

**PERSON-CENTERED CARE:
REFORMING SERVICES AND BRINGING OLDER
CITIZENS BACK TO THE HEART OF SOCIETY**

HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED TENTH CONGRESS

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PERSON-CENTERED CARE: REFORMING SERVICES AND BRINGING OLDER CITIZENS BACK TO THE HEART OF SOCIETY

WEDNESDAY, JULY 23, 2008

U.S. SENATE
SPECIAL COMMITTEE ON AGING
Washington, D.C.

The committee met, pursuant to notice, at 11 a.m. in Room SD-562, Dirksen Senate Office Building, Hon. Herb Kohl (Chairman of the committee) presiding.

Present: Senators Kohl [presiding], Wyden, Lincoln, Casey, Whitehouse, and Smith.

OPENING STATEMENT OF SENATOR HERB KOHL

The CHAIRMAN. Good morning, and we thank you all for being here this morning.

This morning, I will be very pleased, along with Senator Smith, to turn the gavel over to our colleague Senator Casey. While serving as Pennsylvania's auditor general for 8 years, Senator Bob Casey worked to improve the nursing homes in his State, making them safer and exposing holes in State oversight. We are very grateful to have him on the Aging Committee, and we are pleased that he is holding today's hearing.

The issue we will consider today is one that should seem obvious. When providing someone with healthcare or long-term care, our first consideration should always be that particular individual's needs and desires. This is known as person-centered care. What a very simple idea.

Unfortunately, our health and long-term care industries have grown so complex that such a straightforward concept has gotten lost and, to some, providing personalized care with the individual senior in mind has become inconvenient.

Twenty-one years ago, Congress passed a landmark nursing home reform known as OBRA 87. OBRA laid the foundation for person-centered care. Today, Senator Casey will examine facilities called "Green Houses" that are successfully implementing person-centered care. Green Houses that are successfully implementing person-centered care are all too rare.

We will also hear about the medical home model that CMS is exploring, which reorganizes the way that physicians, nurses, and others work together to tailor services to each individual. Finally, the Committee will explore ways to make it easier for other nursing homes to move forward toward these model programs.

It is clear that within the realm of long-term care there are many more choices available today than there were just 20 years ago. We are very pleased to see this expansion of options, and we are very hopeful that this trend will continue.

The Aging Committee has a long and a proud history of moving Congress forward on issues of long-term care. So we thank you once again, Senator Casey, for taking us a step further with today's hearings.

We turn now to the Senator's Ranking Member, Senator Smith.

STATEMENT OF SENATOR GORDON H. SMITH

Senator SMITH. Thank you, Chairman Kohl.

Senator Casey, we thank you for bringing this important issue to the attention of this Committee. As debate continues on healthcare reform, we often find ourselves embroiled in discussions of cost control and payment reform, and too often forget the people our reforms are intended to serve.

The recent debate over this year's Medicare legislation was an excellent example of how we can make necessary policy adjustments while improving the Medicare program for our seniors. I look forward to today's discussion as it is in keeping with this positive trend of placing the care of the person at the center of healthcare policy discussions.

We have an impressive list of witnesses today, all of whom will share with us their perspective on person-centered care. I want to extend a personal welcome to Dr. Diana White, who flew all the way from Oregon to be with us today. Dr. White will share with us some of the initiatives going on in Oregon and provide recommendations garnered from the lessons learned.

As an Oregon Senator, I am very proud of our State's healthcare system. We have a large number of community-based care choices, including home care, hospice, and other services. The diversity in care options and our State's continued emphasis on providing a variety of services has supplied Oregonians with one of the Nation's best healthcare systems.

The Oregon model has a strong collaborative philosophy and is designed to get individuals the appropriate care in the settings that best meet their needs. Oregon's system lends itself in many ways to the philosophy of person-centered care. Similarly, person-centered care focuses on the inherent value of each individual and emphasizes the importance in relationships between caretakers and receivers.

As we look for new ways to provide quality care for our seniors, examining concepts and philosophies like the ones discussed today, will help us all make informed decisions. Our seniors deserve the very best. If we can design public policies that maximize choice, autonomy, and relationships between caregivers and receivers, I believe this can go a long way in helping to improve the quality and dignity of care our seniors receive.

I am committed to looking at all of the alternatives that will help our dedicated health professionals in providing the highest quality of care to their patients. To that extent, I welcome the opportunity this morning to learn more about person-centered care and the potential contributions it could hold in providing improved quality

and increased satisfaction of seniors in outpatient and long-term care settings.

So, with that, I turn back to you, Mr. Chairman and Senator Casey.

The CHAIRMAN. Thank you very much, Senator Smith.
Senator Casey.

STATEMENT OF SENATOR ROBERT P. CASEY

Senator CASEY [presiding]. Mr. Chairman, thank you very much.

I appreciate your willingness to bring us together today for this hearing and for your leadership on this Committee that, frankly, we don't hear enough about these issues in the public press, and we are grateful for the opportunity you are giving us today. The families of America, older citizens across this country, as well as the witnesses who are here, we will all benefit from the wisdom and the insight and the experience that these witnesses bring to bear on this important issue.

I want to thank Chairman Kohl and thank him again for his leadership, and Ranking Member Smith as well for being with us today.

I know we are joined by Senator Wyden, long a leader and an active voice on this issue of how we care for and honor older citizens.

I wanted to thank the witnesses for your presence, your scholarship, your experience, but also for your willingness to travel. We have witnesses as far away as Oregon, Colorado, Nebraska. We have some Pennsylvanians here, as well as some from the State of New York as well. We thank you for that.

We want to highlight today the issue that both Senator Kohl and Senator Smith mentioned, which is person-centered care, reforming services and bringing older citizens back to the heart of society. I guess we should talk about the philosophy that brings us together today. It is very simple. Older citizens deserve to live lives of dignity and respect at all stages of their lives.

I was recalling this morning what was written in the Philadelphia Inquirer 10 years ago in a series about long-term care. A writer by the name of Michael Vitez, V-I-T-E-Z, a good man and a good writer. In the middle of one of his stories in a series, he said, and I quote—and he was referring to experts in the field. “Life can have quality and meaning even until the very last breath.” He was using as his foundation for that statement those who were experts.

I think that is critically important to remember today. No matter how old someone is, no matter what stage of life they are in, their life has quality and meaning until the very last breath. Elders have a profound right to be decisionmakers in their own care, to be at the center of their own care with a partnership of family and providers.

Older citizens are critically important to the overall health and well being of our society. I quote one of our witnesses today, Dr. Bill Thomas, and in fact, our hearing title today borrows from a phrase of his. “People of all ages will live better lives when we succeed in bringing elders back to the heart of our society.” A well-crafted summation of what we are doing today, that we have to bring them back to the heart of our society.

I will ask that my full statement be made part of the record, but I did want to review a couple of areas of my statement before I turn to our other colleagues.

[The prepared statement of Senator Casey follows:]

PREPARED STATEMENT OF SENATOR ROBERT P. CASEY, JR.

Good morning everyone and thank you all for being here. I want to thank Chairman Kohl for the opportunity to call this hearing today and I'd like to give a warm welcome and tremendous thanks to the witnesses we have with us today— some of whom have traveled from as far away as Oregon, Colorado and Nebraska, others from PA and NY. Thank you all for taking the time to be here and for your tremendous expertise and commitment to the work we'll be discussing.

Our hearing is called "Person-Centered Care: Reforming Services and Bringing Older Citizens Back to the Heart of Society." What do we mean by person-centered care? It is both a philosophy of care as well as the defining principle of several exciting and specific initiatives within health care and long term care for older citizens. The philosophy is simple: Our older citizens deserve to live lives of dignity and respect through all stages of life. About 10 years ago, the Philadelphia Inquirer reported, "Life can have quality and meaning even until the very last breath." Elders have a profound right to be decision-makers in their own care—to be at the center of their own care, with a partnership of family and providers. Our older citizens are critically important to the overall health and well being of our society. I quote one of our witnesses today, Dr. Bill Thomas, and in fact our hearing title borrows a phrase from the following quote of his, "People of all ages will live better lives when we succeed in bringing elders back to the heart of our society."

