from today's very rich experience -- program that you have ahead of you and to learning from each of you ideas that we might try to move forward as part of our research agenda. Thank you. [APPLAUSE]

W. DAVID HELMS, PhD: Thank you and for the commitment of the Commonwealth Fund for this colloquium. It's not only, I think, moving research into policy and practice in the long-term care area, but it's helping to raise the visibility of this issue, so I do thank you and Mary Jane very much.

We've seen the vision of this sustained effort, as witnessed by greater involvement of AcademyHealth in the Long-Term Care Interest Group. Some of you were here just two or three years ago when the interest group started with 248 people and, last year in Boston by this time, we had 570. We now have 816 members of AcademyHealth who identify long-term care as their area of interest and, without this colloquium, giving visibility to this area of study, we wouldn't have this interest within the academy. So it's also bringing in a number of people who weren't members of

AcademyHealth and, if you're in the audience and you aren't, we'd also welcome you in the broader AcademyHealth family, but we're thrilled to have so many of you as interested as you are in participating in long-term care.

And, if you look in your program of research which will begin tomorrow, you'll see many more programs devoted to long-term care than have historically been in the AcademyHealth program. So I think this colloquium has stimulated interest here, but it's also spilling over into the interest of our general membership and in the program.

I want to thank publicly Peter Kemper and Penny Feldman who had the vision for making this colloquium and, of course, with the help of the Commonwealth Fund, we've been able to bring this into reality. I also want to thank AcademyHealth staff. These are the folks who do work behind the scenes to make a lot of what you see here visible and possible, but certainly it's been led by Debbie Rogal, Christal Stone, Cyanne Demchak, Amar Narula [?] and Kristine Metter who oversees membership in all of our interest-group activities.

So I think my next task is to introduce my friend, Penny, vice president for research and evaluation at the Visiting Nurse Service of New York and director of their

Center for Home Care Policy and Research. Prior to that, she served on the faculty at the Kennedy School of Government and the Department of Health Policy and Management at the Harvard School of Public Health. A friend and colleague and a great leader in this field of long-term care, Penny Feldman. [APPLAUSE]

PENNY FELDMAN, PhD: Thank you, David. Thank you, David, and thank you, Karen, and special thanks, really, to the Commonwealth Fund, not only for supporting this colloquium initiative, but for all of the wonderful work that you are doing in the areas of aging and long-term care and quality of care.

For those of you -- first of all, it's wonderful to see a lot of people here whom I know. And then, secondly, it's especially wonderful to see a lot of people here whom I don't know, because one of our purposes is, as David said, to really grow the group of people engaged in the kind of discussions in which we're going to be engaged today and in long-term work around long-term care.

For those of you who have not been here before, this is actually our third annual colloquium in -- sitting in the AcademyHealth Initiative. And our long-term care colloquia are not just a one-shot event, but part of a

longer-term initiative in which our aim is really to bring together researchers, policy-makers and practitioners and it's not only to move research into practice and policy, but it's also to really move practice and policy into research, because the research isn't going to be relevant and it isn't going to be meaningful and it isn't gonna be used if it's not more closely informed and better-informed by the people out there actually making policy and doing practice.

We've also had a number of spinoff workgroups from this initiative. Mary Jane Koren is going to tell you a bit more about them before lunch. Some of them met this morning before this meeting. This is all part of our effort and our aim to engage researchers, practitioners and policy-makers in lively, provocative and ultimately productive discussion that will move this field forward.

Our agenda today focuses on two critical issues for long-term care. One is the area of technology and aging services where new opportunities are emerging really daily and where there is so much we need to do to be able to take advantage of technology for the people, the patients, the family members, the consumers, the people who are touched by aging and long-term care. And the second area is

transitional care where, too, the whole range of people involved in aging and in helping their aged family members and their chronically ill friends and relatives and informal and formal providers are so deeply affected by transitional care that works or transitional care that, alas, often does not work.

We have two real visionaries here today who are going to be presenting their papers and we also have a wonderful group of commentators. So I know you're anxious to -- this is the third introduction; it's a little heavy on introductions, I do agree.

Our format is the morning is going to be spent on technology, the afternoon on transitions. And we're doing something which we did last year that worked extremely well. After our presenters and commentaries do their part, we are going to have facilitated discussions at each table, small-group discussion. And, based on that discussion, important points coming out of that are going to come back to the plenary group as a whole. That way, we found that everybody has an opportunity to really sort of thrash through the issues among a very small group and then we have an opportunity to bring them back to the larger group as a whole.

Not all of our facilitators made it. We were -- I'm amazed and delighted at how many people are here, because we had at least a half-dozen people whose flights never got off the ground last night from the East Coast.

Then, later this afternoon, at the very end, Peter Kemper, my co-chair, is going to do the wrap-up. So that's kind of how the day will unfold.

At lunchtime, we have posters and we have several videos and I'm sure you're gonna find the lunchtime opportunities interesting as well.

Technology and Aging Services

PENNY FELDMAN, PhD: One of the people who did not get off the ground last night was Vince Mor, who is our colleague at Brown University. But, fortunately, one of his colleagues was obviously on a different flight and so Eddie Miller, who is an assistant professor of public policy and political science and community health at Brown, is going to moderate our technology session.

Eddie received his PhD from the University of Michigan. I know he's got at least one other Michigan alum here. In political science and I know there are a couple of political scientists in the room; I'm one of them. Long

ago. And Eddie is going to moderate the discussion, so let me just turn it over to Eddie and to our speakers and now we're ready to get into the topic.

EDWARD ALAN MILLER, PhD, MPA: Okay. Thank you, Penny. So I'm Eddie Miller. I'm from Brown University and, as Penny informed you, I am not Vince Mor. I'm considerably shorter than Vince Mor. And not quite as active. But, see, he was detained, so I'm going to substitute for him for now.

And about this panel on aging and technology, this is a very important issue and one which is frequently overlooked in discussions of long-term care. Not only with respect to advanced therapeutic technology and the role of health information technology (say, EMRs or linkages between providers, hospitals and nursing homes and physicians), but also with respect to simple assisted devices and home adaptations and other modifications that enable people to live independently as long as possible.

At one extreme, I got to witness this myself, recently, with the care of my elderly grandmother. The other extreme, I am now on crutches, 'cause I broke my toe last night. And, coincidently enough, they actually gave me a handicapped-accessible hotel room before I broke my

toe, so they knew something was gonna happen, but I wish they had informed me.

But let me introduce our first -- our panelists, our speaker this morning. It's Russ Bodoff and Russell is executive director at the Center for Aging Services & Technologies, CAST and I'm just going to give the podium to him. [APPLAUSE]

RUSSELL BODOFF: Thank you, good morning. Pleasure to be with you here today and a special thanks, I think, to Commonwealth Fund for concentrating on technology this morning, 'cause I think it's such a critical area in the field that we need to look at.

Now, let's just get set up here. Okay.

I think most of us would agree that we have real problems in healthcare in our country today and, with those problems and the aging of our population today, it's probably the aging of our population, in many ways, that'll bring our healthcare system to its knees. And that gives the opportunity for the folks in the long-term care field to really be leaders in how we're gonna provide care differently in the future, how we have to and really set models and best practices that will lead to changes in our entire healthcare system.

So when we look at why are we concerned. Well, right now, healthcare in this country and the slide showing 15, it's actually up to 16% of our gross domestic product right now is being spent on healthcare and most economists will say that you cannot get past 15% and maintain a healthy economy. We're already doing that and projections are, over the next twenty to thirty years, that we'll be at 30 to 50% of our gross domestic product on healthcare, if we do not change. So there's no way that we cannot, we must.

And then we know -- we all heard, about six weeks ago, where Medicare and Medicaid are saying that they'll be bankrupt by 2018 and 60% of our healthcare dollars in this country flow through those organizations. So the problems are certainly in front of us and then add to that projected staff shortages, as we have a -- decreases in our younger population and increasing Boomers demand and what you have in front of us is really a perfect storm.

So we really believe now is the time for significant change and while Boomers will be a disruptive demography, they have been -- I mean, I'm one of the early Boomers and we started when we went to school and we changed everything. You know, we majored in protest and sit-ins and I don't think we've changed since then in changing the

way society has really functioned. And it's a very demanding generation, I think much more demanding than the population that we're serving currently in the aging field.

And then, with that, we finally have ubiquity taking place and that's the convergence of computing communication devices, something that's been promised for twenty years, but it's finally starting to happen and that's what makes it so exciting when we look at what the capabilities can be. And we see the development, a lot of it right now, around entertainment, but it's gonna be very useful for healthcare. Digital homes, expansion of broadband, although I have to say that we are way behind other countries. In the United States, we're still not at 50% of our homes on broadband. And, if you look at Japan and South Korea, you have over 75% of homes with broadband that's about eight times faster than what we offer here.

Wireless is expanding and what is exciting is a new wireless format, WiMAX, which is just being coming available. And it really becomes important, in the long-term care field on our campuses, where we can now go from hundreds of feet to ten miles, twenty miles and eventually forty miles over the next two years with wireless. So new capabilities are coming -- becoming available.

But this is the point I'll start getting a little more controversial and we'll say we've invested most of our money in the United States in what we would call mainframe hospitals and mainframe facilities. You know, we take care of people very well when we have 'em in a building. We don't do a very good job in this country before people get sick and, if we send 'em to a hospital, once they get out of the hospital, taking care of them.

And what technology really offers us is really exciting opportunities for early detecting of problems and disease and just some examples. We participated at the major tech demo at the White House Conference on Aging in December and we were showing some fairly simple technology with floor-based sensoring systems that could potentially pick up early signs of Alzhei- -- I'm sorry, of Parkinson's disease ten years before a physician could, just by changes in gait in early -- but, so you really start thinking about early detection and such.

And then promoting healthy and behavior or wellness, something that we don't do very good in our society right now. The ability to really provide different levels of support to family members and caregiver who provide really the abundance of care in this country is really exciting.

And maybe most important is we need to empower the consumer and we don't in our healthcare system right now and consumers need the information and the ability to make their own decisions.

So if this comes together in what we believe can really happen, we really believe we have the opportunity to improve quality of care and lower cost. So if we get away from our mainframe hospital-type model or institutional model, this is what we talk about as a model as a future center of care.

