BUILDING INNOVATIVE COMMUNITIES:

promoting health reform principles through community-based learning and collective action

Innovative Communities Summit | June 27, 2011
Georgetown University Conference Center | Washington, D.C.

mission statement

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

acknowledgements

Supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund. **www.commonwealthfund.org**

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

Kermit Eide, president of K.M. Eide and Associates in Williamsburg, Va., and Marybeth Fidler, founding partner of Cygnet Strategy LLC in Lancaster, Pa., worked closely with the LTQA core team in the design and facilitation of discussions that involved the Summit participants throughout the day.

This report was written by Geralyn Graf Magan, an independent writer from Clarksville, Md.

www.ltqa.org

For more information, contact:

Doug Pace, Executive Director, dpace@ltqa.org

BUILDING INNOVATIVE COMMUNITIES:
Promoting Health Reform Principles Through Community-Based Learning and Collective Action

PREFACE

INTRODUCTION AND OVERVIEW 1

- About LTQA 2
- LTQA and the Affordable Care Act 2
- Summit #1 3
- Summit #2 4
- Looking Forward to a Future of Innovation and Transformation 5

CHAPTER 1 7

- Innovative Communities and Health Reform

CHAPTER 2 11

- Summit Presenters: An Innovative Community in Microcosm

CHAPTER 3 23

- Opportunities for Transformation in Innovative Communities

CHAPTER 4 29

- Management Tools to Help Innovative Communities Move Forward

CHAPTER 5 33

- Innovative Communities and Health Reform

APPENDICES 35

- Summit Participants

preface

There's no place like home

Courtney S. Tierney, Director
Prince William Area Agency on Aging
Woodbridge, Virginia

Dorothy is 79 years old. She lives alone in Prince William County, Va., in the house where she was raised. Meet Dorothy once and you will have no doubt that her ties to and love of that home are what sustains her and gives her life meaning.

Are there problems with Dorothy's home? Most definitely. When a social worker from the Prince William Area Agency on Aging (AAA) first met Dorothy to discuss her need for legal advice on another matter, the extent of the home's dilapidation was immediately apparent, despite its clean and tidy appearance. The home's most significant issue was running water: it had none. For decades, Dorothy had routinely used bottled water to keep herself and her home clean. As a matter of necessity, she had even become accustomed to burying her waste in the backyard.

A series of mishaps befell Dorothy during the months following her first call to the AAA: a break-in and sexual assault, a hospitalization, a cancer scare, and a car hitting the home. With each mishap, Dorothy became more unwavering than ever in her desire to remain in a home that appeared to be letting her down. It took an entire county government to help Dorothy fulfill her wish.

It took a wise Department of Neighborhood Services to suggest that there might be a solution to Dorothy's hygiene issues other than condemning the property and forcing Dorothy to move. It took a practical Health Department to recommend that Dorothy install a portable toilet in her backyard to resolve public health concerns. It took compassionate police officers and a band of altruistic volunteers to secure Dorothy's home after a break-in so it would be safe for habitation. It took a generous builder to donate materials to make necessary home repairs. And it took a persuasive building inspector to convince Dorothy to spend some of her savings to correct a termite problem that surfaced during the repair process after the car accident.

At each stage in her ongoing encounters with the AAA and its partners, Dorothy made it clear that she wanted to stay at home, even when those helping her had good reasons to disagree. But along the entire journey, Dorothy's AAA social worker recognized that it didn't really matter what the professionals wanted. Instead, it was the AAA's job to make sure Dorothy got what she wanted.

It's been 3 years since Dorothy called her AAA. At the age of 82, she's still living at home with help from the AAA. Dorothy's story illustrates clearly that it takes many people, from many sectors of the community, to help at-risk individuals remain independent. Like her namesake from Frank Baum's classic tale of the Wizard of Oz, Dorothy was lucky enough to find people with courage, heart, and brains to help her live the life she wants to live. In the process, Dorothy taught all of us that there is truly, "no place like home."

introduction and overview

Mary D. Naylor, Ph.D., R.N., Chair
Long-Term Quality Alliance

Amy Boutwell and Larry Minnix, Co-Chairs
LTQA Innovative Communities Initiative

It was fitting that the 120 community activists who gathered in Washington, DC, on June 27, 2011 for the 2nd Innovative Communities Summit should meet a consumer—Dorothy from Prince William County, Virginia—as soon as they entered the meeting room at the Georgetown Conference Center. Dorothy's story, as told to summit participants by Courtney S. Tierney, director of the Prince William Area Agency on Aging, celebrates the spirit of individualism that has become a hallmark of our American culture. But that's not all.

The story of Dorothy also celebrates the great champion that this septuagenarian had in her social worker at the Prince William Area Agency on Aging (AAA). That social worker saw a need, but recognized that it wasn't her job to prescribe a solution. Instead, she facilitated collective action by a variety of partners, all the while advocating for her client's right to self-determination. Because of that social worker and her community partners, Dorothy's story became a tale of consumer empowerment and an illustration of the power that Innovative Communities like Prince William County have to mobilize community stakeholders so they can work together, capitalize on existing resources, and create a continuum of integrated and coordinated services for older people and people with disabilities.

The 2nd Innovative Communities Summit may have begun with Dorothy's story. But by the end of the day-long convocation, Dorothy's story had become the story of the Long-Term Quality Alliance (LTQA) and its commitment to collective community action. That collective action can be a life saver for the more than 10 million Americans who wake up every day confronting functional deficits and other issues that threaten their health, independence, and sense of well-being.

About LTQA

LTQA is a neutral convener of broad-based groups concerned about and committed to advancing change within the nation's health care system. Since its founding in 2010, the alliance has had one overriding goal: to improve the effectiveness and efficiency of health care and the quality of life of individuals while saving health care dollars. That goal is particularly timely given the new mandate in Washington to reform the current health care system, primarily through the Affordable Care Act (ACA).

LTQA's leaders hope that such reform will eventually create effective measures to gauge the quality of the services that consumers receive and to shed light on how consumers and family caregivers experience their services and supports. We want to engage consumers and their caregivers in efforts that improve care transitions and coordination. We want to promote earlier access to palliative and end-of-life care and minimize unnecessary overuse of services. Yet, we understand that no reform will be successful or sustainable unless and until we take steps to introduce efficiencies into the health care system that will trim costs while supporting and strengthening the workforce that we depend on to provide critical care and services to older consumers and people with disabilities.

LTQA and the Affordable Care Act

The ACA gives LTQA an historic opportunity to meet its goals for health care transformation. During the 2nd Innovative Communities Summit, three leaders from the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) confirmed that this is true and offered valuable insight into how Innovative Communities could take full advantage of our current health reform climate. The message we heard from Assistant Secretary of Aging Kathy Greenlee, Partnership for Patients Co-Director Dr. Paul McGann, and CMS Innovations Center Special Advisor Jim Hester underscored the need for Innovative Communities to be bridge-builders between the acute-care sector and providers of long-term services and supports in local communities around the nation.

As you will read in the following pages, Kathy Greenlee outlined ways in which AoA is working to broaden the definition of long-term services and supports by collaborating with the acute-care sector and implementing evidence-based prevention and chronic care management programs.

Dr. Paul McGann urged summit participants to join the Partnership for Patients, a new public-private partnership that brings together health and service providers, patient advocates and state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. And finally, Jim Hester boldly suggested that the nation will need between 2,000 and 2,500 effective and working Innovative Communities in order to achieve health reform's goals.

Like our friends at CMS, LTQA is convinced that the most important health reform victories will take place at the local level, in cities and towns around the country. A broad range of community stakeholders — including physicians, hospitals, AAAs, long-term and post-acute care providers, visiting nurses, affordable housing providers, adult day health programs, home care agencies, and consumers, to name only a few — is needed to help older people, people with disabilities, and other

individuals remain healthy and independent. Health care reform will not succeed unless all of these local stakeholders pool their collective energy, break down the silos in which they operate, and work together in Innovative Communities to devise and implement strategies and interventions that advance and improve care. Those strategies and interventions must be aligned with the needs, preferences, and values of consumers and their family caregivers. LTQA is fully committed to helping communities around the nation take this collective action.

Establishing the Foundation on which Innovative Communities Will Thrive

The 2nd Innovative Communities Summit was designed to build on the great work that participants in the 1st Innovative Communities Summit carried out in Dec. 2010. Participants in that inaugural meeting worked together to create a common vision for a more collaborative future for those who provide and those who receive care and services. That vision, as outlined in our first report, called for:

- Empowerment of consumers through a customized, coordinated life-care plan that is person-centered and developed with the involvement of family.
- Development of community teams made up of equal partners and led by an independent and invested leadership.
- Easy access to information about models and tools for improving care transitions and providing coordinated care.
- Funding programs that feature aligned incentives and flexible funding streams.
- A willingness to reinvest health-care savings back into the local communities that save public dollars.
- Cutting-edge technology that moves care into the home and helps consumers manage their health conditions.
- A robust workforce that is knowledgeable about care transitions.
- A strong volunteer network.
- Public education that helps people with chronic diseases manage their conditions while living in the community.

To help make this vision a reality, participants in the 1st Innovative Communities Summit encouraged LTQA to:

- Serve as a repository for information that could help local stakeholders create and support Innovative Communities at the local level.
- Develop and promote a common language that multi-sector collaborators could use to communicate better with each other and with consumers.
- Serve as a cheerleader for Innovative Communities by coaching fledgling communities and convening regular meetings to encourage sharing of ideas and best practices.
- Help Innovative Communities identify federal and state sources of funding and offer them advice on ways to access that funding.