In recent years, this philosophy of person-centered care has been translated into very specific action. This morning we will hear testimony about person-centered care within two types of settings: (1) outpatient care for older citizens living on their own or in assisted living, and (2) long term residential care in nursing facilities. I think you will find this testimony fascinating, enlightening and inspiring. We have with us experts in policy and academia and medicine. We also have the ultimate experts—family members and direct care workers. All these individuals will testify about how person-centered care has transformed their professional and personal lives.

In hearings before the Aging Committee, we frequently hear the statistics, and they are alarming, about the increase in Americans over the age of 65. We currently have an estimated 38 million Americans in this age group, and that number is expected to double within the next twenty years. In the midst of this, health care costs are rising exponentially, the quality of outcomes is not consistent, older citizens are often abandoned to navigate a confusing and complex health care system. Also, older citizens report extremely low levels of satisfaction with life in nursing homes. This \$122 billion industry includes 16,000 nursing homes and significant concerns persist about maltreatment and neglect of our older citizens in 20% of these homes. As I know from my work in state government, most nursing homes provide quality care but that 20% is what we hear most about. However, a recent survey by the AARP found that fewer than 1% of individuals over 50 with a disability want to move to a nursing home. There has to be a better way, and in fact there is.

Person-centered care provides that better way. It is a straightforward concept and yet it has taken years of hard work to get concrete initiatives underway. We have a long way to go and much to learn. But in order to succeed, we must also examine why this kind of culture change is difficult.

Part of the answer is that our current systems for health care and long term care are neither structured nor rewarded for person-centered care. Medicare offers financial incentives for scheduling multiple patients and single services, not coordinating complex care and providing counseling and genuine partnership in care. This is unsatisfying for both patients and practitioners—and can even be dangerous or deadly. The NY Times contained a report Monday about a Philadelphia man, Robert Williamson, who received a cursory primary care exam which missed the danger signs of an oncoming stroke that Mr. Williamson suffered a short time later. Not only did Mr. Williamson suffer a severe health crisis, he incurred \$30,000 in hospital costs and had to go on disability at a cost of \$1,900 per month.

The number of primary care or "family" physicians, those who traditionally have an ongoing relationship with patients and their family members and the greatest understanding of comprehensive needs, is decreasing. The American Academy of Family Physicians reports a 50% decline in medical students choosing family medicine. Primary care physicians get lower reimbursements from Medicare and need to

see increasing numbers of patients, in already over-crowded schedules, just to stay afloat financially.

In residential care, nursing facilities require residents to revolve around institutional schedules for such personal preferences as waking, bathing and dressing, far too often identifying residents by their health conditions, vulnerabilities and room numbers rather than their unique strengths and gifts. Staff members attracted to the field of direct care service because they want to help older citizens are just as ill-served by this institutionalized culture as are the residents. Workers are minimally trained, over-worked and carry patient loads that make it impossible to engage in any personal time with residents—in fact, such relationships are often discouraged. They have little or no say in decision-making, relegated—like the residents—to the fringes of a system that places the needs of the institution over those of the human beings in it.

The majority of our health care and long term care systems are missing a critical element in caring for our older citizens—and that is the importance of relationships. Elder care has become entrenched in habits and methodology and reimbursement policies that are more suited to “one size fits all” than to personalized, individualized care. We reimburse physicians on the number of patients they can see in a day rather than engaging older citizens and their family members in a partnership of care. We evaluate direct care workers on the number of pills they can dispense in an hour, rather than the joy they can engender in the life of an older individual.

Of course the culture change of person-centered care involves more than just an emphasis upon relationships, and we will hear much about its specific requirements here this morning. But changing the way we care for older citizens does not need to be difficult. We have to stop engaging in “business as usual” and look at what is working. That is why I chose to hold this hearing and will devote a great deal of attention to this issue here in the Senate. That is why I will be introducing a bill that will provide loan funding for long term nursing facilities that commit to the principles of person-centered care.

The movement toward person-centered care has been called a revolution. But although it is revolutionary and “new” in what we are doing, it is also a profound return to the bedrock values of respecting our older citizens and living the golden rule. It’s also about peace of mind for family members. The pioneers of this revolution—and we are fortunate to have many of them with us here today—show us how we can enrich the lives of both our older citizens and everyone around them. I am so grateful to them for their willingness to believe in something better, for their courage and persistence in engaging very entrenched systems in innovative change. They are here today to tell us how to create change in very specific and successful—terms, focusing in particular on the outpatient “Medical Homes” model and the “Green House” model for in patient residential care. Since serious conditions often lead to hospitalizations and periodic rehabilitative care for older citizens, we will also hear testimony about how to best navigate such transitions within a culture of person-centered care.

The solutions we will hear this morning are win-win for everyone. They provide older citizens and their families with better care, better outcomes, and more enjoyable lives; they provide direct care workers long-overdue respect and job satisfaction; they allow health care practitioners to meet the comprehensive needs of their patients; and they save money in the long run.

Senator CASEY. The majority of our healthcare and long-term care systems are missing a critical element in caring for older citizens, and that is the importance of relationships. Just one word, but so powerful and so profound for today.

Elder care has become entrenched in habits and methodology and reimbursement policies that are more suited to one-size-fits-all than to personalized, individualized care. We reimburse physicians on the number of patients they see in a day rather than engaging older citizens and their families in a partnership of care. We evaluate direct care workers on the number of pills they can dispense in an hour rather than the joy they can engender in the lives of an older individual.

The movement toward person-centered care has been called a revolution. But although it is revolutionary and new in what we are doing, it is also a profound return to the bedrock values of re-

specting our older citizens and living the golden rule. It is about peace of mind for families and family members.

The pioneers of this revolution, and we are fortunate to have many of them with us today, show us how we can enrich the lives of both older citizens and everyone around them. I am so grateful to them for their willingness to believe in something better, the people who are here providing testimony and supporting the testimony, for their courage and persistence in engaging very entrenched systems in innovative change.

Finally, the solutions we will hear today are a win-win for everyone. They are a win for older citizens, a win for those who provide the care, and for family members. These changes and these solutions provide older citizens and their families with better care, better outcomes, and more enjoyable lives. They provide direct care workers with long-overdue respect and job satisfaction. They allow healthcare practitioners to meet the comprehensive needs of their patients, and they save money in the long run.

In the end, and I will conclude with this, what we are doing today is, in a larger sense, paying tribute to and affirming the contribution of those who have gone before us, older citizens in our societies, those who fought our wars, who worked in our factories, who taught our children, who gave us life and love. The least that we can do is to stay focused on better ways to make sure their care is the best that it can be and especially to affirm the good work that is done by healthcare practitioners and, of course, the direct care workers who provide most of the daily and hourly care to older citizens.

So, Mr. Chairman, we thank you for your leadership and for this opportunity today. Thank you very much.

Now I have the honor and the privilege, as of chairing this hearing in my about 18th or 19th month in the Senate, to be able to call on a witness, and I appreciate the Chairman allowing me to do that.

I want to call on now another Senator from the State of Oregon, someone I have known for several years now and someone who has been a leading voice on these issues, Senator Ron Wyden.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you. Thank you very much, Mr. Chairman.

I want to commend you, Senator Casey. Thank you for your very fine statements, Chairman Kohl and Senator Smith.

I will be very brief. I think what is striking about this—and Ms. Abrams touches on it in her opening statement—is that when you look at the debates that we are now having in this country about healthcare, it seems that so often the patient is almost an afterthought.

You hear constant references to the providers, to the insurances companies, to various payers and budget experts, and at the end of the discussion, you wonder where does the patient really fit in?

I know in the Senate Finance Committee—Senator Smith and I are part of the Finance Committee—we had a long discussion last week about health information technology, a very exciting development. We also discussed something known as comparative effec-

tiveness analysis so that you could see, for example, which provider gave the best-quality services and at what price. These are all very useful tools.

But after something like 2 hours' worth of discussion, I asked how does the patient fit into all of this? We have heard about why it makes sense for the budgets and for payers and insurance companies. How would you actually get the fruits of these wonderful technologies to patients and their families in a usable fashion?