Now, we use the term a lot, "home-based care," and not to scare people when we say everything's gonna happen in somebody's home. When we describe home, we believe that is a place where a person wants to be and that may be their own home, it could be an independent living facility, it could be an assisted living, it could be housing. It's where the person wants to be, but we really believe that, with technology and digital infrastructure, that we can really have a system where we can have technologies that promote health and wellness activities, provide for remote diagnosis, virtual physician visits and really set up new types of networks of communication between family and friends and caregivers. And, actually, a lot of the

technology being developed for other products and services, particularly entertainment, really give us the opportunity to jump-start in this area.

So I've been told not to talk too much about technology, but just to give you a sense of why this becomes so important and the possibilities are so evident is basically almost everything that we're dealing with now that's electrical has a chip in it and that chip has a radio in it and that chip can send signals. And once you've got -- and you can look at all those appliances that we're all aware of on the bottom sending signals, but add to that your appliances in the kitchen, your alarm clock, your light switches, almost anything electrical in the house, with the ability to send information and the ability to capture that information, you start seeing how a network of information can be developed. And we're really moving and most of the major technology labs and big computer companies are really moving away from the concept of having to go to a computer to type in information and it's a concept of proactive computing and that computers or computer chips will be where you go -- or what -- and they'll pick up what you do.

And what makes a lot of this possible and exciting is the development of sensoring technologies and, in that picture there, what you're seeing are some examples of sensoring systems and actually that little round thing, which is the size of a quarter is probably the most up-to-date one and that's power of significant computers, right? In those little sensoring devices and cost and mass-produce, you can get those down, right now, to about $15 each and probably, as markets develop, even greater.

And then, way over here on the left, those little silver square things are RFID tags and you start hearing about them a lot in the newspaper, 'cause they're using them to track inventory and those things can be made available for pennies, basically, and they're pretty dumb things. They send out signals, but, again, the ability now to start using RFID tags and various sensoring devices to collect information and add to that the development of software, intelligent software that not only allows you to collect information and see what happens, so collect information, see an older adult has fallen, you can respond. But the development of intelligent software that allows you to make projections, so you're getting information that the trend says that person is going to

fall or may fall and give you that information. And that's what really gets exciting, the development of more intelligent sensors and then much more in the development of the software that can make those kind of projections.

So I don't have time to go into all these technologies, but a -- just to give you, you know, some examples and everything from a remote pill-dispensing device that's portable to new type of communications. There's a lot of work in robotics, particularly in Japan. I don't think that's something we're gonna see cost-effectively for many years. Here, telehealth-type activities. Even way over on the right there is what you see is intelligent cooking appliances, which are actually out there right now where there are little RFID tags and recipe books in the pot and in the stove, basically cooking automatically. And the question is pulling a lot of this stuff together into networks that can really help people.

So, to better understand, I think, what the next generation that we're gonna treat really wanted, we did a series of focus groups around the country last year. We did ten sessions in five cities and the only requirement that we had were that the people had to have been exposed to being caregivers for an older adult and that they were

familiar with a PC and a cellphone. We thought basic technology. And we tried to do it in different areas of the country to pick up different types of populations.

And I don't think there were great surprises when you look at what Boomers are most concerned about. Finances, most affluent cohort we have ever seen, but only 25% of Boomers have enough money put away for their retirement. Maintaining health and independence, critical.

What was very interesting, though, was repeated over and over again is that the Boomers felt that their parents sorta had an impression that they would take care of them. That there was a burden placed on them that they never want to place on their own children. That was repeated over and over again and I think that's important.

And, of course, many of the folks said, you know, they would like to stay as independent as they could in their own homes, not having to look at institutional settings.

As a caregiver, their largest concern or the kind of things that really eat up time, transportation. Over and over again, people having to leave work, drive a relative to a doctor, drive to do shopping for 'em, things like that. Trying to maintain social connectedness for the older adult and that meant, to them, in many cases, having

to be there almost every day. And, in our survey, the average time that the individual said that they had to spend on elder care was two hours a day. Some people even more of that and, obviously, two hours every single day really eats into your lifestyle.

Access to information. Many of 'em talked about how their -- the older adult that they would be caring for would go to a doctor. Of course, they didn't understand anything the doctor told 'em once they came out and the person who's responsible for caring for 'em had no idea, then, what medications and what treatment, 'cause they had no access to information. And then the realtime issue of not knowing how that person is doing, particularly if you live distance.

So -- and I have to say that, when we started talking to folks about technology, they had no understa- -- no concept of what we were talking about and what these technologies could be. I mean, that's very similar to members of Congress when we talk to them as well.

But what we did was show pictures, we showed video and, once they started things, the discussions really changed. So, number one, what they were more interested in seeing were products that would help them monitor and --

using sensing devices to know how their parents or relatives were doing, particularly if the parent allowed it to have some sort of visual-audio contact. They're very big on the idea of personal health devices, some way of getting access to the information, controlling information so you can know what you have to do for a particular person.

Telehealth, telemedicine was obviously a key area. The ability to monitor these diseases and, hopefully, to be able to monitor body functions without having to drive the person to the physician. So, frequently, peace of mind, obviously, would be important.

I don't think it was any surprise, they said technology has to be easy to use. Basically, you can't expect an older person to really be doing much. It's gotta run on is own and that we had to be assured that we didn't remove personal touch. That technology should never replace human touch and, if we do that, we are really failing in that area.

Now, I think one of the major differences that we saw was when we talked about "What are you willing to pay for?" and I think this is a big change that we'll all see in the Boomer generation. And without knowing that much about the

technologies themselves but knowing -- trying to address the problems that they face as caregivers, 90% of the folks said that they would pay at least $50 a month for something. Over 50% indicated they would spend over $100 a month. Many of 'em looked at it as what you pay for your cable TV, your telephone. As a service that they could provide -- or they can gain. It would just be worth anything.

And what was really interesting (and I think was surprising to me as well) is that, when we had people in the lowest income levels participating, they were the ones most willing to spend money, 'cause those are the ones who could least afford to leave their jobs to go take care of the older relative. Those are the folks who don't get time off. They'll lose jobs and things like that.

So that -- I think that really does reflect a significant change, 'cause Forrester Research had done surveys of older adults of the current generation and there was really very little willingness to spend money on technology. And, following our surveys, Forrester did another set of focus groups which almost matched identical to the data that we came up with.

So let me just say who we are, CAST. CAST was set up just about 3 1/2 years ago as sort of this virtual environment to bring a lot of people together, looking at this aging problem that we face and trying to say, "Is there technology solutions?" And, from the point where we started with just a concept 3 1/2 years ago, we're about 400 organizations and I think the largest effort in the world right now trying to drive technologies to help older populations.

And what we are trying to do is help industry, which is absolutely critical, understand what the needs are in the field in serving older adults and then is to help providers who are providing the care better-understand the technology and try to get these people talking and partnering so we are getting the best technology moving forward and then dealing -- well, identifying and dealing with a series of policy issues that really slow down the development of technology.

And when we look at policy issues, reimbursement is obviously high on the list. There is very little reimbursement out there right now for a lot of the technology devices. And, even though our surveys say that Boomers are willing to spend certain dollars, I mean, the

real danger is having a society of the haves and have-nots and care available to only those who can pay for it. So we really gotta come up with a -- getting the paying organizations, both in the public and private side, to really look at reimbursement in this field.

A -- we need funding for research in this area. It's not happening from the federal government to any large degree and that's a serious concern. You take HUD and senior housing and there's very little look at how technology can be used in those type of environments to help provide additional care.

We've identified -- cross-state licensure seems to be a real debated issue. But the idea now, through telemedicine, that you can really provide care from almost anywhere, the ability to cross state lines starts becoming very important. It is kinda crazy, if you're Mayo Clinic in Minnesota and you can treat people in Dubai but you can't treat people in South Carolina. And these are the kind of issues that I think probably made sense to have these type of regulations years ago, but need to be revisited.

There's a lot of discussion about liability in this area. You have to realize you got a lot of technology

companies who've never been involved in healthcare that we want to bring in to the healthcare field and they're terribly frightened of the liability concerns in this area. So that we need further discussion.

From a national perspective, even a commercial perspective, we are way behind -- American industry behind companies in Japan, Korea and Europe in what is gonna be a two to three hundred billion-dollar marketplace. And it is a real concern and we've been meeting with folks in the Department of Commerce about that as well. It's the last thing our country needs is a -- more balance of trade problems.

And then the whole area of electronic health records and personal health records. I mean, a lot of that work right now is being drive by the acute care field. And understand, when you're in a hospital in acute care, you see people on an episodic basis. In long-term care, we deal with people every day. We have very specific needs and we are trying and we're working with other organizations in the field to drive more long-term care in the national standards efforts in this area, so the point of view of the long-term care profession is being well-represented.

Now, we think there's a major step that's needed and that is for Congress to take action in setting up some sort of mechanism. We call it a national commission, because we don't know another term. I don't really like the term "commission," but we need to have a way of bringing together the different groups who really are going to impact in how we change care in this country and that is the aging services providers, the hospitals, the physician groups, the nurses' groups, the technology companies, the insurance companies, the homebuilders. There's a whole list -- consumer groups -- that need to come together in some kind of a formal, high-level, directed mechanism under Congress.

I can say, positively, at least, a lot of good work is taking place and we're hoping, in the next couple weeks, to have a bill introduced into the house that will start that process. And I think it will be important to finally get some Congressional action now starting to look at new approaches to help provide better care.

Now, at lunch, you'll have the opportunity to see a video. There's also copies for you of something that we put together to help people see a vision of what care ten years out could look like. And what you'll see is a story

of a four-generational Hispanic-American family and how life has changed for them because of technology and it's a story about a family, not about the technology. But you'll see these different technologies running in the background and, if I had more time, I'd go over it with you, but if you have questions, I'd happily talk to you later about them, but we were able to show these different types of technologies as well as looking at the privacy concerns and we think these are the critical tools. All in labs now, all could be available within the next five to ten years. We're not looking science fiction that can really change the field.

When we look at foundations and what funding organizations need to consider, as I close, I have to say the U.S. is way behind Japan, South Korea and Europe in looking at technology. Primarily, it's a government issue. The governments in those countries have been much more proactive. They've been working with providers and insurance companies. That's just not happening here in the United States. There's little government support or really not a great deal of foundation support to drive a lot of these new approaches to care.