- Launch a national public relations campaign designed to educate consumers about the community resources available to ease hospital-to-home transitions.

- Educate government agency staff, legislators, and policy makers about Innovative Communities and advocate for public policies, regulations, and funding changes that encourage flexibility, innovation, and cross-sector collaboration.

Strengthening Innovative Communities through Shared Learning

During its 2nd Innovative Communities Summit, LTQA gathered a variety of leaders to explore how the alliance can support Innovative Communities and how these communities can work together to improve care transitions and reduce unnecessary rehospitalizations. The wealth of knowledge and experience in evidence during this gathering was truly impressive. Summit participants represented 20 Innovative Communities, 20 federal agencies and 15 state and local governments. Five participants represented the philanthropic community. Seven consumers joined the summit, as did 32 providers of health care, long-term services and supports, and home and community-based services. We also welcomed 14 organizations representing health-care purchasers and payers, and 16 academicians whose area of expertise includes health policy.

In addition to these expert participants, LTQA was honored to introduce 11 presenters who interacted with one another and with summit participants during facilitated panels and small-group discussions. Presenters represented three major categories of stakeholders whose engagement is critical to the success of LTQA's Innovative Communities initiative:

- **Innovative Communities:** Representatives of Innovative Communities in Humboldt County, Calif., northwest Denver, Colo., Greater North Shore, Mass., and Atlanta, Ga., shared how their community coalitions are: providing coordinated services and supports to people with dementia and their families; using community-organizing strategies to engage new partners in reducing rehospitalizations; creating lifelong communities where people of all ages can enjoy a community infrastructure designed specifically to help them remain healthy and independent; and helping consumers manage their chronic conditions so they can transition successfully from hospital to home.

- **National and State Support Programs:** Representatives from the Quality Improvement Organization Care Transitions Theme, the federal Beacon Community Program, the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative, the AARP Medicare Supplemental Plan, and the Michigan State Action on Avoidable Rehospitalizations shared how their initiatives are supporting Innovative

Communities by providing funding and technical support so local collaboratives can create new models of service delivery from which others can learn.

- **Private Foundations:** Representatives from the McGregor Foundation, the Duke Endowment, and The Commonwealth Fund offered instructive presentations that examined the missions of their organizations, explained why these foundations are interested in supporting Innovative Communities, and offered valuable insight into strategies that Innovative Communities could employ to obtain philanthropic support.

Looking Forward to a Future of Innovation and Transformation

Dr. Carolyn Clancy, executive director of the Agency for Healthcare Research and Quality, recently urged providers of long-term services and supports to avoid the temptation to put their energy into "one-shot wonders." These initiatives, while interesting and innovative, are too narrowly focused to be sustainable. Dr. Clancy advised providers to focus instead on major initiatives that are destined to make a difference in the lives of individuals because they focus on large-scale populations, involve a broad-based set of stakeholders, and demonstrate that they can save health care dollars.

The Long-Term Quality Alliance agrees with Dr. Clancy and we are intent on following her advice. To make that possible, the alliance asked participants in the 2nd Innovative Communities Summit to commit themselves to a 3-year effort to establish a learning network of Innovative Communities. This network would provide Innovative Communities with the information and resources they need to establish community-based coalitions that will think creatively and act collaboratively in order to improve the lives of individuals.

chapter 1

innovative communities and health reform

In order to be successful, Innovative Communities must begin building bridges in their local communities between physicians, hospitals, and providers of long-term services and supports. Only when these health sectors work together, says three federal agency leaders, can providers take a holistic and coordinated approach to delivering quality care and services in the most efficient manner as a way to improve population health and reduce costs. Working with the acute-care sector can also give long-term care providers improved access to health-reform dollars.

Kathy Greenlee
Assistant Secretary for Aging
U.S. Department of Health and Human Services

While the Affordable Care Act (ACA) provides many of the tools necessary to reform health care and foster partnerships among health care providers, the legislation could very well stand in the way of partnerships if we let it. The ACA focuses almost exclusively on the acute-care model, despite the fact that health reform cannot achieve its objectives unless it also incorporates long-term services and supports.

The first step in creating a more integrated health care system will involve changing the mindset of practitioners and policy makers who define long-term services and supports far too narrowly. By focusing only on nursing homes, these stakeholders ignore a host of vital services and supports that are available in the community to older Americans and people with disabilities.

The Administration on Aging (AoA) has taken concrete steps over the past several years to advance this broader definition of long-term services and supports, and to collaborate with the acute-care sector. Many of those efforts have focused on the development and implementation of evidence-based practices aimed at improving care transitions and reducing rehospitalizations by helping consumers manage their chronic conditions, supporting family caregivers, and educating community-based providers of care and services. For example:

- AoA is expanding its partnership with the National Institute on Aging (NIA) so that NIA-tested best practices can be applied to the work that Area Agencies on Aging and Aging and Disability Resource Centers are doing to provide services to older people and people with disabilities, and to support family caregivers.

- AoA is incorporating evidence-based practices into its own outreach programs. For example, the Chronic Disease Self-Management Program has trained almost 32,000 individuals using the well-respected Stanford School of Medicine model. In addition, more than 6,000 people have participated in AoA's evidence-based programs for adults with Alzheimer's disease and their families.
- AoA is committed to participating in health reform. Through webinars and other communications vehicles, the agency is educating members of the aging network about fundamental issues like how to ease care transitions and about how to partner with the acute-care system in their local communities.

AoA is participating in health care reform by identifying and sharing best practices and then working with its partners to replicate those practices and take them to scale. We want to ensure that models for care transitions are evidence-based. We want to develop systems to integrate health and human services into care delivery at the community level. Our network is energized and excited about these opportunities and it is ready to move forward.

Dr. Paul McGann
Former Deputy Chief Medical Officer,
Office of Clinical Standards

Co-Director, Partnership for Patients,
CMS Innovation Center

Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Innovative Community partners can begin making meaningful connections with the acute-care sector by joining the Partnership for Patients. This new public-private partnership brings together health and service providers, patient advocates, and state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. The partnership has two primary goals:

- **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would decrease by 40 percent compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over 3 years.
- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20 percent compared to 2010. Achieving this goal would mean that more than 1.6 million patients would recover from illness without suffering a preventable complication requiring rehospitalization within 30 days of discharge.

These are ambitious goals that will save lives and prevent injuries to millions of Americans. Over the next 3 years, they also could save up to $35 billion dollars across the health care system, including up to $10 billion in Medicare savings. Over the next 10 years, they could reduce costs to Medicare by about $50 billion and result in billions more in Medicaid savings.

The Partnership for Patients can't hope to reach these goals without the help of community-based care providers and providers of long-term services and supports. Yet, the vast majority of the initiative's 4,000 partners represent the acute-care system.

Convincing providers of long-term and post-acute care to join the Partnership for Patients is a campaign priority. Community-based care and long-term care play a critical role in keeping a substantial percentage of this country's population healthy and independent. As partners in this bold initiative, these providers can work hand-in-hand with the acute-care sector to transform our health care system.

Jim Hester
Senior Advisor
CMS Innovation Center
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

In order to achieve the Partnership for Patients' goal to reduce readmissions for the total population by 20 percent over the next 3 years, the nation will need between 2,000 and 2,500 effective and working Innovative Communities.

We will need these communities to be true innovators that seek new ways to transform the nation's health care system. Why will innovation be so important? Because every one of the failures we experience when we don't handle a transition effectively has the face of a patient, family member, and caregiver behind it. We owe it to all Americans to think imaginatively and act creatively to improve the quality of their health care and the quality of their lives.

The human face that is behind every transition failure is what drives the work of the CMS Innovation Center. The ACA-authorized center will have $10 billion at its disposal over the next 10 years to find, test, and defuse new models of care delivery and new payment approaches that make those models sustainable. In addition, the Secretary of Health and Human Services will have the authority to scale nationally any initiative that the Innovation Center demonstrates will achieve the outcomes that CMS is seeking.

The Innovation Center will launch three separate levels of initiatives to improve the health care system so it achieves better health care and better population health at reduced costs:

- *Patient-care initiatives* will seek to ensure that every encounter an individual has with the health care system is safe, timely, effective, efficient, equitable, and patient-centered.
- *Coordinated care initiatives* will design funding and payment options that support coordination of care across settings for patients throughout their lifetimes.

- **Community and population health models** will aim to improve the health of all Americans, including the health of communities and specific populations.

The Innovation Center has already launched several new initiatives, including the Section 3022 Medicare Shared Savings Program, the Multi-payer Advanced Primary Care Initiative, and the Federally Qualified Health Center Demonstration. A very impressive and very exciting list of additional initiatives will be announced over the next year.

Each initiative will represent a building block that communities can use to meet the goals of health care reform. The challenge for Innovative Communities will be to arrange those building blocks in a way that makes sense for them and for the populations they serve. In addition, Innovative Communities will need to define their target populations as broadly as possible. Unless we work with the majority of Americans, we will never achieve fundamental change. And, make no mistake about it, we are seeking fundamental change.

chapter 2

summit presenters: an innovative community in Microcosm

During its 2nd Innovative Communities Summit, the Long-Term Quality Alliance (LTQA) gathered together a variety of leaders to help it explore how LTQA can support Innovative Communities and how these communities can work together to improve care transitions and reduce unnecessary rehospitalizations. Summit participants represented a myriad of organizations and agencies that have a stake in the nation's evolving health-care system. The list included:

- 20 Innovative Communities.
- 20 federal agencies.
- 15 state and local governments
- 5 private foundations.
- 7 consumers.
- 32 providers of health care, long-term services and supports, and home and community-based services.
- 14 health-care purchasers and payers.
- 16 academicians whose area of expertise includes health policy.