So that is why I think it is very, very helpful that Senator Casey, with the bipartisan leadership of our Committee, is looking at care that is patient-centered. This topic and this hearing give us a chance to elevate the concerns of patients so that at least they get up to the same plateau as concerns of providers, budget experts, insurance companies, and others.

The Healthy Americans Act is the first bipartisan universal coverage health bill in the history of the Senate—we have now got 16 Senators, 8 Democrats and 8 Republicans. Senator Smith, I am pleased to say, is one of our group. What we do is establish what is called a “healthcare home.” We don't call it a medical home because we want to convey to the world that nurses and physician assistants and others should also be in a position to do the good work that Senator Casey has described this morning.

As this debate goes forward about a medical home—what I call a health home and I am going to ask several of you witnesses to talk particularly about how we can make sure that this concept really gets embedded in the health reform efforts. I think it really is one of the best ways to follow up on this idea of a patient-centered universe in healthcare.

Thank you Senator Casey for this hearing, your leadership and especially for making sure that the patient isn't an afterthought in this debate.

Senator CASEY. Thank you, Senator Wyden. We are grateful for your leadership as well.

I think we will go to our witnesses now, and I think it will start on my left. I think what I will do is just introduce the witnesses as they testify.

First of all, Dr. William Thomas is a Professor at the Erickson School of Aging Studies, University of Maryland. He is the Founder of the Green House model. He is a resident of the State of New York. To say he has been an innovator and a pioneer is a dramatic understatement.

He is a Harvard-trained medical doctor and also known in some circles as a “gentleman farmer.” I will have him explain that if he wants to at some point. But, Doctor, we are grateful for your presence here today and your testimony, and we will start off with you.

We are going to try to keep, as best we can, our witnesses to 5 minutes. Of course, each of your statements will be made part of the record. We will start with you, Dr. Thomas.

**STATEMENT OF WILLIAM THOMAS, M.D., PROFESSOR,
ERICKSON SCHOOL OF AGING STUDIES, UNIVERSITY OF
MARYLAND, ITHACA, NY**

Dr. THOMAS. Thank you, Senator Casey. Thank you to the Committee for having me.

I actually always like to take a question of public policy and dig into the history. It is fascinating to me. As I was preparing my remarks, I went back across the history of medicine and healthcare in America, and it is fascinating to look at healthcare in America in the 19th century.

In the 1800's, it was a wild and woolly environment out there, with just about anybody who wanted to could call themselves any kind of doctor or practitioner they wanted to. Families, consumers, patients really had no way of knowing if this snake oil salesman was really going to offer them some kind of cure or not. I will give you one little anecdote from that era, which I found fascinating.

The early—when oil was discovered in western Pennsylvania, the first use it was put to was as a patent medicine. Some enterprising souls in western Pennsylvania began collecting the oil that was running in the streams out there and selling it as a medicine. That didn't work out so well. So this whole petroleum thing took over instead.

But in 1910, a man named Abraham Flexner, with the support of the Rockefeller family, actually conducted a detailed analysis of medicine in America, and his findings were, as I have described to you, crazy. He recommended that we standardize American medicine and much in the same kind of way that the petroleum or oil industry was being standardized.

As a result, for the very first time, there were specific requirements for physicians to go to medical school. That was new. To actually have faculty who were doctors, that was new. To actually see patients, that was new. All of this was new. The modern medical school was born in the early 1900's.

The result of that, I am really happy to say, was a dramatic improvement in the healthcare made available to American citizens because now you had people who were actually trained in what they were trying to do. There was real research going on, and we began to see real improvements in our health and healthcare.

The other thing that happened as a result of this improved attention to kind of training and prestige, the reputation of the doctor changed from possibly snake oil salesman, "I don't know about this person," to a respected member of the community. In fact, there are some really wonderful pieces of art that are created in the early 20th century kind of showing physicians in very kind and caring and compassionate roles.

We began to match that new social role with some tremendous technology—the development of antibiotics, effective immunizations, effective surgical techniques. Medicine went through a stunning transformation. With each new development, the stature of the doctor rose higher and higher and higher.

In fact, I was a medical student in the 20th century, and when I began my training, it was customary for nurses to rise from sitting when a doctor entered into the room. That was a courtesy that was extended to physicians in part because of this high prestige.

In fact, there was a joke that went around medical schools at that time, which I will repeat here because you guys didn't go to medical school so—what is the difference between God and a surgeon? God doesn't think he is a surgeon.

So what happened is we developed a “doctor knows best” kind of culture, where patients were expected to defer to the expert judgment of the physician. I think that worked well at the time. You know, it had its advantages, but we live in a very, very different world now. I want to lay out for the Committee just the basic elements that are changing so you know where the policy—where this policy impulse is coming from.

First off, medical information is now available to everybody all the time, everywhere. Some of it is very good on the Internet, and some of it is very bad. But people have access to information in ways that were unimaginable in the 1960's, 1970's, and 1980's, you know, before the information boom.

Physicians are now regularly dealing with patients who have sometimes as much information as they do about new drugs and new treatments and new therapies, and it is changing the relationship between doctor and patient.

Also—and I think this is very, very important—we are the inheritors of a system that was built on acute medical care. The system was created and optimized to provide immediate urgent treatment to illness and injury, and it is good.

The problem is we are living in a society where more and more people spend more and more of their lives managing chronic illness. The ongoing management of chronic illness requires a different relationship between doctor and patient than the immediate urgent treatment of an illness or injury.

So we are changing away from an acute care oriented system toward a chronic care oriented system, and social roles are going to have to change to accommodate that.

Next, what used to be—the doctor in Sayre, PA, the Dr. Robert Packer hospitals started by Dr. Robert Packer, OK? There you go. It used to be clear exactly where you went for the answer. Now it is confusing.

In fact, Dr. Robert Kane, who is a well-known expert in the field of aging and public policy in aging, wrote a book about how difficult it was for him, an expert in the American healthcare system, to navigate when his mother became ill, and he was not the expert, he was the son of a woman who needed help. So what we find is that both doctors and patients are increasingly struggling with the complexities of the system we have created.

Finally, there is a need to put patients, as has been mentioned in the opening comments, at the center of what we do. There is a pretty exciting thing that happens when people like me and the other people in the hearing room here get to develop new models based on patient centeredness. That is what is different. That is what is new. That is what has changed.

I am not here today to talk to you about making a nursing home a better nursing home. I am here today to talk to you about transcending that older model with a new patient-centered model and reaping the benefits of that change.

So—and you will hear more about this in detail as we go along, but the medical home concept, I really want to say, I trained in family medicine. My sympathies are entirely with providing people with a healthcare home where they—home-based, where they can go and get reliable information from people with whom they have a relationship.

Senator CASEY. Doctor?

Dr. THOMAS. Yes?

Senator CASEY. I just want to cut you short because we are over by more than 3 minutes.

Dr. THOMAS. On time? No worries.

Senator CASEY. I want to—we won't penalize you today. But—
[Laughter.]

Dr. THOMAS. I thank you for giving me time, and I am sorry I went on so long.

[The prepared statement of Dr. Thomas follows:]

Dr. Bill Thomas Senate Testimony

July 21, 2008

Senate Testimony

Dr. Bill Thomas

Professor of the Practice of Aging Studies

The Erickson School at UMBC



- 1) American medicine in the 19th Century offered a broad range of philosophies and practices. Nearly all of them are forgotten now and, by and large, it is good that we have abandoned them.
- 2) The turning point came with the publication of the "Flexner

Report" in 1910. This book-length analysis of medical practice in America concluded with the following recommendations:

- a. Admission to a medical school should require, at minimum, a high school diploma and at least two years of college or university study, primarily devoted to basic science.
- b. The length of medical education required to last four years.
- c. Proprietary medical schools should either close or be incorporated into existing universities.
- d. Medical schools should appoint full-time clinical professors, who would be barred from all but charity practice, in the interest of teaching.

- 3) These changes led to the rise of the modern profession of medicine. It raised the "allopathic" medical philosophy above all others and put most competing philosophies out of business. The kindly hometown medical doctor became an American legend.



- 4) After World War Two, an unprecedented world historical boom in medical technology empowered the medical profession. New medicines, new technologies and new procedures transformed medical practice and raised the power and prestige of American doctors to unprecedented heights.