One of the things we've been active in trying to do is to drive more trials and pilots. They're certainly needed, but when you see, in the United States, when we struggle to do a trial with 25 people in it, 25 homes and, in Europe, they're doing trials of 500 or a thousand people, you can see the challenge that we have in the kind of evidence they're able to collect compared to what we collect.

There's no question we need to develop more evidence-based research around what these technologies can do. At the same time (and you are the type folks who can really think about this) is we need to think about how we develop that type of evidence. We don't have the time, traditionally, to take four or five years in research projects, in technologies that will develop in one year and change again in two years and change again. We'll be coming with findings on nonexistent technologies.

And there's no magic answer here. I think people in the field have to start thinking through this and help them work with technology companies that we're trying to get to make greater investment in this area.

And then I always make my pitch that foundations and funding organizations need to take some different perspective on the type of activities that they fund and

there are a lot of organizations who are trying to good work -- do some really interesting things and have been successful, but it's -- funding in this area is very, very difficult. You can get funding for specific projects, but you don't get funding to drive vision, to drive important changes in our system. And I think it is something critical to take a look at, also to bring more people together to talk.

I can give you the example of, in this country right now, eight universities working on fall-protection research, all being funded through different organizations, all basically doing the same work. And that's one of our challenges. We don't have enough money to do what we need to do, let alone to repeat technology, so there needs to be more coordination.

So I made it in twenty minutes, that's unusual. And I guess you'll have time for questions in a little while. Thank you. [APPLAUSE]

EDWARD ALAN MILLER, PhD, MPA: Thank you, Russell. We'll have two discussions to react to Russell's presentation. First is Carol Raphael, who's president and CEO of the Visiting Nurse Service in New York, and the second will be Nancy Wolske, director of Care Innovations

for a retirement community, Elite Care at Oatfield Estates. Mark Schultz was unable to join us, again, due to flight cancellations. So, Carol, and you'll have a few extra minutes to make your presentation.

CAROL RAPHAEL: Okay, all right. [SETTING-UP TALK]

CAROL RAPHAEL: Good morning and I also want to thank the Academy and the Commonwealth Fund for sponsoring this and giving us an opportunity to interact on the subject of technology.

Now, I wanted to kind of share with you today why the Visiting Nurse Service of New York is kind of an outlier. I think it was Don Berwick who said my pizza parlor in the neighborhood has more technology than any healthcare organization that I interact with. And we are unusual, because the average healthcare organization invests about 2, 2.3% in technology. A financial services industry invests 8 to 10% in technology and we are investing 4% of our revenues in technology and really are kind of at the top of the graph here. And I wanted to kind of begin and share with you what were the drivers of our own investment in technology and what are the solutions we've come up with and, lastly, what are the lessons we've learned that, hopefully, you can all benefit from.

First of all, I think the main driver of our investment is that we're a highly decentralized service system. We see 25,000 different people every day in 25,000 different locations. And, basically, we have multidisciplinary teams, so that it can involve a nurse, a physical therapist, an occupational therapist, a social worker, a home health aide, a physician and many people who have to communicate, often not face-to-face.

Secondly, I think there were shifts in the payment and regulatory system, particularly Medicare moving to a prospective payment system based on an OASIS assessment and the fact that now one-third of our admissions come from private health plans who really are pressing us for much more in the way of reporting on the conditions of the people we care for.

I think, in line with this, we are under the microscope increasingly in terms of quality. We have to submit our scores, there is public disclosure now that's kinda sponsored by CMS under Home Care Compare, where we can see how our scores compare to others and we can benchmark ourselves. And we are kind of paving the way and expecting some foray into a pay-for-performance system.

And, lastly and maybe most importantly, our capacity is tied to people. It's not beds, it's people and we have tremendous labor market pressures, because we are facing shortages of nurses, nurses in general and then nurses who speak certain languages and are culturally competent. We have shortages of physical and occupational and speech therapists and, in some areas, we have shortages of paraprofessionals.

So we are really challenged to figure out how are we going to deal with the workforce of the future and really increase the capacity of our staff. What are the tools they really need that can make a difference in doing their jobs?

And, lastly, given what happens in medical advances, constantly changing regulations and protocols, how do we continually educate them?

So, what have we done? I think sort of the backbone of our system is our mobile pen tablet computer that all of our clinicians have. And, on that, they do the assessment, they do the progress note, they do the plan of care, they monitor outcomes, they look at medication management and, in some areas, we've even moved to trying to standardize best practice. This is what our computer looks like. It's

mutual fund by Fujitsu. It weighs 3.2 pounds. It has a pen, which is very important for our clinical staff. They are used to writing, but you can also attach a keyboard.

And, basically, this has been incredibly well-adopted. We started with 1500 nurses. Only one of them couldn't kind of get the hang of using this system. And I know it's adopted well, because, if our system goes down, within a nanosecond, we are besieged by calls, because it's almost n appendage of their body. It's not a foreign organism.

We have put a lot of work into using our system to help us to kind of measure and improve quality. And we have spent the last few years really building a quality infrastructure that measures quality in four domains. The process of care; do you intervene when a problem develops? Sort of the outcomes of care; do we help people to regain functioning? How are we doing on cost and utilization? And how are we doing on patient and family satisfaction?

And, for every one of our areas and we run many programs, from short-term to long-term to end-of-life care, some are more medically based, some are more supportive, every single one, even mental health, has to set targets in this area and we are able to not only measure how people do on their improvement and priority targets, but to share it

with the first-line staff. And I would say that is what makes the difference and I want to thank Penny Feldman and Bob Rosati, because they really are the people who made this happen.

And this is sort of, to me, an example of research being put into action, because every one of our teams can go to a web-based system and they can see how their team is doing on all of the key indicators compared to every other team and it's like Major League Baseball. You do not want to be in the basement. And, if another team can get a good result, then there's no excuse as to why your team can't. And what happens is that teams themselves then go to this other team and say, "How are you doing it? And what can we import into our team that can really help us?"

Now, last year, for the first time, working with our union, we developed an incentive system, sort of the notion of walking the talk, so that all of our staff can get bonuses based on meeting the targets in the four areas. And our -- 50% of our staff for 2005 ended up getting bonuses based on their ability to make the target and this has really helped them to focus on this area. And I think we've given them the tools to really get the information

and make it easily available so they can see how they are doing in the course of the year.

We have had, in one area, wound care -- we have many patients with wounds, whether it's postsurgical or coming out of hospitals or with bedsores. We've had, in the course of four years, a 26% reduction in emergency care for patients with wounds as a result of this quality system that we have put into effect.

We also have made forays into telemonitoring. We have a tremendous shortage of speech therapists and I was a great skeptic in this area. I just didn't think we could do speech telehealth. But we decided to triage patients and those who are in sort of our third category, often with minor strokes or Parkinson's, are those candidates who get speech telehealth. And I actually sat with one of our speech therapists to see how this worked and whether or not it could be effective and I was surprised at the fact that patients accepted it, had very high satisfaction, looked forward to their session and we actually have seen improvements in their speech as a result.

We went from a speech therapist being able to make three to four visits a day to now the speech therapist with this monitor is making twelve visits, virtual visits a day.

We also are trying a telehealth pilot and we are fortunate, because we have a research center. We have our own health services enterprise in our organization. So we are testing a telehealth program in the Bronx for patients with congestive heart failure.

And I will tell you, this has been one of the toughest things we've ever done. Although it's in Spanish and a number of languages, we've had two key problems. One has been distribution. How to get these devices out to all the neighborhoods and the homes. The second has been the adoption of our own staff. They've been highly resistant. Most of our nurses have been worried that this is going to replace them in the healthcare firmament and they just don't feel comfortable with it.

So those have been hurdles that we've been able to overcome and we are now getting vital signs in eight different languages at a central station. And our research center completed a study, a one-year study in December '05 looking at the rehospitalization rates for 193 patients with congestive heart failure. The rates for the control group were 61%. The rates for those who are in our telehealth program was 30%.

So it really is making a dramatic difference in our rehospitalization rate and I think we have finally, with tremendous efforts, overcome some of the adoption resistance that we have faced.

We are working now on sort of moving out from our own organization to partnerships. For us, I would say the most important partnership is with physicians, because we have mostly chronically ill patients who we are going to see sporadically and sometimes on a consistent basis for quite a while and we really need to exchange information and work as partners with physicians.

We called in many different physicians and had focus groups with them and it was really astounding. These were primary care physicians who told us that they often don't even know that their patients have been hospitalized, that they only find that out after the fact. And so we kind of got from them what it is that is most valuable to them in an exchange of information. We know what we need, because we are required to get physician's orders and modify those orders and when we have a change in the plan of care. But we have really begun to do alpha-testing with a large physician practice and I myself have been surprised at the enthusiasm of the physicians and our ability to really

begin to exchange information and kind of work collaboratively because of this system.

Now, in contract to -- I guess, I agree with what Russell said. That there's been kind of very limited government support for a lot of efforts in this area. We're fortunate, in New York State, that the state government has committed now, in the first round, $53 million to what are called heal projects to promote interoperability and create networks.

And we were one of the recipients of one of these heal grants, where we are, once again, trying to create a network with four physician practices, two community health center, three different labs, a nursing home and an adult day center and really see if we can set up a system where we can easily all access and share information.

We're also participants in what are called four RHIOs. I don't know if all of you know what these are. They are regional health information organizations that are kind of the vehicle that the federal government is using to try to force the regional collaborations. And, through this, there are some exemptions from HIPAA and other requirements that would pertain otherwise. And we are involved in several in Brooklyn and the Bronx and other regions.

I wanted to go back and talk about one other project which you might find interesting. That is a project that we're working on with twelve hospitals and we are trying to set up a system for the emergency room where physicians in the emergency room in the largest hospitals in New York City, when someone presents, could actually see if that person had been seen by any other emergency room or any hospital or by us within the last year or two and really get much more up-to-date information.

The thing that we bring to the party which is so vital is "What are the medications that this particular patient is using?" because, when we go into a home, we really see what are all the medications, not just what this person came out of the hospital with, but what six other physicians prescribed, what else is in the medicine cabinet and we really try to capture the whole panoply of medicines that any one in an emergency room caring for someone who want to know.

And the last area for us has been e-learning. We do a lot of education and training. When someone starts at the Visiting Nurse Service of New York, they have a three-week training session and a lot of ongoing education and it's very costly. Every time we bring someone in for education,

we have to pull them out of the field and we have to replace them with someone else. So we're really trying to see is there a way to create a kind of e-learning system where we can help people to get the information that they need on the ground without having to leave their cases. And we are planning this now with 1700 nurses. We've done some pilots and, again, unlike the telehealth experience, this really got a very positive reaction from our field staff.