In addition to these expert participants, LTQA introduced 11 presenters representing three major categories of stakeholders whose engagement is critical to the success of LTQA's Innovative Communities initiative: Innovative Communities, national and state support programs, and private foundations. Chapter 2 provides brief overviews of the work these communities and organizations are currently pursuing at the local level.

innovative communities

Humboldt County, California: Dementia Care Coalition

Joyce Hayes
Executive Director
Humboldt Senior Resource Center

Imagine a world in which people with dementia and their family members get the right information and care at the right time, where medical clinicians identify memory loss early in the process and make

appropriate referrals to supportive services, and where people with dementia and their families can continue to be active and engaged community members. That's the dream of the Dementia Care Coalition in Humboldt County, CA.

The 4-year-old coalition was launched in late 2007 after The California Endowment awarded a $222,000 grant to the Humboldt Senior Resource Center. A local grant of $100,000 was also received. The resource center operates an Alzheimer's Resource Center that offers adult day health services, support groups, counseling, information, and education to help people with Alzheimer's and their families. The coalition's 24 members include hospitals, agencies providing social and medical services to the elderly, businesses, community volunteers, individuals with early Alzheimer's disease, and their families.

The Dementia Care Coalition developed and is now implementing a dementia care plan that identifies existing gaps in the local services available to dementia clients and their families and recommends strategies to fill those gaps. The plan calls for increased access to appropriate health care and services for patients and families; improved coordination of care so patients' medical, environmental, and social needs are adequately addressed, and enhanced training and support for caregivers and health care providers.

Implementation of the Dementia Care Plan has focused on several key areas, including information and referral. To date, the coalition has:

- Sponsored an annual dementia conference for consumers, their families, professional caregivers, and health professionals.
- Facilitated early diagnosis of dementia through a Memory Assistance Project (MAP) that links medical offices with the referral system at the Alzheimer's Resource Center.
- Arranged for a neuropsychologist to make monthly visits to the county to facilitate diagnosis and treatment of individuals with Alzheimer's disease.
- Established support groups throughout the county. Some support groups use teleconferencing to reduce participants' travel time.
- Trained 50 volunteers to assist in services related to dementia care.

Looking to the future, the coalition would like to train 50 additional volunteers to serve as medical advocates for clients with dementia. These advocates would be available to help clients and their families at any time of the day or night, but especially during hospital and emergency room visits. Plans also call for increased use of telemedicine to link dementia experts to local medical professionals.

North Shores, Massachusetts: Aging and Disability Resource Consortium of the Greater North Shore

Paul J. Lanzikos
Executive Director
North Shore Elder Services

The Aging and Disability Resource Consortium (ADRC) of the Greater North Shore is a

collaboration of more than 30 aging and disability service or advocacy organizations. The 6-year-old consortium focuses on responding to local residents who have a need for special assistance, assistive technology, accessible environments, care transitions, chronic disease management, and accessible transportation.

Using a variety of funding sources, the ADRC provides information and referral, outreach and education, options and benefits counseling, employment support, advocacy, skills training, crisis intervention, assessment, and service planning. It also serves as the gateway to a variety of local services, including home-delivered and congregate meals, home care, chore assistance, companion services, dementia day services and adult day health services, homemaker services, respite, transportation, group adult foster care, protective services, family care for adults, caregiver support, and personal care attendant programs.

The consortium's primary goal is to create a single, coordinated system of information and access for all persons seeking long-term services and supports, regardless of age, disability, or income. ADRC partners have a shared commitment to the concept that there is "no wrong door" when consumers are seeking services. Partners follow through on that commitment by making sure that staff at all participating agencies are cross-trained to enhance service delivery, coordinating and streamlining key functions within existing organizations, and relying on consumers and community stakeholders to provide guidance on how service delivery could be enhanced.

In addition, the consortium operates several ancillary programs, including "Navigating across Care Settings," a care transition intervention for people with congestive heart failure, chronic obstructive pulmonary disease, or diabetes. The project, which is being implemented in partnership with the Massachusetts Executive Office of Elder Affairs and other partners, is designed to promote healthy, successful care transitions by strengthening communications around consumer health issues across settings, fostering health self-management, increasing awareness about care transitions among health professionals, reducing consumer and caregiver stress, and working to decrease hospital readmissions, preventable hospitalizations, and premature nursing facility placements.

Early findings demonstrate that patients who participate in Navigating across Care Settings are significantly less likely to be readmitted to the hospital. In addition, these patients are more likely to achieve self-identified health goals and to sustain these outcomes for as long as 6 months after they complete the program.

Atlanta, Georgia:
The Atlanta Lifelong Community Initiative

Cathie Berger
Director
Area Agency on Aging
Atlanta Regional Commission

One out of every five residents of the Atlanta, GA, metropolitan area will be over age 60 by the year 2030. This anticipated and unprecedented demographic shift has spurred local stakeholders to take a hard look at how prepared the region is to support

its rapidly graying population. Not satisfied with what they discovered, the partners launched a "Lifelong Community Initiative" to plan for the development of housing, transportation, service, shopping, and recreation options that would allow people of all ages to live in the region for their entire lives. Coordinated by the Atlanta Regional Commission (ARC), Atlanta's Area Agency on Aging, the Lifelong Community Initiative brings together housing, transportation, health, and service providers; public health experts; local elected officials; planners; and older adults and their caregivers. Partners established three basic goals for the initiative after engaging local stakeholders in a charrette that identified a set of design principles for Lifelong Communities. Those goals include:

- **Promote housing and transportation:** A wide range of housing options will be accessible, close to services, available to people with a full range of incomes, and located within existing communities. As individuals age, they will be able to access basic services through mobility options that help them remain independent.
- **Encourage healthy lifestyles:** Communities will create environments that promote physical activity, social interaction, and easy access to health care.
- **Encourage collaboration:** Health and supportive service providers will work together to expand service options. They will also provide opportunities for counseling to help consumers evaluate those options.

The Lifelong Communities Initiative has had a dramatic impact on the internal structure of the ARC, which expanded its mission to include the three Lifelong Community goals and created two new units dedicated to community development and health and wellness. The ARC has also worked hard to develop partnerships with the city's health department, local hospitals, and community planners; redesign its education arm to reach more people; and adapt its service delivery system to a new care transitions model. One new ARC initiative provides newly discharged hospital patients with a special "care package" that includes the services of a care-management coach and access to 14 home-delivered meals, 6 hours of home care, and 2 trips to medical appointments.

Northwest Denver: Connected for Health

Jane Brock
Chief Medical Officer
Colorado Foundation for Medical Care

The Colorado Foundation for Medical Care (CFMC) is Colorado's health care quality improvement organization (QIO). In that role, CFMC works under contract with the Centers for Medicare and Medicaid Services (CMS) to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries in Colorado. Its three-fold task includes: (1) improving quality of care for beneficiaries; (2) ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and (3) addressing individual complaints from beneficiaries and providers.

CFMC is also one of 14 QIOs participating in the CMS-sponsored "Care Transitions Theme," which focuses the efforts of selected QIOs on improving coordination across the continuum of care by promoting seamless care transitions and reducing unnecessary hospital readmissions. Participating QIOs are also expected to implement projects that bring about process improvements to address issues in medication management, provide post-discharge follow-up, and develop plans of care for patients who move across health care settings.

The Colorado care transitions project, called "Connected for Health," is taking place in northwest Denver and is being guided by a steering committee of leaders from two local hospitals, a variety of non-acute medical settings, a large employer, and an end-of-life facilitator. A patient/caregiver and a Medicaid representative also serve on the committee. In addition, four separate volunteer action teams have implemented targeted interventions that have helped the partners achieve a 9.3 percent reduction in 30-day hospital readmissions. Specifically, the teams have:

- Produced and distributed a standardized, paper-based personal health record that is now being used in two large hospitals, senior resource centers, physician offices, and nursing facilities.
- Developed a post-acute care decision support tool.
- Implemented palliative care information programs for hospital discharge planners and hospitalists.
- Developed patient coaching programs.

The Connected for Health partners are now working on a sustainability plan to ensure that they can maintain and expand their care-transition efforts after project funding ends. As a first step in that process, the steering committee is applying for funding from the federal Community-based Care Transitions Program. The program, which is mandated by section 3026 of the Affordable Care Act, will test models for improving care transitions for high-risk Medicare beneficiaries.

Aligning Forces for Quality

Susan Mende
Senior Program Officer
The Robert Wood Johnson Foundation

Aligning Forces for Quality (AF4Q) is a Robert Wood Johnson Foundation (RWJF) initiative to lift the overall quality of health care in 16 targeted communities around the country, while reducing racial and ethnic disparities and providing models for national reform. The $300-million initiative enlists "the people who get care, give care and pay for care" to work together to drive change in local health care markets and document measureable improvements in care by 2015.

Each Aligning Forces community has built its initiative around a core, multi-stakeholder leadership alliance that includes physicians, nurses, patients, consumers and consumer groups, purchasers, hospitals, health plans, safety net providers, and others. These alliances are charged with making sense of health-care quality problems so they can apply local solutions to those problems and then share the lessons they learn with others. To accomplish these goals, local alliances are working in four areas of focus:

1. **Performance measurement and public reporting.** Communities are using common standards to measure the quality of care doctors and hospitals deliver to patients. They are also making that information available to the public. For example, AF4Q communities have produced reports that document the quality of care being delivered in local hospitals and doctors' offices.