There is a joke that every 20th medical student remembers...

Q: What is the difference between God and a surgeon?

A: God does not think he's a surgeon.

- 5) We are now entering another transformational era in health and health care. The relationship between patients and "health care providers" is being remade. The old ideal of, "Doctor Knows Best" is giving way to a new, and much more equal, partnership between patient and practitioner.

Dr. Bill Thomas Senate Testimony July 21, 2008

- a. Patients are seeking, finding and using health information from a wide variety of sources. The consumer information revolution is alive and well in the health care arena.
 - b. Patients and doctors are spending more time dealing with the ongoing management of chronic illnesses and less time dealing with the immediate treatment of acute illnesses and injuries. This trend will accelerate as our society ages.
 - c. Patients and medical professionals face an increasingly complex network of sub-specialists and advanced treatment options that are both powerfully effective and very confusing.
- 6) I think the best new model for the emerging patient-provider relationship is "patient-centeredness." This philosophy of care places the individual patient at the center of the decision-making matrix. It encourages the exchange of information in both directions.
- Providers who adopt this framework soon find themselves working to develop new models, new systems and new approaches to previously intractable problems. These new models include:
- a. The idea of a "Medical Home" offers us a way to manage increased complexity and confusion of the existing jumble of specialists and sub-specialists. http://en.wikipedia.org/wiki/Medical_home
 - b. The "Planetree" model shines a light on person-centered practice in acute care environments. http://en.wikipedia.org/wiki/Planetree_Alliance
 - c. The "Eden Alternative" provides a pathway for existing long-term care organizations to alter their organizations and environments in ways that "bring decision making as close to the elders as possible. <http://edenalt.org>

- d. The “Green House” provides a radically “person-centered” approach to the long-term care needs of people who would otherwise be required to live in nursing homes. It offers a developmental approach to aging and care that adapts the daily routine to the needs of the elders rather than requiring the elders to adapt to an institution’s daily routine.
<http://www.ncbcapitalimpact.org/default.aspx?id=146>
- 7) “Person-centered” care is an authentic grassroots movement that has the power to unite patients and providers in a shared effort to experience how we interact with the health care system. So what can the federal government do to drive innovation forward? Here are my suggestions:
 - a. Weave person-centeredness into the reimbursement system.
 - i. The current system provides outsize financial rewards to people and organizations that concentrate heavily on technology-centered or sub-specialty-oriented care.
 - ii. We are entering a historical period where the greatest advances in our health and well-being are going to come from creative new ways to use the technology and knowledge we already have.
 - iii. Our reimbursement system is based on an outdated “input-based” approach to health care.
 - b. Encourage the development and testing of responsible, evidence-based innovations in new models, work roles and funding strategies.
 - i. We have supported biomedical research and that support has yielded life saving drugs. Now it is time to fund health care system research.
 - ii. Fear of regulatory sanction deters some people and organization

from pursuing new "patient-centered" models. I do not favor a regulatory rollback. I do favor improved mechanisms for understanding and responding to that fear.

- iii. Invest in developing the leaders who will take our entire health care system into a "person centered" future.
- c. Come to terms with the fact that our health care system is heavily biased toward the immediate treatment of acute illnesses and injuries and that the bias needs to be changed so that it favors the ongoing management of chronic conditions. This is the essence of the person-centered reform movement.

Senator CASEY. That is OK. Maybe we will give others a little warning.

Senator Whitehouse is here from the State of Rhode Island. I don't know if he wants to offer a statement now or whether you want to do a statement later?

Senator WHITEHOUSE. I am more than happy to hear from the witnesses and not deliver a statement.

Senator CASEY. That doesn't always happen in this place. [Laughter.]

Thank you, Senator Whitehouse.

Senator WHITEHOUSE. Maybe it will catch on.

Senator CASEY. Let me move to our second witness.

Robert Jenkins is here, and he is the Director of the Green House Project.

Just by way of background, Mr. Jenkins serves as Vice President of the subsidiary of NCB Capital, the Community Solutions Group. He directs the Green House Project and the Coming Home Program, and I know we are going to be hearing—have a chance to ask some questions about all of these and about the elements of the Green House, what characterizes the Green House.

But, Mr. Jenkins, if you have a chance, we will try to give you 5 to 6 maybe. Thank you very much.

STATEMENT OF ROBERT JENKENS, DIRECTOR, GREEN HOUSE PROJECT, NCB CAPITAL IMPACT, ARLINGTON, VA

Mr. JENKENS. Thank you, Senator Casey, Chairman Kohl, Ranking Member Smith, and other members of the Committee for this opportunity to share with you information about one successful model of person-centered care, The Green House Project.

I am Robert Jenkins, Director of the Green House Project. The replication of The Green House model is a partnership between NCB Capital Impact, the Robert Wood Johnson Foundation, Bill Thomas, and the early pioneering providers who have joined with us in this effort.

Person-directed care is about creating a place where people live lives on their own terms while receiving the care they need with dignity and control. Today, I want to share a brief overview of The Green House model, our research, challenges, and what Congress can do to help.

Edna Hess and Zoe Holland will speak on the next panel about their personal experiences with The Green House homes and how they transform the lives of elders and staff. Additional detailed information is available in my written statement.

The Green House model reinvents nursing homes to make them real homes. Not home-like, but real homes with the control, choice, and flexibility that you or I expect when we get home. To do this, the model changes three areas—the environment, the organization, and the philosophy of care typically found in skilled nursing homes. This comprehensive and integrated approach is key to the model's success.

The environment in The Green House homes is a small, warm, and fully independent home with an open common area with a kitchen, dining room, and living room at its core, surrounded by 10 to 12 private bedrooms, each with a private bath and all the sup-

port areas necessary, each organized to meet skilled nursing home requirements and building standards.

At the core of the philosophy is creating an environment where people living and working in the home are in control of their lives and have the chance to get to know each other. When you have control and know someone well, you can better understand and meet their individual needs and preferences.

The organizational design restructures staff and flattens the management of traditional nursing homes. It is an empowerment workforce model where direct care staff called Shahbazim work in self-managed teams. The Shahbazim are certified nursing assistants with 120 hours of additional training. They provide and manage all the critical tasks of running the household—providing care, cooking, cleaning, and doing the laundry.

Self-management and the universal worker approach leverage the Shahbazim's great capacity, creativity, and compassion to create a flexible environment and schedule that meets individual preferences. Just as at home when we care for a small number of people we truly know and care about, we find ways to accommodate and celebrate their individuality. The organization's clinical staff continues to provide skilled services using the best practices we have developed in traditional settings.

Dr. Rosalie Kane of the University of Minnesota, a leading researcher in long-term care, conducted an independent evaluation of the first Green House homes. Her research found significant improvements for the elders in both quality of life and quality of care, areas we have tried to have an impact on for many years. She also found great improvements for staff in their job satisfaction.

We believe these improvements translate into significant Medicaid and Medicare cost savings through greater functional and mental health as well as avoided and shortened hospitalizations and acute episodes. CMS has been supportive of The Green House model, finding that it meets all Federal rules and more fully implements the intent of the Nursing Home Reform Act.

There are three major challenges to spreading The Green House model of person-centered care. The first challenge is capital cost. Green House homes require new construction. State Medicaid rates are generally inadequate to cover the costs associated with new construction for any nursing home, a traditional nursing home or a Green House home.

The second challenge is low Medicaid rates. Nationally, the average Medicaid rate has been found to be less than the cost of good quality care. The Green House model is a high-quality model requiring staffing levels higher than the national average, but at the rate research has shown is necessary to provide good quality care. Low Medicaid rates mean that even the most mission-driven providers are often forced to limit their Medicaid participation.

The third challenge is getting the Green House homes off of campuses and into the communities where people live and homes belong. Community integration requires a scattered site approach. To make a scattered site approach financially viable, multiple homes need to be licensed together so they can share overhead costs. Federal nursing home rules may not support such an umbrella licensing approach.

To assist with these three challenges, we recommend that Congress consider the following. To help with the capital costs, create Federal programs to offset development costs for projects with a low-income focus. Program models could include a dedicated tax credit equity program, targeted grants, and interest rate subsidies.