So what are the lessons learned that I can share with you? I mean, from my point of view, it's not technology per se. It's the way that technology and information is used that really produces advantages. And you have to tackle your core processes, because technology is not a panacea. It's really -- it's only as effective as your ability to redesign jobs and put incentives in place that change how you do what you do.

Implementation takes considerable resources and support. I mean, to me, 15% is the system, 85% is implementation. We have a part of our organization, we call it SAI, that has over twenty people and all they do is work on implementing systems and giving support to the people who, in fact, have to adopt this.

It is very difficult to succeed in this area. I mean, Penny and I both, at different times, attended this session at MIT, sort of teaching non-techies like me how to deal with technology. And one of the things that I learned from that is one-third of systems don't succeed. And we've had our own problems in bringing systems in on budget and on deadline and really getting the return that you project. It is very tough.

You need a clear governance structure. We have a governance structure that involves all our key operating units. They have to have accountability and take ownership. You can't leave it with your information systems area and we actually have a board technology committee that helps to oversee and bring some insight into the areas.

We also have changed our whole project management system to capture total costs which go way beyond what the system costs you and to really do it in two phases.

We think we've hit a home run with technology. This is Yankee Stadium. We think, on our bases, we have improved quality, we have improved capacity and we have improved efficiency with the system investments that we have made.

And I basically just want to end by saying I really think that technology has the opportunity to really help us think through what the long-term care system of the future can look like with technology being part of the DNA of that system. Thank you so much. [APPLAUSE]

NANCY WOLSKE: Good morning. When I have an opportunity to teach administrators and training, I use the title "elder-in-training." And it's with this concept that the Elite Care at Oatfield Estates was developed. And Bill Reed and Lydia Lundberg, the co-owners, husband and wife, that developed this are very passionate in creating a model that is designed for ourselves.

So, for this brief ten minutes, which is very greatly expanded, based on people that generally want about thirty-second thumbnail introductions about Elite Care, I'm gonna ask you to take a virtual audio tour with me, much in the same way that potential consumers, when they call me on the telephone, want to know about what it is that makes a smart home. In all-too-many cases, people are calling me from discharged planning situations, most family members and, in fact, many elders today are not doing the research needed to find out very basic concepts.

They are familiar because of the industry growth and explosion in assisted living, very familiar with that concept. They are very familiar with the long hallways. So when I try to describe a smart home, I try very carefully to describe one of the most powerful new concepts that has been operating for about five years.

The Elite Care, Oatfield Estates campus is in Milwaukee. Prior to my five years with them, I was an administrator in assisted living and I worked in environments of eighty assisted-living units or more without this technology.

Our current campus, as I mentioned, is about five years old. We have no government funding. This is, again, privately held. It is six acres. The smart homes are surrounded by edible landscaping, organic gardens, berry patches, caneberry patches, fig trees. I'm describing these things to actually literally humanize the powerful technology that we have implemented there.

My dog, Schooner and I, are a pet therapy team, so Schooner also does tours with me. Again, the technology is very, very powerful, but we want people to feel comfortable with it and my experience of over fifteen years is that it is fear-based. People are very fearful to look at long-

term care, period. Now you look at adding technology, which is a very sharp-sounding word, and now they're even more fearful.

So whether or not someone inquires over the web or through the telephone, again, we're going to take a virtual audio tour together and see if I can describe it for you.

So, the first thing is the edible landscaping and organic gardens is a huge feature to the smart homes. There are six smart homes on our campus and if the gentlemen that cook in the audience will forgive me, I describe them as "smart" homes because Lydia designed the kitchens, okay?

So they are marble countertops. They are located on the second floor. They have gas ranges, Dacor ovens. You can't see the technology in the kitchen level. There are six private residential care suites upstairs, all one bedroom, hydronically heated. Six on the main foyer level and we actually have live-in suites for the caregivers that choose to live there.

We have chefs in every house, no one looks like chefs, no one looks like nurses, no one looks like administrators, no one has the title of "marketing," because it doesn't

align with the organics and the homelike environment. So I'm very passionate on that issue.

The smart house technology. It's designed for community living. It's designed for extended-family environment. We want families to feel welcome and excited and enthused about coming up and we want them to feel peace of mind and increased safety. We want the residents to feel a real sense of sovereignty, meaning that the technologies that are available to them they are confident and they are at peace with and they have a clear understanding as to its uses.

We do not use visuals.

[END OF AUDIOMORNING1.MP3/BEGINNING OF AUDIOMORNING2.MP3]

NANCY WOLSKE: We do not use cameras. The houses are wired with infrared sensors and radiofrequency transmitters and all the community members wear a pendant and the pendant serves a dual purpose. It's a supplemental call system; there's a little button on it, so that people don't have to conveniently be next to a pull cord or fall next to a pull cord when they need assistance. It also serves as a location and tracking system.

So, for the staff that live and work there, they can also get help for themselves. The sensors will always tell us the last known location of both a community member and a team member. Some of the classic examples of how the team members use the technology is if they are offering very personal care by way of a shower and there's a sudden change of condition, perhaps a blood pressure drop, and they need to help the resident by getting assistance, they can call for assistance themselves and we will know where to find them.

There's a computer monitor in the first level, mezzanine level, the great room, living room. There's a computer monitor on the second floor. And we will have a live demonstration how that works during the lunch break, so you can actually see how the information is generated and how it becomes archival.

So, again, when you walk into the campus, you -- it doesn't look anything different. Looks like a really beautiful retirement home. Six houses on the campus, greenhouse, lots of water features. We even have a mallard and a drake and a hen nesting in some of the water features, in the koi ponds there. So it doesn't look like a smart home.

We have, in the last six months, particularly -- since the White House conference, actually, on aging, we don't advertise, but yet there's been an increasing amount of very high-level media. Throughout my experience there, we have been in the *Wall Street Journal* a couple of times, *The New York Times* and so forth.

But, in the recent six months, we have been featured in the *AARP Bulletin* for the organic gardens and edible landscaping and the gardencies that we produce. April 9th, we were on the front page of the *Chicago Tribune*; in fact, we were part of a larger article on technology. And we were most recently featured on National Public Radio with Joe Shapiro. I found out, in that experience, that two days with Joe Shapiro equals about eight minutes of airtime, which is interesting. Oregon Public Broadcasting is about to air a piece, for those of you in this area, and we just finished that. And I'm currently working with *USA Today* and I'm waiting for a photojournalist to come out and follow the journalist. That'll be Janet Kornblum's work.

So the reason I share that with you is that I feel, very passionately, that the momentum is growing in what we know is a viable solution. I'm also very passionate about how we introduce the message of technology and its power

into the consumers today that it's helping and the consumers tomorrow. And so, again, it's bringing the humanity and the mercy into the environment by use of technology.

Some of the most exciting developments what -- that the media is just going crazy over currently -- and, by the way, we have our own software department, Elite Care Technology. And Oatfield Estates is the prototype campus for the technology that we began introducing five years ago. It's live data, schematics and data collection, no visuals. We use our own software engineers, software developers to design these.

The most powerful to date that we have implemented is called our family portal. I don't know if anyone here has seen any of the recent media on it. It's still in its first rendering. I describe the family portal as the FAQs to any family member researching and wanting to know what's happening with their loved one.

It's very powerful for a couple of reasons. Number one, if you are the elder living in our community, you can revoke privileges to your family member if they began to notice that your weight trend is going up. Or down. I

mean, if they abuse the privilege of helping you stay independent, then you can revoke that privilege.

It is web-based. I recently had a family member that was in Hawaii. This is a family member that her father passed away in December and, in January, they had to find a quality venue for their mom, a quality environment for their mother. Very emotional time for these two sisters. It was the first vacation she had taken. She was gone for three weeks in Hawaii. The whole time she was gone, she was using the family portal.

She used the family portal to see who her mom was socializing with. Was her mom sleeping well or not? Because every bed, they bring their own possessions, their own treasures and every bed sits on a series of four load cells and I can -- if you can see the projector here, there'd be one load cell underneath each four -- the feet of the bed. Does that make sense? So we're able to see if someone rests well or not with data, it trends it.

You are able to see who they're socializing with, what activities they've gone on. We are now adding clinical vital signs, because we believe that, with the age wave and, in fact, I have seen this, with the industry growth prior to my experience at Elite Care, the physicians are

getting absolutely overwhelmed with faxes, so are the nurses that work with the physicians, when we look at it relative to industry growth, from non-licensed staff who are working in community-based care. And so we have to be able to tool the staff that work in these environments with clinical, objective and accurate data.

So our vital portion on the family portal is doing everything from MMSC, geriatric depression scale, the most common vital signs, their blood pressure. We're also doing blood oxygen levels, pulse rates and so forth. This, in conjunction with the load cell data, if you can imagine someone receiving a new prescription, someone that's never taken, perhaps a Vicodin or a diuretic or a trazodone, something that they're coming back from a sudden change of condition. And you look at the vital screen and this unlicensed staff is able to interpret this electronic medical record and be able to talk to the family member and/or physician and give them accurate data.

And then you look at the load cells. The load cells show that, prior to this new medication, they were up and down all night, but yet now, three days after that medication, we're looking for a particular response. Hopefully, it's the right response. And now we look and

they're sleeping very restfully. This is significant data. It's quantifiable data. It's data that tells us where to look.

Conversely, if you are in Hawaii and looking at your parent and you know your parent's -- because you were the primary caregiver. In fact, the first name of our system was Daughter One. And you are -- you know that your mom's pattern was she slept like a rock, but, yet, right after her move into tran- -- into community-based care, we are all anticipating, collaboratively, transition trauma and now she's up and down all night. This is significant, quantifiable data. This is going to tell us we need to look further.

The other thing it does is that you have proactive, positive support of the team members that work there. By becoming transparent, using the technology, you have family members that are completely informed. They know what's happening. So, instead of coming in to the swing-shift staff (I know many of you have seen this experience or had to manage it) and saying something like, "Hey --" without the technology, it's not transparent, right? "Hey, my mom was in that EZ Chair before I went to work and I came in after work and she's in that same EZ Chair." With the

technology, you look and, my gosh, she could stay in that chair because she went on a sternwheeler, she went on a speedboat trip, she went to the theatre and so forth. That's fine.