2. **Consumer engagement.** Communities are encouraging patients to be active and effective managers of their own health care. For example, some communities are collaborating with employers and community organizations to disseminate tools and information to help patients make informed choices and become better partners in managing their own health.

3. **Quality improvement.** Communities are implementing techniques and protocols that doctors, nurses, and staff in hospitals and clinics can follow to raise the level of care they deliver to patients. For example, AF4Q alliances are helping health care providers improve their skills and are collecting best practices for reducing medical errors from nurses at local hospitals.

4. **Developing and testing payment models.** During the latest phase of the AF4Q initiative, the 16 participating communities are exploring new ways of paying for health care based on value—not volume—of services provided by physicians and other providers.

Beacon Community Program

Jason Kunzman
Project Officer
Office of the National Coordinator for Health Information Technology

The Beacon Community Cooperative Agreement Program provides funding to help 17 selected communities throughout the United States build and strengthen their health information technology (HIT) infrastructure and health information exchange (HIE) capabilities. The program is designed to demonstrate and accelerate the role of HIT in improving care coordination, increasing the quality of care, and slowing the growth of health care spending.

Beacon communities are on the cutting edge of HIE and electronic health record (EHR) adoption. The federal funding they receive is intended to equip these tech-savvy communities with the tools and resources they need to achieve a new level of health

care quality and efficiency with the help of doctors, hospitals, community health programs, federal programs, and patients. The 36-month grant program is designed to show how communities, regions, and states can use EHRs and other HIT resources to bring about comprehensive performance improvement.

Each Beacon Community has set specific and measurable improvement goals that vary according to the needs and priorities of its particular community. For example:

- The Tulsa, Okla. Beacon Community is working to increase appropriate referrals for cancer screenings, use telemedicine to increase access to care for patients with diabetes, and reduce preventable hospitalizations and emergency department visits by 10 percent for conditions that could be better handled in clinical settings.
- The Bangor Beacon Community in Brewer, Maine is aiming to improve the health of patients with diabetes, lung disease, heart disease, and asthma by preventing unnecessary hospital admissions and readmissions and facilitating access to patient records using HIT.
- The Colorado Beacon Community in Grand Junction, Colo. is working to demonstrate how costs can be reduced and patient care improved through the collection, analysis, and sharing of clinical data, and the redesign of primary care practices and clinics.
- The Central Indiana Beacon Community in Indianapolis is engaging new community providers in the country's largest HIE in order to improve cholesterol and blood sugar control for diabetic patients. The initiative will also attempt to reduce preventable readmissions through telemonitoring of high-risk chronic disease patients after hospital discharge.
- The Rhode Island Beacon Community in Providence is promoting several HIT initiatives to support Rhode Island's transition to the Patient-Centered Medical Home model.

AARP Medicare Supplement Plan

Charlotte Yeh
Chief Medical Officer
AARP Services, Inc.

At the direction of AARP's wholly-owned taxable subsidiary, AARP Services, Inc., United HealthCare Group (UHG) implemented a series of integrated care management pilot programs for policyholders of AARP® Medicare Supplement Plans insured by UHG and living in Central North Carolina, Cleveland, Los Angeles, New York City, and Tampa. These programs are designed to improve the health outcomes of participants and help AARP Services, Inc. and UHG determine whether care coordination can successfully be achieved within the traditionally fee-for-service Medicare environment. The programs are provided at no additional cost to eligible participants.

The pilot initiative is comprised of programs supported by a variety of integrated services designed to ensure a more holistic approach to health care. The Heart Health, Coronary Artery Disease, and Diabetes Health Management programs provide eligible members with resources and tools to reduce the risks of coronary artery disease, congestive heart failure, and diabetes progression. Furthermore, eligible members with multiple conditions also have access to a High Risk Case Management program (Chronic Conditions). Depending on their needs, patients may be assigned a nurse case manager who will coordinate care via phone or in person. Patients will also receive a personalized care plan developed by the nurse case manager in collaboration with their physician and caregiver(s).

All the programs integrate depression management components through screening, symptom monitoring, and relapse prevention. Participants have access to nurses 24 hours a day, seven days a week through Nurse HealthLine, as do all AARP members with AARP-branded Medicare Supplement plans insured by UHG. Trained social workers assist eligible enrollees with social services such as facilitating in home assessments, coordinating meals and social activities and identifying transportation options. Furthermore, the programs include medication compliance monitoring designed to help consumers and providers better understand the barriers to medication adherence in order to provide support that improves compliance. Technology and innovation also play an important role in the program with initiatives that include in-home monitoring devices for patients with congestive heart failure, automated calling designed to improve medication adherence along with web-based resources and tools.

Eligible members are enrolled in the pilot programs through self referrals and data analysis as well as through referrals from caregivers, family members, and physicians. More than 16,300 AARP members have participated in the program since it launched in December 2008. Currently, there are approximately 6,000 active participants each month in the program.

During its first year, the AARP/UHG initiative reduced hospital admissions by 25 percent. The case management program yielded net savings of about $6 million for Medicare, while Medicare costs savings from the depression management program totaled $1.5 million. Even though only 38-40 percent of participants surveyed reported that their actual conditions had improved, over 90 percent of individuals said that the programs had positively impacted their lives, and expressed satisfaction with them.

Given the nature of chronic diseases, these programs are less about changing disease trajectory and more about positively impacting the quality of peoples' lives by, for example, enabling them to live confidently at home.

*Michigan STate Action on Avoidable Rehospitalizations (MI STA*AR)*

Nancy D. Vecchioni, RN, MSN, CPHQ
Vice President Medicare Operations
MPRO, Michigan's Quality Improvement Organization

Based on the belief that hospitals cannot reduce rehospitalization rates by themselves, the Michigan STate Action on Avoidable Rehospitalizations (MI STA*AR) is designed to create local health teams

made up of post-acute providers, physician offices, home health agencies, home and community-based service providers, consumers, and other local organizations. The teams, which are associated with the over 65 hospitals that have joined MI STA*AR since May 2009, are free to adopt specific strategies that they feel are best suited to the local patient population and community.

Taking a "rapid cycle change" approach, the typical transition team chooses to focus initially on one of the four key STAAR strategy areas until all strategies are addressed. STARR strategies include: enhanced admission assessment for post-discharge needs, enhanced teaching and learning, patient and family-centered handover communication, and post-acute care and follow-up. Next, the team chooses one or two hospital units in which to test strategic interventions; when the intervention proves successful in this small setting, it is then gradually expanded throughout the hospital. In addition, the teams are free to establish affinity groups that are charged with addressing particular issues or barriers that they discover at the local level.

MI STA*AR is part of a four-state pilot program that is directed by the Institute for Healthcare Improvement (IHI), with support from The Commonwealth Fund. The Michigan program is managed for IHI by MPRO, Michigan's quality improvement organization, and the Michigan Health and Hospital Association (MHA). Since the project launched in the third quarter of 2009, the state has experienced a 10-percent statewide reduction in hospital readmissions among Medicare beneficiaries.

The MI STA*AR initiative is guided by a steering committee consisting of leaders from statewide organizations whose members can impact rehospitalizations. This statewide committee and staff from MPRO and MHA support local efforts by providing training and networking opportunities, as well as hard data that teams can use to develop local strategies and measure outcomes.

The McGregor Foundation

Rob Hilton
President and Chief Executive Officer

Although it is a relatively young organization, the McGregor Foundation has its roots in more than 125 years of service to older people. In 1904, Tootie McGregor Terry established the A.M. McGregor Home to provide care to older men in East Cleveland, Ohio. Mrs. Terry built the home in honor of her husband, Ambrose McGregor, who was a close associate of John D. Rockefeller and had served as president of Standard Oil of Ohio. In establishing the organization, Mrs. Terry also created a generous endowment to ensure its continued longevity and success.

Today, the A.M. McGregor Home, as well as several affordable senior housing communities and two Programs of All-Inclusive Care for the Elderly (PACE), make up the A.M. McGregor Group, which also includes the McGregor Foundation. Established in 2002, the foundation awards grants in three categories: home and community-based care, with an emphasis on affordable housing

with services; workforce development, especially related to providing ongoing education and training opportunities for workers engaged in direct contact with, or providing services for, seniors in home and community-based settings; and total quality-of-life programming for seniors in all settings.

In carrying out these priorities, the foundation:

- **Convenes stakeholders.** Five years ago, for example, the foundation worked with the LeadingAge Center for Applied Research to explore housing-with service models through a series of meetings among housing sponsors and service providers.
- **Helps to build the evidence base for innovative programs.** The foundation's support helped researchers test the efficacy of the House Calls initiative, which brings geriatric physicians and their students into affordable housing neighborhoods to perform assessments and connect residents to community services.
- **Provides pre-development costs for promising projects.** McGregor was an early investor in a major intergenerational housing community in Cleveland and sponsored a multi-day design charrette that has helped garner pre-development funds for two affordable senior housing communities.

Duke Endowment

M. Tina Markanda
Program Officer, Health Care

The Duke Endowment was established in 1924 by James Buchanan Duke, a longtime resident of North and South Carolina. Over the years, the endowment has focused its grant-making activities on serving residents of these states through four areas of giving: child care, health care, higher education, and initiatives that strengthen the rural Methodist church.

In 2010, the foundation awarded grants of $151 million across all these areas. Within the health care division alone, it awarded $70 million through 70 separate grants to projects that focus on community outreach, equitable access to quality care, prevention and wellness, rural health, and workforce development.