Senator Casey, the proposal you plan to introduce, the Promoting Alternative Nursing Homes Act, will be a significant resource in this area if passed.

To improve access for Medicaid-funded individuals, develop long-term Federal Medicaid incentives to encourage States to provide adequate rates designed to support the operations of Green House homes and similar innovations. Long-term incentives are necessary to align with the 20- to 30-year commitment providers assume when they develop these models.

Finally, to get Green House homes into the community, form a workgroup to identify an acceptable community-based Green House strategy and license and identify and resolve any conflicts with Federal rules.

Thank you again for this opportunity to testify today.

I look forward to your questions.

[The prepared statement of Mr. Jenkins follows:]

**Person-Centered Care:
Reforming Services and Bringing Older Citizens Back to the Heart of Society**

**Testimony before the Senate Special Committee on Aging
July 23, 2008**

**Robert Jenkins, Director
THE GREEN HOUSE® Project**

Thank you Senator Casey, Chairman Kohl, Ranking Member Smith, and other members of the Committee for the opportunity to appear before you today and share with you one successful approach to person-centered care; THE GREEN HOUSE® Model.

I would like to begin by asking each of you to picture a time you were in a nursing home. What did you see? How did you feel? Did you sense the elders were living lives of meaning and hope? Or were there elders sitting idle for long stretches of time with little to do, waiting for the next meal or friendly face to come along? In nursing homes, we ask people to live private lives in public places.

Now, wipe away that scene. Picture elders waking up when they choose, to a breakfast of their choice, made fresh and hot just for them. They spend their day according to their choices and preferences, with staff who know them very well. Their family and friends are welcome and feel comfortable visiting a place that is truly mom's, dad's, or grandma's home. Person-directed care is about creating a place where people live life on their own terms, with dignity and control. The Green House® Model is a powerful example of person-centered care in action, of creating private places for private lives.

I Model Overview

The Green House® model de-institutionalizes nursing homes and reinvents them with the goal of restoring elders to a place they consider home. It combines small houses with the full range of personal care and clinical services needed by elders typically served in skilled nursing facilities. Green House® homes are licensed as nursing homes, but totally transform the elder care experience in a home that is small, warm

and private. The program creates an intentional community to support the most positive elderhood and work life possible. To achieve these goals, the model changes the architecture, organizational structure, and the philosophy of care.

The Green House® model was created by Dr. William Thomas, from who you just heard. The replication of The Green House model is being spearheaded by a team at NCB Capital Impact with generous financial and technical assistance from The Robert Wood Johnson Foundation. NCB Capital Impact is a not-for-profit, mission-driven organization providing innovative assistance and services to low and middle income communities, in the areas of healthcare, affordable housing, and education. The Robert Wood Johnson Foundation is the nation's largest philanthropy dedicated to improving health and helping Americans get the care they need. This team works hand-in-hand with long-term care providers and other community-based organizations to bring Green House® homes to communities across the country.

The Robert Wood Johnson Foundation has provided support for this replication effort, with the goal of developing Green House® homes in at least 50 communities.

The Green House model is a fully integrated approach to transforming the way long-term care is provided. It calls upon an organization to transform 3 areas simultaneously:

- The philosophy of care
- The architecture & physical environment
- The organizational structure, including the workforce

The Green House approach is about much more than building small, residential-style homes. The elements of philosophy and structure are at least as important as architecture, if not more so, in creating an environment that truly supports person-directed care and an empowered workforce.

The Philosophy of Person-Directed Care

The Green House home is a place where the elders have the ability, the power, and the support to make decisions about their own lives. This reframes the view of aging from one limited to declines and losses to one of wellness and potential.

The Green House philosophy is consistent with the central tenets of person-centered care and calls on long-term care providers to create an atmosphere that offers dignity, autonomy, and privacy for daily lives.

Added to these core values is the idea of creating a relaxed environment of “knowing” between elders and staff. Knowing is a critical component in The Green House model’s ability to improve quality of care and quality of life. When you know someone, you can better understand and meet their individual needs. You can be a friend and companion. Each Green House® home is designed to foster an intentional community that creates ‘knowing’ relationships and provides a meaningful and therapeutic community in balance with autonomy and privacy.

Architecture and Physical Environment

The Green House home is a small, flexible environment, typically of 10 elders, organized around the central common area called the hearth. The hearth includes the kitchen, living area and dining area in an open plan and is intended to support intentional community and strong relationships. This home is able to truly align the physical spaces with the mission of person-directed care and to make the home a tool that supports elders to live lives with dignity and control.

A core feature of The Green House home is a private bedroom and bath for each elder, to provide sanctuary and privacy.

The open kitchen becomes a hub for elder and staff activity and normal social life. The aroma of fresh, home-cooked food stimulates appetite and makes meals comfortable and familiar again.

The homes are self-contained and the design supports an intensive level of care and services by being small and accessible. Current technology is incorporated in communication systems and ceiling-track lifts to create 'smart' homes. The design creates a therapeutic environment, encouraging self-reliance through short distances and a safe environment for elders.

Organizational Redesign

The third area of transformation in the Green House model is the organizational structure. The model reorganizes staff and flattens the hierarchy of the traditional organization. It is an empowered workforce model, where direct care staff, called Shahbazim, are recognized as the most critical staff members in the daily life of the elder. The Shahbazim are certified nursing assistants, expert in providing personal care and services, but also in managing and executing all of the tasks of running the household - cooking, housekeeping, laundry - and are the primary group of individuals facilitating the elders' frequent and continuing opportunities for engagement in pursuits and activities of interest. The Shahbazim are universal workers taking responsibility for cooking, housekeeping, activities, as well as personal care in partnership with elders. You will hear much more about the role of the Shahbaz from Edna Hess on the next panel.

Each house functions independently, with consistent and separate Shahbazim staffing. They function in self-managed work teams, reporting to the Guide, a position typically assumed by the nursing home administrator. The Guide acts primarily in a coaching and mentoring role, facilitating the team to effectively make decisions and solve problems.

The team holds its own regular meetings to make decisions and resolve issues, develops its own schedules, with each person accountable to the other members of the team in the event of a need for a change in schedule, and is responsible to the

Guide, both individually and collectively, for managing the household and caring for the elders in accord with organizational standards, expectations and constraints.

The organization's clinical staff forms the Clinical Support Team. Nurses from the team meet the clinical needs of the elders (1 - 1.2 hours total per elder per day) in partnership with the Shahbazim (4 hours per elder per day), for a total of 5.2 direct care staffing hours per elder per day. The remaining clinical professionals visit the house on a routine basis and as required by the needs of the elders.

The Sage - a new role in The Green House model - is an elder community volunteer who provides his or her guidance and wisdom to the team to help them grow and develop their team capacity and skills.

The model shifts to one that in many ways is more like Home Care than institutional care, with the elders at the heart of their home and making decisions about their lives.

II Tracking Successes of Person-centered Care in The Green House® Model

Currently there are 41 Green House® homes on 15 campuses in 10 states, with another 12 homes due to open by then end of this year. There are 120 additional houses in planning on 19 campuses, expanding Green House homes to 22 states. In time, the model is expected to spread to all 50 states. One indicator of success is the future plans of many of the current sites to build additional Green House® homes.

Rosalie Kane, Ph.D. of the University of Minnesota conducted an independent evaluation of the first Green House® homes, developed by Mississippi Methodist Senior Services in Tupelo, MS.

A 2-year longitudinal study compared elders living in the first 4 Green House® homes with elders in traditional nursing home care and found significant improvements for the elders in Green House® homes in the areas of privacy, dignity, autonomy,

enjoyment of food, relationships, emotional well-being, feeling safer and meaningful engagement. These are very important areas that the model was designed to address and we were excited to see improvements since we have been working for many years to improve these aspects of life in a nursing home without a great deal of success.

Just as important, areas of clinical care improved as well. This was an added benefit and one we believe is attributable to the smaller environment where staff know and understand the elders much better. Areas of improvement included greater independence in functional areas defined as “late-loss activities of daily living” (ie., bed mobility, transfer, eating and toileting), less depression, and fewer elders who were bedfast or had little or no daily activity. These successes illustrate improvement in major domains of quality of life and quality of care that translate into better lives and care.