Many of the times, what we forget to do is to -- and, as we learn how to interpret this data, we forget that the families are coming from a very emotionally charged, subjective perception, rightfully so. By becoming transparent, they are informed. By putting the technology in a homelike environment that's real, it's not about bingo, that focuses on gardening, that focuses on relationship, that focuses on independence, you have family members that want to come up to the community. You have family members that are intrigued and want to help you further the technology. You also have physicians that are beginning to interpret the data with us.

A couple of things that are on the horizon and my colleague, Silmon Lodi [?], is here with me today and he'll be at the lunch break. We're gonna describe to you some of the things we're working on after this campus that are sort of in the research and development, but we're doing some renderings on them currently. We're going to be expanding the clinical vital screen that you'll see demonstrated on

the family portal, because the physicians have to have access.

We have to be using common language. We have to be able to use the web. We have to be able to honor the HIPAA regulations. However, we all have to speak the same language. Imagine if the family member, the physician and the nurse and the primary care provider all knew what was happening in the apartment behind those closed doors because of the data. It's very simple. It's very powerful, but look at how much proactive, positive results instead of reactive.

Another future that we're working on currently -- again, this is privately held with some very passionate people, but, again, it speaks to lack of funding, so we're working on this, too. But we are taking some of the most significant components of what we have demonstrated to be the most successful and we are going to be bringing it and modifying it for in-home use.

There are many, many, many family members that are honoring their loved ones and wanting them to stay at home as long as possible and I'm sure, as many of you know, they stay at home way too long. They stay at home way too long, so that when they do come into community-based care, many

of them are beyond the point of enjoying what's there for them to enjoy. So we believe that let's get the data into the home, let's speak the common language because primary caregiver, family physician and certainly the community member.

I'm often asked, "What does it feel like?" A lot of the media talks about "What does it feel like to live in an environment that's so transparent?" and I can only quote one of my favorite quotes; I'll see if I can do it verbatim. She says, "My God. I'm 92 years old. What have I got to hide now?" And that's how she feels. And that's very common.

We are very much elder-driven. We look to the elders to help us pioneer. We look to the family members for the first -- well, actually, for the first time, for the last five years, we have been taking this message to the streets, to the people that are using it and that's not very often that you see something in research and development working directly with end users.

How much time left?

MALE SPEAKER: [INAUDIBLE]

NANCY WOLSKE: Ooh, a few minutes, okay. I think, as we move forward, I'm very excited about how this is going

to completely change. We've been changing the paradigm for a very long time. It's very exciting to be in a group where everyone is finally focused on the same things.

As elders-in-training, we have the opportunity to very dramatically change our own futures. When I do HR work, when I work with students, when I work with professionals or mentor, I talk very much about that. I'm very passionate that just the model that we've been seeing with the industry growth is the wrong model. It was not designed with the elder in mind. The long hallways are not conducive to building relationships.

We have demonstrated very successfully at the Elite Care campus that technology, by humanizing it and making it real, it's a very viable option and thank you for your time. [APPLAUSE]

FEMALE SPEAKER: Hello. Now it is the table discussion time and y'all find in your folders that there are a list of questions and we have assigned each table a facilitator, but, due to some absences and plane snafus, we want to find out whether or not each table has a facilitator. So if you're a facilitator, please raise your hands. And David and I will be by your tables to help get you guys started.

[ROOM NOISE/CONVERSATION]

FEMALE SPEAKER: Thirteen. Table 7. All right, we'll be by your tables to get y'all started.

Yeah, I'm -- I've got that.

And you'll have approximately forty minutes, so, at 11 -- or 10:40? At 10:40, we'll come back to the group and, as you're going through, we're going to ask the youngest member of your table to take notes on your discussions and leave at least five minutes at the end to -- excuse me, sorry, we're not quite ready to get started yet. At the end, leave five minutes at the end to make sure you come up with your most pressing question or most important point you want to make so that, when we come back to the group, each table will stand up and make their point and have a chance to ask the panel sort of an additional question and we'll go around and Eddie'll help facilitate that process, so.

MALE SPEAKER: I think ... [INAUDIBLE] raring to go.

FEMALE SPEAKER: Yeah, I guess so. Hopefully, they ...

[ROOM NOISE/CONVERSATION]

[RECORDING STOPS/RESUMES]

W. DAVID HELMS, PhD: Good. Everybody's talking, that's good. I just want to make sure everybody feels that they've been properly launched. I was flying across the country on United yesterday and I -- they were showing a movie, *A Failure to Launch*, so I don't want anybody not to feel properly launched here. And I just want to clarify that we're hoping that the recorders for each table will summarize and give to our staff the full and rich conversation that you're having, but we're only asking you, at the reporting time, to give us one issue that you want to share your judgments about or one question that you want to focus the panel on to give you an answer. So that's all you have to do at the reporting time, but we are hoping that our wonderful recorders will help our staff capture this rich conversation.

So now that I know you're properly launched, I can relax. That's good.

[ROOM NOISE/CONVERSATION]

[RECORDING STOPS/RESUMES]

EDWARD ALAN MILLER, PhD, MPA: Okay. Time is up. Or so I've been told. So what I would like to do is have each table ask their question of the panel and the appropriate panel member will address and -- or if you want to make a

point, doesn't have to be a question. So let's behind with table 1, calling table 1.

All right, there are microphones. Yes, there are two microphones, one up front here on either side.

MALE SPEAKER: This was actually an interesting exercise, both to get to know people who are new to -- we were all new to each other, I think, and also to hear what we thought about some different perspectives. One of the things that came out in our group was really money does make the world go 'round and, in order to sell technology, you have to show some sort of benefit.

And there are several ways that that could be done. That could be either in cost savings or in outcomes, which are related to expenditures.

There were some barriers that we also thought were possible that the technology needs to prove its worth. That if no one's going to use it or if it's just data that's collected that's kind of abstract and has no value, that it's probably not a good idea. It's also very hard to speak in public, I'm finding out.

You need to sell transparency. That one of the things in order to sell the increased use of technology is to show that the family members, that you can keep an eye on or you

can have an idea what's going on with your loved one when you're far away. So this idea that it's transparent and it's also not hard to use can help make that happen.

And also reimbursement is very, very key, either in paying for things that aren't currently paid for or paying for things to encourage -- offer higher payments for use of this kind of stuff or even a reverse kind of incentive. That you might want to pay less to a -- not that you want to, but facilities that don't use technology might get a different kind of payment than facilities that do.

And also privacy, that there was this idea that you're collecting tons and tons of information, but that can be too much of a good thing and so some sort of either switch to turn things on and off is a good idea or just to really ensure that the data is gonna be used and is -- well, just everything that comes with privacy.

And I think that's -- and also the other thing was coordination of care across providers, that the long-term care situation has lots of different players who play lots of different important parts and they're still not talking a whole lot together. And then, in order to have a higher adoption of technology, showing that this is useful, I think, Penny, your -- your stuff and also Carol's with what

you're showing, if you show -- share information across different providers, we're really interested in making a better outcome for a person. That's where adoption really comes in very, very strong.

And that's it.

EDWARD ALAN MILLER, PhD, MPA: Table 2, please. And, John, please identify yourself.

JOHN McCARTHY: Hi, Eddie. I'm John McCarthy. I'm a VA researcher. I guess that'll do.

We had a very nice discussion. We covered a lot of interesting issues, dimensions. And I'm just gonna sort of summarize what those were.

We talked about disparities, how we -- we had concerns about it being a two-tiered system and not just for consumers, but also among providers, where providers vary in their access to these resources.

We had concerns about managerial competence for deploying new technologies, where many executives have experience with marketing, for example, but not with technology itself.

We wanted to make the point that the focus should not just be on institutional care, but also on technology to help people to stay in home settings.

We considered the fact that, when we say "technology," I mean what does that mean? That there are multiple dimensions, multiple purposes and multiple perspectives to be considered.

And, finally, we -- I don't -- it would be too dramatic to say we mourned the lack, but we noted the lack of models of effective implementation or evaluations of technology out there.

Thank you.

EDWARD ALAN MILLER, PhD, MPA: Table 3. Come on down.

HON DAMOMEN [?]: My name is Hon Damomen [?] from Stonybrook University. Well, our group had a nice discussion over the range of topics, which we thought was getting at the core issues in terms of the topic, but -- so we focused our -- on our discussion primarily on four areas, financing, feasibility, tailored needs in terms of medical versus social and privacy and security issue.

We choose one question as our final question for the panel and discussion in the audience is that: How do we sort of -- I think, at the end, the group reached a point where we take one step back and saying, let's think about the bigger picture. How do we get a culture change or a culture shift? That is, we all know that it's important to

increase the need-based technology. By that, we meant an individualized and tailored to the -- and responding to the continuum of long-term care needs. And also what's the value of related -- of this question, what's the value of health IT to specifically the long-term care continuum? From patient perspective, what the patient thought. Do we know evidence about it? And also caregivers and do they agree or not? Thank you.

EDWARD ALAN MILLER, PhD, MPA: Any of you guys want to take that?

RUSSELL BODOFF: Well, let's take your question. The larger picture. There's no question that we have to figure out how to get people thinking about different ways of delivering care. We're locked into models that don't work, frankly, and, as a society, I -- and I'm mentioning that, in other countries, there's much greater leadership. So we have an administration that, well, we're not hearing very much; we have a Congress we're not hearing very much from.

So, at some point, we've gotta figure out how we get different groups and the key elements and that is the aging services providers, the physicians, nurses, hospitals, insurance companies, tech players, homebuilders and stuff working together. It's why we are working very actively

right now in Washington on development of a new Congressional initiative that would bring these type of folks together. 'Cause, as a society, we tend to look at the problems in the healthcare arena by piece by piece and you try to fix one little thing and it doesn't fix anything else in the total picture and we're never addressing the total picture.

So it's not an easy answer. It's -- you know, I'd like to point out, in 1961, when President Kennedy said we're gonna go to the moon by the end of the decade, no one had a clue we were gonna do it. But there was a -- there was a national drive to make it happen and we did it. And we don't hear much about a national drive or commitment that we're gonna change our healthcare system in ten years. Talk to doctors, talk to consumers and talk to phy- -- government -- we all know it's broken, but there's no one out there saying that we have a timeframe in front of us and we know our population's aging, we know when the Boomer crunch is coming and we have no target and no mandate to drive that.