When James Duke established his foundation, he was very specific about the individual organizations that would be allowed to apply for foundation support. In the health care area, for example, these eligible grantees include not-for-profit hospitals, not-for-profit health organizations in a county without a not-for-profit hospital, academic health centers, North Carolina Area Health Education Centers, and South Carolina Area Health Education Centers. The first health care dollars awarded by the foundation were used to build hospitals and support those hospitals by adding new wings or clinical programs. More recently, however, the foundation has supported initiatives that feature partnerships and implement innovative strategies to generate lasting improvements. Health and wellness programs supported by the foundation fall into seven categories:

- Community programs that provide education, outreach, and coordination of services to encourage appropriate use of preventative approaches and primary care.
- Early intervention programs that have been proven to address developmental delays in children and manage targeted diseases in early stages.
- Equitable care initiatives that reduce disparities for vulnerable populations.
- Prevention and wellness programs that support programs to eliminate chronic disease.
- Initiatives that advance evidence-based practices to improve care quality and safety.
- Rural health programs that provide adequate and convenient primary and emergency health care services.
- Workforce development programs that improve the recruitment, training, and retention of physicians, nurses, and other health care professionals.

The Commonwealth Fund

Mary Jane Koren
Vice President

In 1918, Anna Harkness founded The Commonwealth Fund with a gift of nearly $10 million and the mandate that the foundation should "do something for the welfare of mankind." Throughout its history The Commonwealth Fund has sought to be a catalyst for change by identifying promising practices and contributing to solutions that could help the U.S. achieve a high-performance health system. It is especially interested in projects that address the challenges that vulnerable populations face in receiving high quality, safe, compassionate, coordinated, and efficiently delivered care.

For past 10 years, The Commonwealth Fund has focused primarily on two areas: improving quality in a variety of different settings for frail elderly, children, and other vulnerable populations; and reforming the health care system, most recently through the implementation of the Affordable Care Act.

Several fund initiatives, administered through the Picker/Commonwealth Fund Long-Term Care Quality Improvement Program, address issues relating to frail elders. Specifically, the Picker program seeks to identify, test, and spread measures, practices, models, and tools that will lead to person-centered, high-performing long-term care services; build strong networks among stakeholders to create a sense of common purpose and shared interest in improving performance; assess, track, and compare the elements of long-term care performance at the state and national levels; and ensure that long-term care is incorporated into payment, health information, and delivery system reforms. Specific initiatives include:

- *Advancing Excellence in America's Nursing Homes*, a national, public-private quality improvement campaign. To date, more than 7,400 facilities, representing over 47 percent of all U.S. nursing homes, have joined the campaign. Since it began in late 2006, clinical outcome data has shown a definite "campaign effect." That is, facility participants have, in the aggregate, improved further and faster than those not in the campaign.
- *Preserving Critical-Access Nursing Homes*, which worked with 17 "1 star" nursing homes in four states to stabilize them enough to forestall their closure and improve them sufficiently to warrant continued participation in the Medicare and Medicaid programs.
- *The Pioneer Network*, which reaches out to long-term care providers across the country, particularly nursing homes, which are seeking to become truly person-centered organizations through what has been referred to as "culture change."

chapter 3

opportunities for transformation in innovative communities

As they seek to bring transformative change to their communities, Innovative Communities will encounter many challenges, but they will also find many opportunities to take a new look at, and establish innovative models, in these areas:

- Forming partnerships with local organizations and agencies that share a common mission.
- Engaging consumers in their own health care.
- Using data to drive and demonstrate outcomes.
- Ensuring the financial sustainability of promising initiatives.

These four areas of innovation sparked a great deal of discussion during the 2nd Innovative Communities Summit. Those discussions, summarized below, took place during plenary roundtables and in small groups.

Partnerships

Because collaboration among local stakeholders is at the heart of Innovative Communities, it should come as no surprise that much of the discussion among participants in the 2nd Innovative Communities Summit revolved around how to create and sustain strong, broad-based partnerships at the local level. Summit participants and presenters alike agreed that the most successful partnerships will capitalize on partners' growing interest in collaboration, use grassroots action to identify and mobilize partners, and focus on strengthening partnerships by emphasizing personal relationships.

Capitalize on the Desire for Collaboration

Getting partners to participate in an Innovative Community may be easier than expected, according to several summit participants. For example, when the Atlanta Regional Commission (ARC) first proposed the Atlanta Lifelong Communities initiative, it was pleasantly surprised to find a new culture of collaboration within its community. The ARC had to capture stakeholders' attention by providing data on Atlanta's growing aging population and demonstrating the region's lack of preparedness to serve that population. But once stakeholders recognized the need for a Lifelong Communities initiative, they acknowledged that they could never accomplish the initiative's goals by themselves.

The ARC fostered partners' collaborative spirit by encouraging its own staff to step out of their silos and to think about assets and resources they could bring to the community table. The organization's willingness to contribute to the initiative, rather than simply demanding contributions from others, changed the community conversation and encouraged everyone to collaborate.

The Humboldt Senior Resource Center in rural Humboldt County, Calif. also found willing partners when it began laying the groundwork for the Dementia Care Coalition. Partners in this rural community already knew one another well and had worked together on other initiatives. These ongoing relationships make it possible to launch projects more quickly because partners can skip the relationship-building phase and get right to work.

Emphasize Relationships

For partners who don't yet know each other well, relationship building is critical to good partnerships. For example, a variety of stakeholders in the Greater North Shore area of Massachusetts came together somewhat reluctantly about 6 years ago to form the Aging and Disability Resource Consortium (ADRC) of the Greater North Shore. At the time, the partners didn't see the advantage of forming the ADRC, since they had received minimal funding from the Administration on Aging for this initiative. That dearth of funds proved to be an advantage for the consortium because it forced the partners to rely more heavily on their relationships to get things done. Those relationships have helped to sustain the consortium over time.

Relationship building was particularly important in the Greater North Shore because leaders of all of the ADRC's founding partners—three area agencies on aging and an independent living center—had never met. As these leaders became acquainted, however, they recognized that their common missions would make it easier for them to make a commitment to collaborate on efforts that transformed the way people with chronic conditions are cared for in the community. That commitment, sealed by personal relationships, became their collective call to action.

Engage in Grassroots Action

While steering committees play an important role in setting a general course for an Innovative Community, success also depends on grassroots action to move a community's agenda forward. About a year into its Connecting for Health initiative, the Colorado Foundation for Medical Care used grassroots organizing strategies to recruit 10 community members, called "master mind leaders," who agreed to lead local action teams. Team leaders rolled up their sleeves to recruit additional members and to develop specific tools aimed at reducing hospital readmissions in a section of northwest Denver. The tools, credited with helping to reduce the local readmissions rate by 9.3 percent, included a paper-based personal health record that was distributed to consumers through grocery stores and pharmacies, and a palliative care training program for hospital discharge planners.

Keys to Success

Participants in the 2nd Innovative Communities Summit identified a number of additional keys to developing successful partnerships:

- **Build on existing partnerships in the community.** Communities participating in the Aligning Forces for Quality initiative don't build their multi-sector alliances from scratch. First, they look at initiatives already taking place in the community. Then, they work to bring together the leaders of these often disparate initiatives, often providing them with their first experience working together.
- **Engage senior organizational leaders.** Case workers or other staff at an organization are important participants in Innovative Community activities, but they cannot provide the leadership you need to plan and steer the initiative. Identify the top leaders in each partnering organization and rely on them to be the change agents within their organizations and within their sector of the community.
- **Involve stakeholders with whom you're not used to engaging.** This will include frontline staff, like medical assistants and nursing aides, who have the most direct contact with consumers and probably understand their needs better than anyone. In addition, don't forget pharmacists, who play a critical role in ensuring smooth care transitions through better medication management. Finally, interns from local schools of social work and nursing can bring great enthusiasm and valuable sweat equity to Innovative Community initiatives.
- **Don't forget about the business community.** Businesses will join Innovative Communities if they are convinced that their participation will help lower health care costs. In Maine, for example, the Aligning Forces for Quality initiative convinced local businesses to offer their employees lower out-of-pocket costs if those workers selected higher performing health providers.
- **Personalize your message to attract partners.** Communicating a lofty set of principles won't do much to galvanize your partners. Instead, personalize those principles by telling real-life stories that make your vision more real.

Consumer Engagement

More than anything, consumers want health care professionals and service providers to help them achieve vitality, purpose, and connectivity to their community, family, and friends. These consumers are most interested in finding out what steps they can take to ensure that they will be able to attend a granddaughter's wedding, walk to church tomorrow, or take their medications without worrying that side effects will sideline their quality of life. These every day, real-life aspirations need to be incorporated into health care practice so they can be used to motivate consumers to pursue healthy behaviors and play an active role in managing their chronic conditions.

Before this can happen, however, local care and service providers need much more information about what is important to consumers. For example, surveys by AARP Services Inc. indicate that participants in the organization's Medicare Supplemental Plan view hearing loss, fear of falling, incontinence, and depression as far more significant barriers to quality of life than diabetes, congestive heart failure, and coronary artery disease. In addition, most consumers are open to receiving a few tools to support them so they can manage their own health conditions and, in the process, maintain their quality of life.