Workforce Outcomes

Universal workers in self-managed work teams are a very efficient way to deliver care and services. This approach to care delivery supports the Shahbaz to organize work logically without navigating many departments and systems. Nursing homes have groaned under the weight of complex silos and systems, resulting in costs wasted in bureaucracy and redundancy. This has been an expensive mode of delivering care with many resources going into non-care related activities.

Specific successes related to The Green House workforce include:

1. Significant decreases in staff turnover are consistently reported by Green House® homes. In a field where turnover of direct care workers averages 71% this is a critical finding. Serious attention is needed to the issue of job quality and satisfaction if we are to have a sufficient workforce ready to care for a rapidly aging nation. The stabilization of staff in Green House® homes reflects the higher staff satisfaction reported by Shahbazim, nurses and other clinical support team members.

2. Just as important is the development of close, knowing relationships that grow out of this model. The Shahbazim and nurses get to know and understand elders well, which results in more immediate recognition of small, but potentially significant, changes in health status. The potential for minimizing acute health problems and avoiding expensive hospitalizations adds to the benefits of a person-centered model of care.

The Robert Wood Johnson Foundation is currently funding research to measure these outcomes as well as the efficacy of the Nurse/ Shahbaz relationship related to clinical outcomes, and a work flow analysis examining the universal worker model of care delivery. Results from these studies will be available early in 2009.

Regulation and Policy

The big question asked by providers and the public is: can a person-directed care model be fully realized within existing federal and state nursing home regulations?" There are currently Green House® projects open or in development in 22 states. Each open Green House® home has met the building codes, life safety and clinical care system requirements to operate as a licensed nursing home within their state.

The Centers for Medicare and Medicaid Services (CMS) carefully reviewed both the structural and programmatic elements of the model and in a letter to Congress last year stated it found no barriers to certification of homes developed under The Green House model as skilled nursing facilities. The letter also indicated that innovations like Green House more fully implement the Nursing Home Reform provisions of the Omnibus Reconciliation Act of 1987, from which CMS nursing home regulations are derived. I have attached a copy of a letter and ask that it be included in the record with my written testimony.

Financial Viability

Information on the financial viability of this model is emerging as open projects track operating and capital costs over time. The good news is that it is viable for 15 organizations across the country and many of those providers are building more homes and campuses. Success to date means significant fund raising to off-set capital costs and limiting Medicaid funded residents particularly in lower reimbursing Medicaid states. Some providers with good direct-care staffing levels have found operating costs to be comparable to their traditional nursing home operations.

However, The Green House model's operations require slightly more direct care staff than the industry average. According to data available on CMS' Medicare Compare website, the national average nursing home staffing for Certified Nursing Assistants and licensed nurses (including those in administrative roles) is just under 3.5 hours per resident per day. By contrast, The Green House model calls on organizations to provide a combined total of direct care licensed nursing (*exclusive* of administrative nursing time) and Shahbazim time of 5 - 5.2 hours per elder, per day.

This is appropriate because the Green House model's staffing is at the level that research has shown is required for positive outcomes. With positive outcomes, other costs may be saved in clinical care and acute care areas. To extend these benefits to the majority of Medicaid funded nursing home residents, some changes will be required or it will not be possible for the majority of providers. Issues like Medicaid reimbursement rates, debt load and the capital expense of constructing new homes impact the ability of a provider to build successful Green House® homes. Economies of scale—where several homes can share costs and systems—are also critical to the model.

III Identifying the Challenges Ahead

The Green House® Project and the Robert Wood Johnson Foundation are committed to making a person-centered model of care, specifically The Green House homes,

available to those of all income groups needing skilled nursing care. This necessarily requires Medicaid reimbursement rates that adequately support a consumer-driven, humane model of care. Medicaid rates range from an average rate of \$100 in Illinois to over \$225 in New York in 2006. Currently, Green House® homes are serving elders receiving Medicaid funding only in states with higher reimbursement rates.

An additional challenge is the capital costs for building new buildings. In the 1960's the Hill Burton Act provided funding for building many of the nursing homes that exist today. The capital costs were significantly defrayed so that only the operating costs needed to be covered for the nursing home to be viable. Today, many state Medicaid reimbursement rates cover only a small percentage of the actual capital costs of constructing a new skilled nursing facility. This problem is even more acute for Green House® providers due to the model's focus on private rooms and home-like common areas as important features of improved quality of life.

IV Recommendations for Policymakers

To move person-centered care forward, action on the federal, state and local levels is needed. We recommend that policymakers consider the following:

1. Form a national workgroup including providers, consumers, elders and regulators to make recommendations to streamline the process for developing and operating Green House® homes and other innovative models that support person-centered care. Specifically charge the workgroup to explore the creation of a skilled nursing license category or allowance to provide for locating Green House homes individually or in pairs in residential neighborhoods. This license would need to allow multiple homes (each with full-time nursing available on site) that are physically distant from one another, to operate under one license to achieve economies of scale. This will truly support elders to stay integrated within their own multi-generational neighborhoods. People do better when they stay connected and identified with their own community.

2. Incentivize providers to build new models through public support of capital costs, including tax credit equity programs, targeted grants, and interest rate reductions. These mechanisms should help generate equity investments in innovative skilled nursing models while also reducing debt service costs.

3. Work with states to enhance Medicaid reimbursement rates for true person-centered models of care, by supporting fast-track review processes for state plan amendments that relate to payment rate changes for Green House® providers.

In Closing

We are only beginning to understand how far we can go in challenging the status quo in nursing homes. For too long, most of us have accepted that good care in nursing homes meant keeping our elders clean, dry, and fed. If the clinical outcomes were pretty good, we said that was the best that we could achieve.

But we now know that we can do a lot better. And life is better today in 41 Green House homes for 430 elders. We hope that you will support our efforts - and the efforts of others developing truly person-centered care models - to create places in every community across the country where our elders can live life on their own terms, with dignity and control.

We hope that you will take the opportunity to come and visit a Green House® home and see for yourself the difference it is making in the lives of its elders and staff.

Senator Casey, Chairman Kohl and Ranking Member Smith, thank you again for holding this very important hearing and for the opportunity to testify before you today. I look forward to answering any of your questions.

Senator CASEY. You are under your time. That counts for a lot around here.

Next we have Melinda Abrams, who is the Assistant Vice President, Director of Patient-Centered Primary Care, that project, I should say, of the Commonwealth Fund. She does direct that particular patient-centered project. Ms. Abrams has a distinguished career in health policy. Since coming to the Commonwealth Fund in 1997, she coordinated the Fund's Task Force on Academic Health Centers, Commission on Women's Health, and the Commonwealth Fund Harvard University Fellowship in Minority Health Policy.

She has played a lead role in reviewing and modifying State policies regarding preventive healthcare that addresses early childhood development. It is an honor to have you here, Ms. Abrams, and you have the floor.

Thank you very much.

STATEMENT OF MELINDA ABRAMS, M.S., ASSISTANT VICE PRESIDENT, PATIENT-CENTERED PRIMARY CARE, THE COMMONWEALTH FUND, NEW YORK, NY

Ms. ABRAMS. Thank you. Thank you, Mr. Chairman, Senator Smith, and Senator Casey, to testify on person-centered care for older adults in ambulatory care settings.

I am Melinda Abrams, Assistant Vice President of the Commonwealth Fund, where I direct our program on patient-centered primary care.

An approach to providing person-centered care in primary care settings is the patient-centered medical home. We can call it a healthcare home, I don't mind. But the point is that it organizes care around the relationship between the patient and the personal clinician.

In February of 2007, four primary care specialty societies, representing more than 300,000 physicians, released joint principles outlining and defining key characteristics of a medical home. In practical terms, a medical home promises a personal clinician whose practice provides better access and effective care coordination within the context of an ongoing relationship.