So I think there is something that we really have to push hard on our elected representatives to make them much more aware that this problem has to be challenged and we've

gotta bring groups together, you know, willing to really look at that.

The other piece, when you talk about value of the technology to the individual, to the older adult, to the caregiver, the biggest problem is most people aren't aware of what it is out there or what is possible. It's hard to talk to people about value if they don't e- -- they can't even comprehend what you're talking about. If you talk -- you know, 200 years ago, if you told somebody you could pick up a little device that you wore on your belt and talk to anyone in the world by pushing some buttons, they wouldn't have any concept of what you're talking about. So we are gonna have to start educating people of what the potential is and that's probably one of the reasons that Boomers aren't putting a lot of pressure right now on their elected representatives, because you're just not aware of what potential is out there.

So it's not an easy answer. I think it is the greatest challenge that we face as a nation is how do you energize everyone to come together in the national interest and say, "We have to rebuild our healthcare model."

FEMALE SPEAKER: [OFF-MIKE] Could I just -- so we -- we have a lot of tables, so let's ask each group to be very

disciplined and say your one thing very succinctly so that we can get all these ideas out onto the table ... because, otherwise, we just have -- you know, just kind of one and one ... [CROSSTALK]

MALE SPEAKER: Will-nill.

FEMALE SPEAKER: I mean, what we'd really like to do is have this discussion, but it takes a lot of discipline. Get up and say your own thing and sit down ... [DROPS VOICE]

EDWARD ALAN MILLER, PhD, MPA: So, table 4, your one thing. Just one.

LUCIA: I'm Lucia, occupational therapist representing the Nevada Healthcare Association. We had -- we think that we have a lot of technology that we aren't already implementing and we felt that we needed to spend maybe a little more effort and time onto getting the right technology to the right people and use what we currently have. And maybe having one person, an impartial party that serves as that kind of liaison, that contact that we could help implement that so that it's not just an effort to sell more or -- you know, matching up the right technology with the right people that we already have.

EDWARD ALAN MILLER, PhD, MPA: Great. Table 5.

PETER BROADHEAD: Peter Broadhead from the Australian Department of Health and Aging. We had two questions. How do you get past early costs and convince policy-makers to support, which is pretty much the question you were rehearsing earlier. And the balance between diversity and standardization and how this plays in terms of the role of government in supporting. So where should we be on that continuum between diversity and standardization in adopting these things?

EDWARD ALAN MILLER, PhD, MPA: Table 6.

ANDREA GRUNYER [?]: I'm Andrea Grunyer [?], I'm a student at Brown University. And our question was really that there are multiple stakeholders here, there is the patient him or herself, the family, the organization, the clinicians and everybody has different goals for which technology can serve and how can you really reconcile those. So, for instance, the examples put forward, that, in some cases, you can see where monitoring would be very beneficial, but, on the other hand, there's something that might seem -- and I'm quoting here, something kinda creepy about taking note of every step that your grandmother takes. So how can we really bring those things together and make sure that everybody's goals are best met.

EDWARD ALAN MILLER, PhD, MPA: Okay. Why don't we actually just work our way through the tables and then we'll have the panel kinda react. So, the next table? Table 6? Or 7? 6. 7, 8, let's go on to 8. Hearing 8, 9?

CARRIE LEYDA [?]: And I am Carrie Leyda [?] with the American Public Human Services Association and our one primary point, how can tech- -- we had two, but I'll just give one. How can technology be implemented while not -- maybe ratchet down or reduce or replace -- or reduce costs? And we talked about the value in looking at foundation or government funding for large demonstration projects across the country and I don't know where this discussion is happening yet. We just talked -- brainstormed at our table and what will the next steps be. So.

EDWARD ALAN MILLER, PhD, MPA: Okay. Table 9.

JANICE FAUST [?]: Hello. I'm Janice Faust [?], nurse researcher at the Visiting Nurse Service of New York. Our conversation was very much -- echoes a lot of the conversations and points thus far. Largely focusing on financing and the challenges of really moving towards supporting prevention and monitoring and some of our discussions were to (1) look at the definition of technology and begin to look at how, perhaps, things that

are already in place could be defined as technology and perhaps move in framing it in incremental steps towards funding. And then also looking for other opportunities with the continuing care retirement communities for perhaps using those as test-pilot sites.

EDWARD ALAN MILLER, PhD, MPA: Great. Number 10.

LEE GOLDBERG: Hi. I'm Lee Goldberg with the Service Employees International Union. Our one point really was also sort of focused on a question, which is the impact this technology would have on the isolation of the consumer and the monitoring and the privacy concerns. And the isolation question was sort of based on the sort of a sub-question of what services are really being delivered here. Sometimes, it's just a health service monitoring blood glucose and stuff like that, but sometimes it's actually the human touch and it's personal care services and that is not something you can substitute for for technology.

And then sort of with that, the isolation and the privacy issues for the workers. 'Cause we've mentioned and I swear this wasn't me, somebody else mentioned this, I mean, we've been talking about the consumers and the providers and the government, but there's also another stakeholder in all this.

And then, as part of that, how do you make all these services and the technologies and the mode to delivery more available to people who, beyond sort of the type of facility you have and the type of demographic that you're serving in Oregon?

EDWARD ALAN MILLER, PhD, MPA: Next table.

J.P. SAHI [?]: I'm J.P. Sahi [?] with Center for Elders' Independence, a PACE organization. The major concern or question that our table had was ethical issues related to technology and inputs from the patients and how do they feel and how we propose to deal with these issues.

EDWARD ALAN MILLER, PhD, MPA: Great. And I guess we have one more table?

LAURA SMITH: So we had a very spirited discussion at our table. My name's Laura Smith. I'm at Brown University. And I would have to say that we agree with a lot of things that were already said and I'm not sure that this is actually even distinctively different, but a major concern is about whether or not people are potentially being distracted by sort of this big word "technology" that's not well-defined, when there really needs to be a deci- -- firm decisions made about sort of allocation of resources and whether or not the changes that might be

being made are really the best place where we should be putting our funding to be effective to help actually improve problems that are visible on the ground.

EDWARD ALAN MILLER, PhD, MPA: Okay. So --

NANCY WOLSKE: May I --

EDWARD ALAN MILLER, PhD, MPA: Nancy? You look like you're -- want to say something.

NANCY WOLSKE: May I? Well, I think some of the key points which, again, are not just from all of you here, but that I've heard throughout my experience at Elite Care, that the technology is creepy or invasive and, first of all, I want to respond to that. That we do not ask the staff, we do not have family or the team members sitting at computer monitors. That does not happen. The system, in and of itself, collects the data. We have been working with different research groups, universities and now a private group helping us to understand what we're gonna do with all the data. The data is mined and harvested when there is a need.

Transition trauma is the first and foremost. We know that transition trauma occurs. It's very emotional for the community member. It's certainly very emotional for the family and the family member's usually the person that

feels safest in hearing, not the provider, because that's the safe relationship.

So, first of all, I don't at all and it's been my experience that it has not at all been perceived as creepy or invasive. And, again, we are working very diligently to humanize it and to help the staff who choose to be in this service-related field to be with the residents in the first place. And, with the technology, it's actually giving them additional time for the healing touch and the comfort care.

The second point. I have many, but I'll stick to two in the interest of time. The isolation. I thought that was an interesting component. No one has ever asked that question before.

I think what I would like to add to this is that, because we have a significantly demonstrated increased piece of mind to the family members, they feel good about coming up. Many of them volunteer on all the different outings. I think it actually is very contrary to an isolationist perspective, because the family members actually look forward to coming up and hanging out. It's all about family. They never have to pay for guest meals.

They use the technology because they are completely informed and so, thereby, when they come in after work,

which most people do, they're already informed and so they don't take away the med aide's time who has eight blood glucose sugar and insulins to administer and Parkinson's medication to make sure is delivered in a timely manner. They don't have a family relations crisis on their hand that takes away from quality of care, delivery of care from the other community members. In fact, family members are completed well-tooled. And so it gives the staff more time to do what they're there to do which is to give compassionate care.

Thank you.

RUSSELL BODOFF: How many people here have alarm systems on their house? Okay. They're running all the time. The only time you want to hear from 'em is somebody's breaking a window, breaking into the door. And I think that's the way you oughta be thinking about the technology. They're just not dumping all this data every se- -- and particularly as the software becomes more sophisticated and is able to make projections, it's sending warnings when warnings are needed or it's sending information when something is dramatically changing. So it's not this constant stream of information that I think -- you know, that we're thinking about.

But there's no two ways about it, we're collect- -- there'll be tons of information collected. I mean, you can't deny that in any way. But what I say is it's really not a privacy issue, it's a security issue. And you settle the privacy issue by saying to the older adult it's their choice who gets the information. They make the total choice, but then there's the obligation that it -- you have to live to that and then that's a security concern that you have the right security systems in place to be able to protect that data.

But it -- I think, as long as you give the individual the control over the data, that's the key to really dealing with the privacy issues.

Quickly, when somebody mentioned ethical kinda issues. I think there are ethical issues that need to be discussed. I think, particularly when we start dealing with people with dementia who are not in position to make their own decisions and I think those are important debates to take place about what should be monitored, who does with what infor- -- who does what with what information, 'cause those people are -- do not have the capacity to do it themselves. So I think that really is important to consider.

And I guess that's the -- oh, on isolation. Again, I'm gonna invite you to look at the video that we did. 'Cause I said, if we isolated older adults, we'd fail. But we live in a mobile society and let's face it and a lot of people don't have relatives who are close by. So what's more isolation to the older adult who never sees their great-grandchild who lives a thousand miles or, through technology, that grandchild or others is in their home every day through some video, two-way type of communication. And think about that.

The older adult who is not able to get out, because they can't walk that well and suddenly the world is coming to them with new hobbies and new activities and again. So there's a balance, without a doubt, but I think you have to go into it open-mindedly saying that somehow we figure out the right balance. We don't lose use human interaction, but you can really use technology to open up the world to people as well.

CAROL RAPHAEL: I was just going to say that one of the things that struck me listening to people was, in a way, the discussion around technology, however we define technology. Just kind of highlights a lot of the issues we're grappling with in long-term care. I mean, look at

the issue of financing. I mean, we are grappling with whether or not this is a public responsibility or a private responsibility.