Those tools are more important than previously thought, according to preliminary data from AARP's High Risk Case Management pilot, which provides both telephonic and face-to-face case management services to Medicare beneficiaries. AARP researchers were surprised to find that the program's telephonic case management yielded a larger cost savings than face-to-face sessions. AARP theorizes that the telephonic program is successful because it reaches consumers who are willing to self-manage their conditions but don't know how to get organized. These consumers appreciate the opportunity to talk by telephone with someone who can recommend a customized and workable approach to help them manage their medications and doctor visits, find the information they need, and track their progress toward meeting goals.

Likewise, consumers and their families are responding favorably to invitations by the Colorado Foundation for Medical Care to become more active in their care after a hospital discharge. Building the capacity of families to deliver high-level care in the first 24-72 hours after discharge has made a difference in the local readmission rate.

Person-Centered Living

Participants in the 2nd Innovative Communities Summit agreed that their communities should focus just as strongly on improving the lives of consumers as they do on improving consumers' clinical care. Communities that focus on this goal will be facilitating "person-centered living" rather than "person-centered care."

The Dementia Care Coalition in Humboldt County, Calif. found that offering services and supports to people with dementia and their families involves much more than simply coordinating their medical care. Clients with dementia are dealing with enormous environmental challenges and they fully expect to remain engaged in the community. Helping them reach these goals can be challenging for an Innovative Community and requires meaningful communication with consumers.

For this reason, consumers who have been diagnosed early with Alzheimer's disease are part of Dementia Care Coalition. Their candid insights have helped the partners understand more clearly the challenges of the disease and identify what steps they can take to enhance their clients' quality of life. One key to success that emerged from these discussions is the importance of meeting each client in the present and offering them the services and supports they need right now, to get through today. These are the needs that most concern the consumer. When those needs are met, then clinicians and service providers can move on to other needs.

Data and Information

Data is becoming an increasingly critical component of quality improvement and a tool that Innovative Communities can use to identify local needs and measure their progress toward meeting those needs. For example, the Colorado Foundation for Medical Care, which serves as its state Quality Improvement Organization (QIO), is beginning to use zip code maps to identify hospital readmission rates in specific geographic areas. The organization is hoping that if it can show whether readmission rates and emergency department visits are increasing for Medicare beneficiaries in a particular zip code, then it will be able to convince community coalitions to work on changing those numbers.

Using data to drive outcomes is part of the core mission of the federal Beacon Community program. The Office of the National Coordinator for Health Information Technology is looking to create a technology infrastructure that helps communities connect disparate stakeholders in order to collect a common set of data and then share that data with the right people at the right time in order to identify needs, plan appropriate action, and measure outcomes. This ability is critical for system transformation, which must be rooted in hard data.

Over the long-term, interoperability—the ability of disparate information systems to communicate with one another—is the ultimate goal. But communities cannot wait for interoperability. Instead, they need to find imperfect solutions today that allow them to identify, collect, and share needed data.

Funding Innovative Community Initiatives

Innovative Community initiatives often suffer from a serious lack of sustainability. Nowhere is that better illustrated than in Humboldt County, Calif., where plans for a Dementia Care Coalition changed dramatically after the agency selected to drive the initiative was suddenly eliminated from the state budget. That budget crisis forced the coalition to cobble together a collection of funding sources, including private foundation dollars.

As government funds become harder to secure, the role of private foundations in supporting Innovative Communities will become increasingly important. Three of those foundations told participants in the 2nd Innovative Communities Summit that they were interested in supporting Innovative Communities but advised that grant applicants are most likely to succeed if they:

- **Work hard to educate and convince foundation that they should fund Innovative Communities.** Don't be hesitant to play this role in a deliberate fashion and as a way to supplement the education efforts that foundations already carry out with their boards.

- **Demonstrate that partnerships are authentic.** This means that partners have a track record of working together and that each partner is actively engaged in the current project, both fiscally and operationally. A foundation will want to know about the activities on which partners have collaborated to date, what partners learned from those activities, and how they will apply those lessons to the current project.
- **Ensure that their projects are compatible with a particular foundation's priorities.** Even the most impressive proposals will not be funded if they don't fit the foundation's agenda.
- **Convince the foundation that you can take your idea and drive it forward.** Foundations are attracted to projects that have the potential to become models, tools, and best practices. They will reject projects that seem destined to be "one shot wonders" that end up sitting on the shelf.

Once a project is funded, successful grantees should:

- **Measure and demonstrate the project's impact.** It's important to share this data with the foundation and the community.
- **Remember that your funder is also your partner.** By supporting your work, a foundation becomes a member of your Innovative Community. In addition to providing fiscal resources, that foundation can offer you an opportunity to convene experts to discuss ideas. It can also offer you technical assistance that might not otherwise be available.
- **Be flexible enough to modify a project when change is necessary.** A foundation will be impressed by your willingness to think about how you and your partners might improve your approach to completing a project.

chapter 4

management tools to help innovative communities move forward

Larry Minnix
President and Chief Executive Officer

Cheryl Phillips
Senior Vice President for Advocacy

LeadingAge

A system is an imaginary machine invented to connect together in the fancy those different movements and effects which are already in reality performed... The machines that are first invented to perform any particular movement are always the most complex, and succeeding artists generally discover that, with fewer wheels, with fewer principles of motion, than had originally been employed, the fame effects may be more easily produced. The first systems, in the fame manner, are always the most complex, and a particular connecting chain, or principle, is generally thought necessary to unite every two seemingly disjointed appearances: but it often happens that one great connecting principle is afterwards found to be sufficient to bind together all the discordant phenomena that occur in a whole species of things.

Adam Smith

The writings of economist Adam Smith remind us that our health care system is an imaginary machine and, like most machines, its first versions are always the most complex. As we progress in developing these systems, we start to make the machine simpler and more efficient.

Whether our health care system has followed the trajectory predicted by Smith two centuries ago is a matter for debate. In the eyes of many, that system appears to be as complicated and chaotic today as it was decades ago. It is chaotic for consumers and their families, as well as for governments and policy makers. Its payment systems are complex and its measurement standards are inconsistent and unclear. That chaos and complexity can serve as barriers to the system transformation that Innovative Communities promise. However, there are tools available to help those communities navigate the system's complexity and reduce, if not eliminate, its chaos.

Integrating Systems

One of those tools is the Self-Assessment for System Integration (SASI), which is designed to help health care systems plan, organize, measure, and evaluate

their efforts to create a seamless care delivery system for individuals with chronic disease. Organizations can use the tool to gain a better understanding of how to support coordination of care, build an integrated, multi-organization delivery system, and develop a baseline set of measurements to evaluate progress in meeting goals.

An Innovative Community can use the SASI tool to build its leadership team, communicate its vision and mission, set its goals, and engage people in its work. The tool can help an Innovative Community answer critical questions about its initiative, including who will be served and with what services; who will participate in its initiatives, how it will measure success, and how it will be sustained over time. In addition, the assessment tool sheds light on several key principles that should be incorporated into any Innovative Community, including the following:

- Persons served and their care partners are involved in their own health decisions and are strongly supported in self-care.
- Sub-populations within the community are identified and stratified for risk. Targeted interventions are directed to the unique needs of those populations. One size doesn't fit all. Instead, the community pays attention to how it targets different services for different people.
- Local residents have access to a full array of person-centered services that represent the continuum of care.
- Seamless care—including person-centered care transitions—is integrated across settings.
- Information systems allow providers in all settings to share meaningful data, including goals of care, advance care directives, and person-centered care plans.
- Chronic care services include self-management, medication therapy management, and care coordination to link interventions that focus on the person's needs and not just the setting of care.
- Financing systems promote community-wide tracking of cumulative costs tied to care outcomes.
- Organizational structures promote cross-site, interdisciplinary service models and allow providers to work in a collaborative manner.

Applying Management Principles

When local stakeholders decide to establish an Innovative Community, several management-related obstacles may stand in their way. At a very basic level, not all the stakeholders will define the Innovative Community in the same way. They may not all refer to the people they serve in the same way. What one partner calls a client, another partner may call a resident, patient, consumer, or beneficiary. Finally, it may be difficult for all the stakeholders to agree that the Innovative Community's agenda must be a transformative agenda, not a piecemeal agenda.

How do Innovative Communities become transformative communities? Management science gives us a number of hints, including the following:

- **Put consumers at the heart of the Innovative Community.** Helping that consumer stay healthy and independent will require a host of interconnected resources, including information, assessment, coaching, case management, and protection for the most vulnerable. Every person who lives in a community has a stake in that community and, therefore, every person must play a role in that's community's design and in its process.
- **Enlist well-established organizations** *to support your work*. That includes academic institutions that can provide research outcomes, tools, demonstrations, and interns; government agencies that can become your partners by providing applied research, regulation alignment, and financial support; and a host of community-based philanthropic organizations, volunteers, media outlets, and businesses.
- **Get leadership buy-in. Everything starts with leadership.** There has to be a leadership commitment to what you are doing and that leadership must come from the top of every entity that is involved in the Innovative Community. Otherwise, community-related tasks are delegated to junior people who come to meetings but can't make decisions.
- **Secure a 'backbone' commitment.** One organization must take full-time responsibility for the Innovative Community. That community doesn't necessarily require a substantial infrastructure, but it cannot become a collective "side job" for every partner.
- **Agree on shared measurements.** Many groups fall apart because they haven't defined together what their success will look like.
- **Establish the community's infrastructure.** Develop a plan that outlines when partners will meet, how they will build and support their team, and what specific responsibilities each partner has to that team.
- **Define what it takes to make relationships work.** These factors include a commitment to a vision and mission, shared governance, clear roles and responsibilities, a collaborative style, agreed-upon rules of engagement and work, and judicious use of power. But it also means paying attention to building trust among partners, an outcome that doesn't happen overnight. Each partner should sign an agreement stipulating how they are accountable to the Innovative Community and how other members of the community are accountable to them.

chapter 5

moving forward with LTQA

Larry Minnix
President and Chief Executive Officer
LeadingAge

The Long-Term Quality Alliance (LTQA) is not an academic exercise. Instead, it is an organization seeking to make a big impact in a practical way. LTQA is not interested in creating Innovative Communities. There are many communities around the nation that are already doing that work. Instead, the alliance wants to support Innovative Communities by creating a process through which those communities can measure outcomes and share experiences through a shared learning network.