In a medical home, for example, a patient can expect to obtain care from the practice on holidays, evenings, and weekends without going to an emergency room or have medical questions answered by telephone or email on the same day that she contacts the office. In a medical home, the primary care clinician helps a patient select a specialist and, with support from designated staff, proactively follows up with both the providers and the patient about tests or examination results, reviews treatment options, and helps to resolve conflicting advice possibly received from multiple providers.

To carry out these enhanced functions, the medical home requires improved infrastructure, such as an electronic health record, patient registries to organize clinical information, ability to review results remotely, and the capacity to collect and analyze information about the quality of care provided. That information about quality should also include information from patients about their experience.

I want to emphasize the importance of the medical home for older Americans. Since 86 percent of Medicare beneficiaries have one or more chronic conditions, investing in improving coordination of care in primary care is critical to reduce unnecessary and redundant services, gaps in service, problems with care transitions, and medical errors.

The patient-centered medical home also requires fundamental payment reform. Many medical home services are reimbursed either inadequately or not at all by the current fee-for-service system. Primary care practices would submit to a voluntary and objective qualification process to be recognized as a medical home, and in exchange, the practice would be supported with an enhanced or additional payment to cover the improved care management infrastructure and care coordination.

There is substantial evidence showing that a strong foundation of primary care can reduce costs and improve quality. The Commonwealth Fund's 2007 International Health Policy Survey found that only half of all adults in the United States have a medical home. Patients with a medical home were more likely than those without to report better access to care, more time with their doctor, fewer duplicative tests, and greater involvement in healthcare decisions.

Among adults with chronic illness, patients with a medical home were less likely to report medical errors and more likely to have a written care plan to manage illness at home.

The Commonwealth Fund is supporting evaluations of several medical home demonstrations, including one in Rhode Island, to determine if they slow the growth of healthcare expenditures. There is data to suggest—however, there is data to suggest that this approach can reduce health system costs.

For example, a medical home pilot project at the Geisinger Health System, an integrated delivery system in northeast and central Pennsylvania, showed a 20 percent reduction in hospital admissions and a 12 percent decrease in hospital readmissions at their Lewistown hospital.

Although not serving a large proportion of elderly patients, a few State Medicaid programs, such as North Carolina, have demonstrated cost savings of about \$225 million in 2004 when beneficiaries were enrolled in networks of medical homes. In both of these examples, primary care clinicians were paid an additional per member per month fee to manage and coordinate patient care above and beyond the standard covered by traditional fee-for-service payments.

Congress has recognized the potential value of stronger patient-centered primary care. The Tax Relief and Healthcare Act of 2006 instructs the Centers for Medicare and Medicaid Services to develop an eight State demonstration of the medical home under Medicare. The recently passed Medicare Improvements for Patients and Providers Act of 2008 provides an additional \$100 million to augment the demonstration. I commend the Congress for its willingness to test this promising approach in Medicare.

As the Committee considers legislative and regulatory strategies to encourage person-centered care for older adults in ambulatory care settings, there are a number of steps Congress could take.

First, you can ensure greater transparency of the Medicare medical home demonstration. In light of the keen interest from numerous stakeholders to reform and improve primary care, regular reporting to Congress and the public about the progress and early lessons from the Medicare demonstration can inform policy and practice around the country as well as ensure timely evaluation results.

Second, direct the Centers for Medicare and Medicaid Services to join commercial and State payers in the Medicare medical home demonstration. With explicit encouragement from Congress, Medicare could collaborate with several of the commercial payers in State Medicaid programs around the country that are already willing to change payment rates to primary care practices to test this concept.

Another strategy is to pursue an intermediate and incremental financing changes to promote components of the medical home. One option is to authorize a separate payment for discrete services associated with key care coordination functions, such as hospital discharge planning which could help reduce unnecessary hospital readmissions. Another is to implement the recent recommendation of the Medicare Payment Advisory Commission to increase payment levels for evaluation and management services provided by primary care clinicians to help support care management, care coordination, and patient-centered care.

Finally, consider implementation of scholarships or educational loan forgiveness programs to encourage medical students to choose careers in primary care. This strategy would address the current shortage of primary care physicians to staff medical homes.

Thank you for the opportunity to participate, and I look forward to your questions.

[The prepared statement of Ms. Abrams follows:]



**ACHIEVING PERSON-CENTERED PRIMARY CARE:
THE PATIENT-CENTERED MEDICAL HOME**

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**Invited Testimony
Special Senate Committee on Aging
Hearing on "Person-Centered Care: Reforming Services and Bringing Older
Citizens Back to the Heart of Society"**

July 23, 2008

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**ACHIEVING PERSON-CENTERED CARE:
THE PATIENT-CENTERED MEDICAL HOME**

Melinda Abrams

Thank you Chairman Kohl, Senator Smith, Senator Casey and the Members of the Committee for this invitation to testify about medical home in your hearing about care for older Americans. I am Melinda Abrams, assistant vice president at the Commonwealth Fund, and responsible for the Patient-Centered Primary Care Initiative. The Commonwealth Fund is a private, grantmaking foundation that aims to promote a high performing health care system that achieves better access, improved quality and greater efficiency, particularly for society's most vulnerable populations, including elderly adults.

The principle driving patient-centered care is relatively simple: the health care system should be designed around the person – not around administrators, physicians or financing. The Commonwealth Fund 2007 International Health Policy survey showed that an overwhelming majority of Americans want care that is accessible, well-coordinated and family-centered.¹ And yet, today's health care system has difficulties focusing on the patient. Care is generally reimbursed with little or no regard for medical outcomes, physician offices rarely schedule patient appointments in the evenings or week-ends convenient to patients and there is little coordination between primary and specialty care providers.

In this testimony, I am going to discuss how a medical home, by providing patient-centered primary care, can improve health outcomes. I will define the concept, present evidence showing its value and review policy options for future Congressional action.

Defining the Patient-Centered Medical Home

A patient-centered medical home is an approach to primary care that organizes care around the relationship between the patient and the personal clinician. Although the concept was first introduced by the pediatricians, their broad definition is relevant to other populations, especially older adults with multiple chronic conditions – a medical

¹ C. Schoen, R. Osborn, M.M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adult's Health Care Experiences in Seven Countries, 2007", *Health Affairs* Web Exclusive (Oct. 31 2007); 26(6):w717-34.

home is a practice that provides primary care and is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.”²

In February 2007, four primary care specialty societies – representing more than 300,000 internists, family physicians, pediatricians and osteopaths – released Joint Principles defining the Patient-Centered Medical Home with the following characteristics:³

- **Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Team Care** – the physician directs team of professionals and staff who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services).
- **Quality and safety** – practices use evidence-based medicine and clinical decision-support tools to guide decision-making. Physicians advocate for their patients defined by care planning and partnership with patients. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met. Patients and families participate in quality improvement activities at the practice level.
- **Enhanced access** to care is available through availability of same-day appointments, expanded hours of operation and new options for communication between patients, their personal physician, and practice staff.
- **Payment** that recognizes the enhanced value from care coordination, health information technology and team-based care.

So what does this mean in practical terms? In a medical home, a patient could expect to obtain care from the physician practice on holidays, evenings and week-ends without going to the emergency room. The patient could have medical questions answered by

² American Academy of Pediatrics, “The Medical Home: Medical Home Initiatives for Children with Special Needs Project Advisory Committee” *Pediatrics*, 1 Jul 2002; 110(1):184-186.

³ American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association, “Joint Principals of the Patient-Centered Medical Home”, March 2007.

telephone or email on the same day that she contacts the office. Non-urgent care appointments could be scheduled one or two days ahead of time, instead of weeks or months. In a medical home, care coordination is vastly improved. The primary care clinician helps the patient select a specialist and (with support from staff) proactively follows up with both the providers and the patient about test or examination results. In a medical home, the personal physician reviews treatment options with the patient and her family to help understand or resolve conflicting advice received from multiple providers. Patient-centered medical homes require improved infrastructure – such as electronic health records, patient registries, ability to review test results remotely and electronic prescribing or referrals – to deliver primary care effectively. The medical home patient could expect to receive email or telephone reminders from the practice about overdue appointments as well as telephone notification about test results with the option to view her patient record online through an Internet link. Patient could expect to routinely complete surveys or participate in focus groups to report on the care experience. The medical home practice would use that information, along with data about clinical quality, to improve how the practice is structured or managed. Patients must perceive that the medical home serves their needs to be truly patient-centered.