And I think, in the sector of technology, I -- the same issue emerges. Should we look to the private sector to make these investments? Should we look to the consumers of the future to be the ones who will want to purchase desirable consumer goods or is this a public good that should be financed by the government, because only the government has the interests of bringing this fragmented system together and it's never going to happen naturally.

I think the other area. We think about caregiver burden. I was interested in, I guess, Russell saying that, in the poll, most people said that they didn't want to be a burden in the future to their children. And most of the people I see even today, the one thing they say repeatedly is "Please, I do not want to be a burden to my children."

So, for me, a question is: To what extent does this hold the promise of really giving people their most fervent desire. Not that they don't get help and support when they need it, but that they not end up being a burden to the people they care about.

RUSSELL BODOFF: Just one other thing to the gentleman from SEIU, which you could say -- from a labor issue, you know, we've been talking all about the older adult and technologies around monitoring. But when you talk to the staff themselves, what's the number-one complaint they always tell us? Paperwork. You know, "We can't do high-touch, because we're busy with paperwork." And we do have the potential and one of the things we're looking at, the same concepts, the same technologies that would do monitoring in a home to be used in a facility to capture lots of data to -- so staff do not have to manually enter that kind of data and that then frees them up to do more of the kind of work that they --

And I said we have larger examples outside the United States, unfortunately, than inside the United States and there are certainly examples. I know of a major provider in the Netherlands, 12,000 employees, who has brought their turnover down from 30% to 8%, based on putting technology in the hands of the employees and giving them that empowerment then to take action on behalf of the older adult.

And so I think you can see examples that indeed technology can make the job much more rewarding for the people who are on staff as well.

FEMALE SPEAKER: Well, we have questions.

CHUCK FAHEY: I'd like to make an observation, if I may.

My name is Chuck Fahey. And for purposes of researchers and also for public policy action, I think there needs to be a little clearer delineation of the issues at stake. For example, there are four or five functions in which technology may be involved and they're different. You know? It's information-gathering and maintaining. There's the questions of communication among stakeholders that oughta have it and what's the technology to assure what that should take place. There are assistive technologies from the very simple thing like hearing aids to various others. There's the question of monitoring that's here. Okay? Each one of those areas and domains is different. With different responsibilities, different opportunities and so on.

Secondly, I would suggest that there are different populations in people we're talking about. I think all of us, I've -- I heard it around here. You start with a

person who is in need and how indeed are we going to empower them to minimize their frailty, if you will? Starting with a minimalist approach, what's the minimal you can do so people can manage their own lives? Well, moving all the way upward to the person who's lost executive functioning and physical capacity. The ways in which technology can intervene differs very much with the degree in which that person is unable with their internal capacity to deal with external demands.

So I think all of these things have to be parsed out for intelligent conversations, for research and for public policy kind of considerations. So.

FEMALE SPEAKER: [INAUDIBLE]

CHUCK FAHEY: You know, I gotta tell a story. We Irish tell stories. And I was reminded of it here. Way back in Syracuse days when David and I were there, wherever he is, the city was burning down. And you remember it? And University College had this big community roundtable of all the movers and shakers. And, you know, we have fifteen discussion groups and everybody's, at the end, getting up and saying the same thing, you know? Until it got to the last one and it just happened that the person there was one of -- was a priest, whom we didn't call Fulty [?] for

nothing, because, at the end, he gave this absolutely magnificent declaration and, at the end, he said, "I'm not sure this is what we said, but it's what we should have said."

Penny?

PENNY FELDMAN, PhD: Yeah. Our table also had this discussion of categorizing what -- you know, for whom and I think that is a very important set of categorizations that would move us forward. On a very practical level, it -- and one issue that came up at our table, partly because I raised it I guess was the question of uncertainty. And I think, Leslie, you actually brought it up. That organizations or physical places that would be interested in investing in a particular kind of technology, for whatever function or whatever, are unclear at when is the technology ripe enough to be tested. At what point do you worry that you invest in something too soon and the technology is quickly going to be beyond you? And even before we get to outcomes, what are gonna be the costs that are entailed and the behavioral issues, like the ones that Carol raised and I don't think we have a very systematic way of looking at that right now. And I do think that that probably impedes experimentation in the real world.

NANCY WOLSKE: If I could just touch on that a little bit. We have -- I have been listening to the lack of models and, in fact, you know, we're one of the only, if not the only model, that's been deploying this for this long. And it is Bill and Lydia and their entrepreneurial endeavor, their money, their vision and it does create something for us to fine-tune and it touches on almost everything that people are bringing up here. It is so varied and there are so many different components to it.

I can tell you, from my experience, it also touches on the culture change, because one of the things that I value most is being able to discuss in a group setting instead of one person at a time, which is what's been happening for over five years, is saying the same type of message or positive intent, what we're trying to create, trying to gain momentum towards the culture change, trying to hammer out this model. And I gotta tell you, there are a lot of people that have been rowing this boat and we -- you've been getting kinda tired. So this is a great opportunity.

I do think the momentum is shifting. In terms of the government and funding, I think that we will need some very big giant steps, but I would hate to have those giant steps

step all over what we've been working so hard at there at this point.

MALE SPEAKER: Mary Jane?

MARY JANE KOREN, MD: Mary Jane Koren from the Commonwealth Fund. One of the things that we haven't really hit on or talked about and it's more related to health information technology is that long-term care is not at the table as these systems are being developed. They're largely being developed from the acute care and the ambulatory care side. And so a lot of the infrastructure, excuse me, that's being developed does not include the kinds of domains of interest to those in the field of long-term care, so functionality, cognitive function, psychosocial networks and so on which are fundamental to our providing a high-quality service are not being hardwired into the information systems that are being developed, which we have got to be aware of, simply because the succ- -- our success as a system is going to be dependent upon interoperability between levels of care. So I think that's something we all have to keep in mind and try to think about, from a policy perspective, how do we insert long-term care into the initial and beginning discussions.

A quick story to go with Chuck's. I was at a meeting on -- what is it? EHRs, a couple months ago. And I was sitting, by accident, next to a gentleman from Maine who said that they were developing an electronic platform for Maine and I said this is great, you know, we can really facilitate the transfer of the postacute care and he goes, "Well, we're not doing long-term care yet." So, you know, here was a whole state that was going forward to develop interoperability and leaving out an entire sector and this is happening again and again.

CAROL RAPHAEL: I think that's a really very important observation and I think, even in New York State, they're beginning to invest in technology, but I don't think long-term care really has a seat at the table. And it really creates enormous problems, because the major systems being used out there, EPIC, NextGen, you can -- there are a handful of systems. We're -- when we are trying to build some kind of interoperability, it's very difficult to do it, because of the fact that we weren't there when these systems were created and as they're evolving.

RUSSELL BODOFF: Yeah, and without a doubt, it is essential for the long-term care community to be more involved. I mean, you're seeing it now, OSSA, ACCA, HEMA,

others are coming together, but the reality is that 95% of work is acute care-driven, the corporations involved are the companies selling big systems to hospitals and they have a much higher knowledge level on informatics than we do in this field. But, you know, at some point, the field has to take certain levels of responsibility also and it is pulling teeth to get providers to participate and support these type of activities.

And the credit I give to Elite Care is a husband and wife put their own money in to start a fresh idea, hire some young software engineers and design something and we've got big providers in the aging services field all over the continuum who are still afraid to do anything and make investments. So there's gotta be at some point where we say we've gotta take leadership and, if you don't, we're gonna live by what the acute care community drives and it's not gonna serve our needs.

EDWARD ALAN MILLER, PhD, MPA: Would you like to say something?

MARY JANE KOREN, MD: Yeah, I -- as Russ knows, both of us sit at OSSA and I want to bring the conversation back to Aegis [?] to -- what are we? Is this still Aegis [?] or

I guess -- AcademyHealth, I'm sorry. I'm sorry, I'm way -- way too old at this point.

But I wanna make an observation, because I -- many of us are researchers, many of us sit in applied environments. I have the luxury now of -- of working with, you know, sometimes as many as 6000 providers. I get a lot of phone calls every day in my office from providers who ask me, "Should I buy this technology? Should I build a greenhouse? Should I build a smart house? Should I -- should I be doing this technology? Should I be wiring? Should I be putting wireless in my entire low-income housing building?" And I have to go back and ask the basic question which I think we as researchers need to keep asking and sometimes I'm not sure I'm hearing that here. What is the problem we are trying to solve?

This is a piece of technology in the -- whenever the heck -- whatever his name was -- Lewinson or whoever it was that first identified the eyeglass. This was a technology that helped us to see. The pens that we use in writing our documentation are as -- are technology. We have lost our way in talking about technology as though it's some end in itself and I would just like us to get back to focusing on what are the questions we are trying to solve.

I really liked Carol's presentation because she was really clear and concrete about the focus of VNS on very operational questions around continuous quality improvement. And I have followed VNS's from the day that Joan Marron [?] started talking to me about rolling out the tablets and working with the staff around improving continuous quality improvement. I also know it was a little bit of a struggle in the beginning and it's been a journey, but they had a very clear vision of what they were doing and why they wanted to use particular technologies to get there.

I do not see that, for the most part, among the providers that I talk to. They want to jump on the newest bandwagon. They don't have an idea of what works and what doesn't work, but, more fundamentally, they don't know what question they're trying to solve. And it's -- it's what we try to do at -- in our institute, at OSSA, is to get these folks to understand they're all researchers. They're trying to figure out a problem and they gotta know what they want to solve first.

And I'll give you one quick story and then I'll get down. We're working with Susan Horn on something called realtime care planning, improving documentation around

decubitus ulcers. And she went in trying to actually get documentation to happen with front-line caregivers and, working with us, realized very soon that, as with a number of other projects, this is about organizational development and staff workflow and not really about any kind of technology, whether they're using a digital pen or whether they go to electronic kiosks or whether they go to whatever. If they don't have front-line caregivers who even know what a piece of data is let alone how to enter it and use it, it's all gonna be worthless.

And most of the investment that has gone into the AHRQ program is around processes and workflow and team development and empowerment and all of those kinds of things that have nothing to do with technology. The technology may come to help make things more efficient; we're not even sure of that yet. So let's not lose sight of where we are and, as researchers, if we don't hold people's feet to the fire around what questions they're asking, there's nobody that's gonna hold people's feet to the fire.

EDWARD ALAN MILLER, PhD, MPA: Well, I'd like to conclude the panel, 'cause I think we have updates. [APPLAUSE] So I'd like to thank Russell and Carol and

Nancy and, remember, I guess, the technology serves us and not us the technology. So.