Participants and presenters at the 2nd Innovative Communities Summit felt a great sense of urgency around the issues of care transitions and preventable, avoidable rehospitalizations. They know that these junctures represent the points when consumers run the greatest risk of losing quality of life and when the health care system wastes the most money. And yet, if local health care stakeholders work differently, and if they work together, these junctures are also the times when Innovative Communities can have the most impact. The Long-Term Quality Alliance wants to help Innovative Communities do just that.

Creating a Learning Network

LTQA would like to create a learning network of Innovative Communities that strives to account for the optimum safety and health of every vulnerable senior within every community in America. Innovative Communities that agree to join that network would meet twice each year for a highly structured, yet interactive experience. They would come to those meetings prepared to share how they carried out initiatives that were successful and what they learned from initiatives that were tried and didn't work. Between meetings, Innovative Communities would continue to share with one another through work groups, listservs, and other connectivity tools.

Additional stakeholders would also participate in the Innovative Communities learning network. These stakeholders would include consumer groups like the Senior Service Corps, through which more 500,000 senior volunteers offer services to keep people living independently. These volunteers could offer insightful feedback on the needs and preferences of older people and people with

disabilities. We would also invite researchers to share their latest findings, explain evidence-based practices that Innovative Communities could replicate, and disseminate outcomes data to scholarly journals so that government officials would know that our approach was working.

A 3-Year Commitment

Members of the LTQA Learning Network would make a 3-year commitment to improve care transitions and reduce hospital readmissions. Specifically, the goal of that learning network would be to:

- Identify 50 Innovative Communities throughout the country that could serve as models for other communities.
- Work together to reduce hospital preventable hospitalizations and readmissions by more than 20 percent.
- Publish a journal and other learning materials to provide critical information to Innovative Communities and to highlight the work of those communities for a national audience.
- Convince the Centers for Medicare and Medicaid to make significant policy changes so that Innovative Communities are increasingly easier to organize and manage.
- Make Innovative Communities a part of the culture of local communities and an accepted part of the solution as we continue to transform our health care system.

Conclusion

No one—not hospitals, physicians, providers of long-term and post-acute care, government agencies, or consumers—will dispute the fact that our nation is in the midst of a health care crisis. We can't spend our way out of this crisis. Cutting the budget won't end the crisis. The collective experiences and expertise demonstrated at the 2nd Innovative Communities Summit should convince all Americans that innovation is the only hope we have to transform our health care system.

Innovative Communities hold great potential for providing the transformative change that the nation needs so desperately. And LTQA stands ready to do everything we can to ensure the success of those communities.

Are you with us?

appendices

INNOVATIVE COMMUNITIES SUMMIT
participant list

This list includes the names of individuals who pre-registered for the LTQA Innovative Communities Summit, held at Georgetown University Conference Center in Washington, D.C., on June 27, 2011. LTQA apologizes in advance if the names of participants who registered on-site are not included here.

Katy Abbott | Research Assistant Professor
University of Pennsylvania School of Nursing
Philadelphia, Pa.

Donna Abrahams | Senior Editor
Health Affairs | Bethesda, Md.

Christopher Adamec | Specialist, Federal Affairs
Alzheimer's Association | Washington, D.C.

Joseph Agostini | Senior Medical Director
AETNA | Hartford, Conn.

Mary Austin | Vice President Health Services
New Courtland | Philadelphia, Pa.

Wayne Bazzle | CEO
Home Healthcare Partners | Dallas, Tex.

Carol Benner | National Director
Advancing Excellence Campaign | Washington, D.C.

Emma Berca | Director of Policy
Long Term Care Pharmacy Alliance | Washington, D.C.

Kathy Berger | Director of Area Agency on Aging
Atlanta Regional Commission | Atlanta, Ga.

Brian Bixby | Advanced Practice Nurse
University of Pennsylvania School of Nursing
Philadelphia, Pa.

Alice Bonner | Director, Division of Nursing Homes
Centers for Medicare and Medicaid Services,
Office of Survey and Certification | Baltimore, Md.

Amy Boutwell | President
Collaborative Healthcare Strategies | Lexington, Mass.

Jane Brock | Chief Medical Officer
Colorado Foundation for Medical Care | Englewood, Colo.

Kathie Brogan | Chief Nursing Officer
New Courtland | Philadelphia, Pa.

Gary Christensen | Chief Operating Officer/
Chief Information Officer
Rhode Island Quality Institute | Providence, R.I.

Carolyn M. Clancey | Director
Agency for Healthcare Research and Quality
Rockville, Md.

Jennifer Cockerham | Chronic Care Program Coordinator
Community Care of North Carolina | Raleigh, N.C.

(continued on next page)

LTQA: INNOVATIVE COMMUNITIES SUMMIT PARTICIPANT LIST (continued)

Chris Condeelis | Senior Director, Quality
American Health Care Association | Washington, D.C.

Patrick Conway | Director, OCSQ and CMO
Centers for Medicare and Medicaid Services
Baltimore, Md.

Mary Tess Crotty | Vice President of Quality Management
Genesis HealthCare Corporation | Andover, Mass.

Paul Crowley | Executive Director
Greater Lynn Senior Services | Lynn, Mass.

Mary Anne Daley | Associate Director
University of Pennsylvania Health System | Oreland, Pa.

Ramona Davies | Director, Community Services
Northern California Presbyterian Housing Services
San Francisco, Calif.

Emilie Deady | Vice President of Administration and Operations
Visiting Nurse Associations of America | Washington, D.C.

Aurora Delespin | Program Analyst
District of Columbia Office of Aging | Washington, D.C.

Kermit Eide | President
K. M. Eide and Associates | Williamsburg, Va.

Bob Eiffert | Long Term Care Program Manager
Fairfax County Health Department | Fairfax, Va.

Nancy R. Eldridge | Executive Director
Cathedral Square Corporation | South Burlington, Vt.

Michael Fachko | MSN,RN
University of Pennsylvania School of Nursing
Ridley Park, Pa.

Franklin Farmer | Quality Leader
University of North Carolina Health Care
Chapel Hill, N.C.

Lynn Feinberg | Senior Strategic Policy Advisor
AARP Public Policy Institute | Washington, D.C.

Marybeth Fidler | Founding Partner
Cygnet Strategy LLC | Lexington, Pa.

David Fuks | CEO
Cedar Sinai Park | Portland, Ore.

Morgan Gable | HCBS and Health Legislative Representative
LeadingAge | Washington, D.C.

Denise Gannon | Vice President of Wellness
Eliza Jennings Senior Care Network | Lakewood, Ohio

James Gardner | President and CEO
The Council on Quality Leadership | Towson, Md.

Landon Gibbs | Executive Director
SHOUTAmerica | Washington, D.C.

Amy Gotwals | Director, Public Policy and Legislative Affairs
National Association of Area Agencies on Aging
Washington, D.C.

Kathy Greenlee | Assistant Secretary for Aging
Administration on Aging
U.S. Department of Health and Human Services
Washington, D.C.

John Hannay | Senior Research Associate
LTG Associates | Takoma Park, Md.

Jennie Harvell | Senior Policy Analyst
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services | Washington, D.C.

Joyce Hayes | Executive Director
Humboldt Senior Resource Center | Eureka, Calif.

(continued on next page)

LTQA: INNOVATIVE COMMUNITIES SUMMIT PARTICIPANT LIST (continued)

Jim Hester | Senior Advisor
Center for Medicare and Medicaid Innovation
Baltimore, Md.

Rob Hilton | President and Chief Executive Officer
The A.M. McGregor Group | Cleveland, Ohio

Karen Hirschman | Research Assistant Professor
University of Pennsylvania School of Nursing
Philadelphia, Pa.

Margaret Hoffman | ADRC Office Coordinator
Howard County Office of Aging | Columbia, Md.

Steven B. Horner | Director,
Division of System Restructuring
Department of Public Welfare/Aging,
Office of Long-Term Living | Harrisburg, Pa.

Kimberly Irby | Project Coordinator
Colorado Foundation for Medical Care | Englewood, Colo.

Stephen Jencks | Consultant in Healthcare
Safety and Quality
Baltimore, Md.

Frances Jensen | Medical Officer
Center for Medicaid and State Operations/Survey
and Certification Group | Baltimore, Md.

Lauren Jones | Program Manager
AARP | Arlington, Va.

Ruta Kadonoff | Program Analyst
Office of the Assistant Secretary for Planning and
Evaluation, U.S. Department of Health and
Human Services | Washington, D.C.

Dan Katz | Executive Assistant
Jewish Senior Life | Rochester, N.Y.

Sharon Katz | Vice President,
Medical Management and Quality
Palo Alto Medical Foundation,
Mills-Peninsula Division | Burlingame, Calif.

Emily Kearns | Assistant Director of
Planning and Development
Greater Lynn Senior Services | Lynn, Mass.

Joanna King | Long Term Care Access Unit Director
County Office of Services For the Aging | Eddystone, Pa.

Linda Kluge | Director
Georgia Medical Care Foundation-QIO | Atlanta, Ga.

Mary Jane Koren | Vice President
The Commonwealth Fund | New York, N.Y.

Jason Kunzman | Project Officer
Office of the National Coordinator for
Health Information Technology | Washington, D.C.

Martha Kutik | President and CEO
Jennings Center for Older Adults | Garfield Heights, Ohio

Holly Lang | Hospital Accountability Project Director
Georgia Watch | Atlanta, Ga.

Paul Lanzikos | Executive Director
North Shore Elder Services | Danvers, Mass.

Sabrena Lea | Director
NC DHHS Office of Long Term Services
and Supports | Raleigh, N.C.

Lisa Lehman | President
Holleran | Mountville, Pa.

Cooper Linton | Vice President of Marketing
Hospice of Wake County | Raleigh, N.C.

Swati Lotlikar-Kamath | Project Manager
Healthcare Quality Strategies Inc. | East Brunswick, N.J.

(continued on next page)

LTQA: INNOVATIVE COMMUNITIES SUMMIT PARTICIPANT LIST (continued)

Karen Love | President
Center for Excellence in Assisted Living | Falls Church, Va.

John Lynch | Chair
D.C. Cancer Consortium | Washington, D.C.

Janice Lynch Schuster | Senior Writer
Altarum Institute | Washington, D.C.

Sharon Lynn | Acting Director
Fairfax Area Agency on Aging | Farifax, Va.

Gail MacInnes | National Policy Analyst
PHI | Washington, D.C.

Geralyn Magan | Writer/Editor
Clarksville, Md.

Tina Markanda | Program Officer, Health Care
The Duke Endowment | Charlotte, N.C.

Sandy Markwood | CEO
National Association of Area Agencies on Aging
Washington, D.C.

Jen Martchek | Executive Director
Southwestern PA Partnership for Aging | Warrendale, Pa.

Lisa Martinez | Director, Strategy and Planning
AARP | Washington, D.C.

Olivier Masson | Web Designer
ToolMaven.com | Arlington, Va.

Susanne Matthiesen | Managing Director,
Aging Services and CCAC
Commision on Accreditation of Rehabilitation Facilities |
Washington, D.C.

Kathy McCauley | Associate Dean, Academic Programs
University of Pennsylvania School of Nursing
Philadelphia, Pa.

LeAnn McCusker | Wellness Center Director
Fauquier Hospital | Warrenton, Va.

Paul McGann | Co-Director, Partnership for Patients
Centers for Medicare and Medicaid Services
Baltimore, Md.

Peggy McNamara | Senior Analyst
Agency for Healthcare Research and Quality
Rockville, Md.

Mark Meiners | Professor
George Mason University | Farifax, Va.

Susan Mende | Senior Program Officer
Robert Wood Johnson Foundation | East Princeton, N.J.

Chris Miller | Project Manager
Aging Together | Culpeper, Va.

William L. (Larry) Minnix | President and CEO
LeadingAge | Washington, D.C.

Abigail Morgan | Social Science Analyst
Administration on Aging
U.S. Department of Health and Human Services
Washington, D.C.

Lisa Morgan | Director
Fauquier Health Home Care Services | Warrenton, Va.

Mary D. Naylor | Dean
University of Pennsylvania School of Nursing
Philadelphia, Pa.

Stephanie Naylor | Assistant
Long-Term Quality Alliance | Philadelphia, Pa.

Gary Nelson | Director
UNC Center for Aging Research and Educational Services
Chapel Hill, N.C.

(continued on next page)

LTQA: INNOVATIVE COMMUNITIES SUMMIT PARTICIPANT LIST (continued)

Myles Nienstadt | Chair,
Workforce Development Committee
Fairfax County Long Term Care Corrdinating Council
McLean, Va.

Cynthia Northom | Hospice Administrator
Goodwin House Incorporated | Falls Church, Va.

Kieun Oh | Senior Advisor
AARP | Washington, D.C.

Paul C. O'Shea | Senior Vice President
for Corporate Integration
Northeast Health System | Beverly, Mass.

Doug Pace | Executive Director
Long-Term Quality Alliance | Washington, D.C.

Valerie Parker Callahan | Director of Planning
and Development
Greater Lynn Senior Services | Lynn, Mass.

John Parrish | Executive Director
Erickson Living Foundation | Catonsville, Md.

Brent Parton | Program Director
SHOUTAmerica | Washington, D.C.

Mary Perloe | Project Manager
Georgia Medical Care Foundation-QIO | Atlanta, Ga.

Cheryl Phillips | Senior VP, Advocacy
LeadingAge | Washington, D.C.

Jackie Pinkowitz | Chair, Board of Directors
Consumer Consortium Advancing Person-Centered
Living | Colts Neck, N.J.

Lon Pinkowitz | Advisor
Consumer Consortium Advancing Person-Centered
Living | Colts Neck, N.J.

D.E.B. Potter | Sr Survey Statistician/Co-Lead
AHRQ LTC Program
Agency for Healthcare Research and Quality
Rockville, Md.

Christal Ramos | Senior Research Associate
George Washington University | Washington, D.C.

Aditi Rao | RN, MSN
University of Pennsylvania School of Nursing
Philadelphia, Pa.

Marybeth Ribar | RN Consultant
Centers for Medicare and Medicaid Services
Baltimore, Md.

Chesley Richards | Director
Centers for Disease Control and Prevention,
Office of Prevention through Healthcare | Atlanta, Ga.

Tanya Richmond | Program Coordinator
UNC Center for Aging Research and Educational Services
Chapel Hill, N.C.

Ashley Ridlon | Health Insurance Specialist
Center for Medicare and Medicaid Innovation
Baltimore, Md.

Marjorie Rifkin | Managing Attorney
University Legal Services | Washington, D.C.

Martina Roes | Harkness Fellow
University of Pennsylvania School of Nursing
Philadelphia, Pa.

Patricia Rohrer | Long Term Care Program Development
Fairfax County Government | Fairfax, Va.

Candice Rose | Chair
Arlington Commission on Aging | Arlington, Va.

Jeff Rubin | Executive Director
Body Recall | Berea, Ky.

(continued on next page)

LTQA: INNOVATIVE COMMUNITIES SUMMIT PARTICIPANT LIST (continued)

Caroline Ryan | Aging Services Program Specialist
Administration on Aging
U.S. Department of Health and Human Services
Washington, D.C.

Marisa Scala-Foley | Social Science Analyst
Administration on Aging
U.S. Department of Health and Human Services
Washington, D.C.

Katie Smith Sloan | Chief Operating Officer
and Sr. VP, Strategy
LeadingAge | Washington, D.C.

Heather Smith | Associate Director, Quality Initiatives
American Physical Therapy Association | Alexandria, Va.

Mary Smith | Vice President,
Senior Services and Rehabilitation
Fauquier Health | Warrenton, Va.

Denise Stewart | Deputy Director
County Office of Services for the Aging | Eddystone, Pa.

David Strain | Associate Executive Director
and Nursing Home Administrator
Christian Living Communities | Centennial, Colo.

Ya-Ping Su | Director-RAS
Healthcare Quality Strategies Inc. | East Brunswick, N.J.

Shirley Tabb | Case Manager
The Shirley Tabb Show | Washington, D.C.

Joan Thomas | Social Services and
Admissions Director, Marketing
Birmingham Green | Manasass, Va.

Cecili Thompson Williams | Outreach Director,
Campaign for Better Care
National Partnership for Woman and Families
Washington, D.C.

Courtney Tierney | Director
Prince William Area Agency on Aging | Woodbridge, Va.

Fikir Tilahun Sanders | Manager, N.A.
Corporate Social Responsibility
Sanofi-Aventis US | Washington, D.C.

David Tillman | Consultant
Partners in Care Foundation | Long Beach, Calif.

Mary Tinetti | Health and Aging Policy Fellow,
CMS Innovation Center, and Professor
Yale University School of Medicine | Washington, D.C.

Juliana Tiongson | Social Science Research Analyst
CMS Innovation Center | Baltimore, Md.

Tricia Tomkinson | Regional Director of Operations
Ciena Healthcare Management, Inc. | Southfield, Mich.

Gail Towsley | NRSA Postdoctoral Research Fellow
University of Pennsylvania | Philadelphia, Pa.

Julie Trocchio | Senior Director,
Community Benefit and Continuing Care
Catholic Health Association of the United States
Washington, D.C.

Sue Vaeth | Administrator
Howard County Office of Aging | Columbia, Md.

Janet Van Cleave | Clinical Assistant Professor
New York University College of Nursing | New York, N.Y.

Nancy D. Vecchioni | Vice President
Medicare Operations
MPRO | Farmington Hills, Mich.

Alayna Waldrum | Legislative Representative
LeadingAge | Washington, D.C.

Susan Walker | MSW, LICSW, LCSW
District of Columbia Coalition on Long Term Care |
Greenbelt, Md.

(continued on next page)

LTQA: INNOVATIVE COMMUNITIES SUMMIT PARTICIPANT LIST (continued)

Sally White | Executive Director
IONA | Washington, D.C.

Christina Williams | Manager, Patient Safety Initiatives
The Quality Institute | Columbus, Ohio

Charlotte Yeh | Chief Medical Officer
AARP Services, Inc. | Tewksbury, Mass.

2519 Connecticut Ave., N.W. | Washington, D.C. | www.ltqa.org
For more information: Doug Pace, Executive Director, dpace@ltqa.org