FEMALE SPEAKER: We have a fifteen-minute break at this point and back at 11:30. [BREAK TALK/ROOM NOISE/CONVERSATION]

Workgroup Updates

FEMALE SPEAKER: We're ready to get started for the workgroup updates, so if you can all take your seats. [ROOM NOISE/CONVERSATION]

If everyone can take a seat, we'll get started for the next presentation and, after that, there's lunch, so the sooner this is done, we can move on to some fun activities.

Mary Jane Koren, program officer at the Commonwealth Fund, is going to give us an update on the workgroup breakfast and the different long-term care workgroups that have been taking place out of all the last colloquiums for the "Building Bridges: Making a Difference in Long-Term Care."

I also want to make an announcement that, after this, there's lunch and there are quite a few posters presented for y'all to take a look at and there's also going to be a live demonstration of the Oatfield Estates web portal and

the video that CAST produced, all taking place in the lunchroom. So now it's Mary Jane Koren.

[SETTING-UP TALK]

MARY JANE KOREN, MD: Good morning and thank you all for coming and paying such attention and having such good discussions. It's really been a -- an exciting morning for me.

Just as a brief bit of background, I remember it was, I guess, in Nashville that we sort of sat down and had a discussion and some of the people from AcademyHealth and other researchers got together with me and said, "Do you think that you could perhaps think about funding another long-term care meeting?" And I said, "You know, to be honest with you, I think this is too important a topic to do one meeting and so let's think about it as an overarching kind of continuum and let's think about maybe a five-year effort."

So this is really part of something that we're trying to do to build momentum and to keep the field moving and to get all of you talking to each other and knowing each other. And that's one of the reasons that we wanted to talk a little bit about the workgroups.

What's really important to us is not that this is what we would call a one-off meeting that you all get together and you kind of enjoy talking to each other for a couple hours once a year, but, really, we're trying to bring together different, to use the jargon, stakeholder groups, researchers, people from the provider community and also policy-makers to really start to talk to each other and get to know each other, so that the kind of research that's done will help to answer the questions that are out there and really help us think about what do we need to know in order to do it better, to do long-term care better and how to make a difference in this group.

So, as we were designing the colloquium series, one of the things, one of the challenges that we had was "How do we try to maintain the momentum that has been started as you sit around the tables, as you talk to each other?" And what we thought was it would be really nice if we could have workgroups that coalesced around the topics that each of the presenters each year were going to do.

So, initially, we started with two workgroups. Initially, I think our first colloquium, we talked about the use of information to improve quality. Vince Mor gave a talk. And we also then looked at the issue of the dual-

eligibles and the whole issue of payment and financing for long-term care. And then we move, next year, into housing and into the whole issue of consumer-directed long-term care, so each year, what we've been trying to do is to add two workgroups that will gradually continue the themes that have been begun in the previous years.

One of the big problems, of course, is when you are able to sit around a table and talk to each other face-to-face, you're able to read the body language of what people are kind of interested in and do they resonate to what you're talking about and that's a very hard thing to do on a conference call. And it's one of the reasons that we have the breakfast meeting before this session starts, so that you can really get to see who these people are that you're talking to, these disembodied voices, and also to sort of get some idea about "Are these the things that they really want to talk about and be interested in?"

Our different groups, I think, are really moving ahead nicely. Some of them are just at the beginning phases. Others have been going on a little bit longer, but, as I said, we now have six groups. What we realized was that some of the topics were very broad and the biggest problem was really trying to focus down in a meaningful way, so

that people could get a handle around it. And so, in addition, for example, to consumer-directed long-term care, we had a sort of spinoff on promoting culture change, if you will, within long-term care, which is, at this point, is -- represents or is a term that we use to represent a movement toward resident-directed care or person-directed care, mostly within residential long-term care, but certainly it's a concept that is equally applicable to home and community-based services. So, in some -- in some instances, we've really had sort of binary fission here, that we've had one group kind of morph into two and go off into different directions that they're most particularly interested in.

This year, of course, we'll be adding two more workgroups, hopefully, and what we'd like to do is to get an expression of interest from people who are here to find out, you know, "Is this a group you'd like to work on? Is this something that you think would be of interest?" And maybe even, over lunch or during the afternoon, to talk to each other about what the focus might be, because, obviously, as we've heard today, technology in long-term care is an enormous topic and trying to kind of think about what aspect of that do you really want to focus on. And we

may actually have two groups end up, one would be health information technology, another would be sort of assistive devices. So we may really think about -- or as Chuck had pointed out, monitoring communication, sort of different aspects of technology.

So, these are just the broad areas and please don't feel constrained by them. They're really trying to just provide a framework for you to have discussions.

We've tried to highlight three groups in particular. Our home health group has really been guided and led by Eliot Fishman and have really tried to think about what quality measures might be for home health. And Eliot's not here, but one of his other staffpeople or team members is here. I'm trying to see where she is. There. And what I thought is, rather than me trying to sort of say what had happened, is to ask the three groups that we're going to highlight today to just give you kind of a paragraph, an encapsulated sentence or two about what the group has been doing and also about their experience in running and managing the groups and kind of how it's been going. So if you'll -- yeah.

FEMALE SPEAKER: So our aim ... [OFF-MIKE]

Our aim has been to contribute to the ongoing discussion at CMS on home care quality measures and pay-for-performance and we have identified five domains and our goal is to come up with very specific measures that we will recommend and we've actually con- -- achieved consensus on two of them. And, over the next year, we do -- we will be working on the other three. And I will have a update that people can pick up with the -- with the other materials on our progress and we generally meet every few months on a conference call.

MARY JANE KOREN, MD: Great. I think that this group kind of epitomizes a group that's been under -- or has been active for a while and if -- what's very interesting is they really have focused on a couple of areas and they have, in a sense, worked both with the researcher and the provider community to look at things that are of interest to both and that are perhaps able to be measured, evidence-based, but then, in terms of the next steps, it's really thinking about a mobilization of support for changes at a policy level. So you can kind of see how all three interests are merged, in a sense, in the workings of the group, so it's -- you know, what is the evidence base, what is the measure, what is it that providers need and -- in

order to measure their own performance and improve? And then, how do we move that into a policy arena?

Last year, as you know, we talked about the importance of housing relative to long-term care and Annette Totten from Idaho has -- I know she laughs, well -- she's also from Brooklyn, but -- could tell us a few things, in terms of the housing group.

ANNETTE TOTTEN: The housing group is one of the ones that's just getting started. We had our first conference call in the Spring and so we're at the point where we're trying to just -- to narrow down the topics and sort of the three big areas we've been talking about is first following on Dr. Golant's paper and talking about affordable options that combine housing and care. The second kind of related is, as we push state governments or organizations like the VA towards rebalancing and an increased reliance on home and community-based care, how do we make sure that the housing component is included in that and what are the issues we need to be concerned about? And then, the third was sort of the policy issue of, when we talk about community planning or regional planning, we talk about health services and then we talk about housing separately.

And so those were sort of three issues that we brought up and we're at the point of focusing and we're not that established yet, so anyone who's interested, I wanted to do a commercial to get involved. And my role, as the coordinator, is to make sure that nobody works too hard or not enough. So that's the goal for our group is to come up with a targeted thing and make it actually happen. And, particularly, I guess, 'cause the other community I serve on is the next generation, I would encourage those of you who haven't done anything active yet or who are newer to the field to join on, 'cause we'll find a way to make sure you get your word in edgewise when you sit at tables like the one I was at.

MARY JANE KOREN, MD: Not that you think that Robin sometimes can't dominate a conversation, but it's okay.

FEMALE SPEAKER: [OFF-MIKE] ... edgewise ...

MARY JANE KOREN, MD: The other group that we can talk about a little bit is the consumer-directed long-term care and Ted Benjamin has been kind of -- kind enough to coordinate that group and might want to say a couple words about where they are and what they're thinking about.

TED BENJAMIN: Thank you. We, like the prior group, are getting started, so we're in the "Let's focus" stage. We had also our first conference call.

First, let me say 25 to 30 people expressed in this workgroup and we had a conference call with a dozen of us in April. It was a very interesting call. It was a diverse group of people. State and federal agency people, advocates for consumers and workers, academics, policy analysts of various stripes. So a lot of interesting ideas emerged.

Some of them basically about what are the definitions here? What are the various models used? Or that have been identified under the rubric of consumer-directed home care. How it -- what are the issues that have emerged in the implementation of these models, paying attention to Cash and Counseling as well as other state-level efforts. And paying attention to stakeholders and competing interests, including the worker as well as the consumer in discussions about whose interests are served by consumer-directed approaches.

We're -- we've discovered that 7:15 AM breakfasts aren't a vehicle for our workgroup to set an agenda, so we

may try evening cocktails some other -- but we're on our way. Thanks.

MARY JANE KOREN, MD: Thanks, Ted. So, as you can see, we have groups in different stages development and I'd really encourage you to get involved with them, if for nothing else that you get to talk to different people around the country and that you really, in a sense, enable others to access your network and you find out information about what's going on in their network. Really just, sometimes, the power of conversation and finding out what other people know, because it is such a diverse field and there's so much going on and so much ferment in it that just the opportunity to talk to each other, I think, is an important one.

For the next two groups or even if the existing groups, if you want to know more about it, probably the best thing to do is talk to Christal, who's standing there in the back, and she will help you kind of get connected, help set up the infrastructure to enable you to go forward on this, 'cause AcademyHealth sort of helps organize the calls and sort of does some of the administrative work that goes on with managing a workgroup such as this, which is

very helpful, because, otherwise, it would be very difficult to do.

I'm standing between you and lunch, so I hope that you enjoy lunch. Also, we've -- we have, in the past, used this as an opportunity to bring together a lot of the posters that are going to be posted during the session here, so that we have them all concentrated at one time and it really is an opportunity for you not only to get lunch, but also to talk to the people who are with the posters, find out what they're doing, you know, bring them into the group and to try to learn a little bit more about it. We also have the CAST video and the demonstration from -- excuse me, I'm forgetting the organization, but from the group, the Milwaukee, Oregon. And so it's really an opportunity to use the time to kind of further the agenda.

So, enjoy lunch and then we'll see you back after lunch.

MALE SPEAKER: The posters are listed in ... [OFF-MIKE]

[END OF MORNING SESSION]