The patient-centered medical home also requires fundamental payment reform that is intended to strengthen and reward primary care. For successful implementation, primary care practices would submit to a voluntary and objective qualification process to be recognized as a patient-centered medical home. In exchange, the medical home would be supported with an enhanced or additional payment to support the improved care management, infrastructure and care coordination.

I want to emphasize the importance of the revised approach to payment and practice to helping older Americans. Approximately 125 million Americans are living with chronic illness.⁴ Among the Medicare population, 86 percent of the nearly 40 million beneficiaries have one or more chronic conditions and 23 percent have five or more chronic conditions.⁵ In a medical home, patients would receive individual care that is integrated and coordinated across all providers, which would reduce duplication of service and ensure consistency of a care plan for patients with multiple conditions.

⁴ G. Anderson and J. Knickman, “Changing The Chronic Care System to Meet People’s Needs”, *Health Affairs*, November/ December 2001, 20(6): 146-160.

⁵ M. Maxfield, et al., “Design of the CMS Medical Home Demonstration”, submitted to the Office of Research Development and Information at the Centers for Medicare & Medicaid Services, June 19, 2008.

Evidence Demonstrating the Value of the Patient-Centered Medical Home

Evidence on Medical Home Improving Quality of Care

Health care systems with a strong foundation of primary care can reduce costs and improve quality. People with primary care clinicians are more likely than those without to receive preventive services, to have better management of chronic illness and report better experiences with their care.⁶ States with more primary care providers have lower total mortality rates, lower heart disease and cancer mortality rates and higher life expectancy at birth compared with states that have few primary care providers.⁷ In contrast, increases in specialist supply are associated with increased cost, but not improved quality.⁸

Edward H. Wagner, MD, MPH, director of the MacColl Institute for Healthcare Innovation, developed the Chronic Care Model, which has shown that an effective way to help people with chronic conditions is to structure care around productive interactions between “an informed, activated patient” and a “prepared, proactive practice team”. Achieving this effective dyad requires organization and support of individual practices in ways that are equivalent to a patient’s having a medical home. Self-management support and appropriate health information systems are necessary components of the practice infrastructure. The literature shows that implementation of these elements improves quality of care for patients with diabetes, asthma, and depression.^{9,10,11, 12}

⁶ Dartmouth Atlas Project. 2006. The Care of Patients with Severe Chronic Illness: An Online Report on the Medicare Program. Hanover, N.H.: Dartmouth Medical School, Center for the Evaluative Clinical Sciences.

⁷ B. Starfield, L. Shi and J. Macinko. “Contribution of Primary Care to Health Systems and Health”, *Milbank Quarterly*, September/October 2005, 83(3): 457-502.

⁸ B. Starfield, L. Shi, and J. Macinko, *Health Affairs*, Web Exclusive (March 15, 2005), w97-w107.

⁹ M.W. Battersby, “Health Reform Through Coordinated Care: SA HealthPlus, *British Medical Journal*, 2005 March 19; 330:662-665.

¹⁰ P. Lozano, J.A. Finkelstein, V. Carey, E.H. Wagner, et al., “A Multisite Randomized Trial of the Effects of Physician Education and Organizational Change in Chronic-Asthma Care”, *Archives of Pediatrics & Adolescent Medicine*, September 2004; 158(9): 875-883.

¹¹ G. A. Piatt, T. J. Orchard, S. J. Emerson, et al., “Translating the Chronic Care Model into the Community”, *Diabetes Care*, April 2006; 29(4):811-817.

¹² M. Dwight-Johnson, K. Ell, P.J. Lee, “Can Collaborative Care Address the Needs of Low-Income Latinas with Comorbid Depression and Cancer? Results from a Randomized Pilot Study”, *Psychosomatics*, June 2005; 46: 224-232.

Two recent Commonwealth Fund surveys show a number of benefits of having a medical home.^{13, 14} In both studies, presence of medical home was determined by specific patient experience reports. The Commonwealth Fund's 2007 International Health Policy Survey defined medical home if respondents reported

- a) They had a regular doctor or source of primary care,
- b) A provider who had information about their medical history,
- c) Their provider could be contacted by phone during office hours and
- d) The provider coordinated their care.

Based on these criteria, only half of all adults in the United States have a medical home. Across all seven countries that participated in the survey, patients with a medical home compared to those that did not were more likely to report positive care experiences. Specifically, patients with a medical home were more likely to experience better access to care on holidays, evenings and week-ends; greater involvement in care decisions; more time with their doctors; fewer duplicative tests and assistance in selecting a specialist. Among adults with chronic illness, patients with a medical home were less likely to report medical errors (e.g., medical mistake or wrong medication) and more likely to have a written care plan to manage their illness at home and receive reminders for preventive or follow-up care. The 2006 Healthcare Quality Survey showed similar benefits of the medical home for adults with the added advantage of demonstrating substantial reduction of racial and ethnic disparities.¹⁵

Evidence on Medical Home Reducing Health Care Costs

The Commonwealth Fund is supporting rigorous evaluations of several medical home demonstrations to determine if they slow the growth of health care expenditures. Preliminary data from one medical home pilot and results from a few studies suggest that widespread adoption of patient-centered medical homes can reduce health system costs and achieve better quality and health outcomes.

The Geisinger Health System, an integrated delivery system in northeast and central Pennsylvania, shows positive, early results from its medical home pilot. The health system encompasses 40 community practice sites, several specialty hospitals and multiple

¹³ A.C. Beal, M.M. Doty, S.E. Hernandez, K. K. Shea, K. Davis, "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey" (New York, NY: The Commonwealth Fund, June 2007).

¹⁴ C. Schoen, R. Osborn, M.M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adult's Health Care Experiences in Seven Countries, 2007", Health Affairs Web Exclusive (Oct. 31 2007); 26(6):w717-34.

¹⁵ A.C. Beal, et al., "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey", 2007.

tertiary medical centers. All clinicians and practice sites are connected through a fully integrated electronic health record. As part of the patient-centered medical home pilot, Geisinger expanded patient care to include ongoing telephone monitoring and case management, telephone follow-up post-hospital discharge and post-emergency department visits, easy access to clinicians by telephone, group visits, educational services and personalized tools such as chronic disease report cards. Participating providers were paid an additional fee for the improved access and care coordination. After one year, preliminary findings show a decrease in hospital admission rates, ranging from a 14 percent reduction in Lewisburg Community Hospital to a 20 percent drop in Lewistown. Hospital readmission rates also declined dramatically. The Lewistown hospital demonstrated a 12 percent decrease in hospital readmissions while Lewistown declined by 48 percent.¹⁶

Although not serving a large proportion of elderly patients, a few state Medicaid programs have demonstrated that medical homes can reduce health care costs across a system of care. The North Carolina Medicaid program, called Community Care of North Carolina, enrolls beneficiaries in local, primary care networks of medical homes. An analysis by Mercer Consulting found that a \$10.2 million investment resulted in savings of \$225 million when compared to traditional, Medicaid fee-for-service.¹⁷ In Iowa, Medicaid beneficiaries were enrolled in a primary care case management (PCCM) program, which slowed Medicaid spending by 3.8 percent (saving \$66 million) over an eight-year period, with the effects strengthening over time.¹⁸ Under this model, primary care clinicians are paid an additional per-member-per-month fee to manage and coordinate patient care beyond the standard care covered by traditional fee-for-service payments.

Recently, the Commonwealth Fund issued a report, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, which includes 15 options for slowing the growth in health care outlays while improving access and quality of care. One option estimated the savings accrued if all Medicare beneficiaries in traditional fee-for-service were required to enroll in a medical home for primary care. In

¹⁶ G. Steele, "AHRQ: Who Should Pay for Health IT? Institutional Commitment to Health IT", Presentation at AcademyHealth Annual Research Meeting (June 9, 2008).

¹⁷ M. Lodh et al., "ACCESS Cost Savings—State Fiscal Year 2004 Analysis," Mercer Governmental Human Services Consulting letter to Jeffrey Simms, State of North Carolina, Office of Managed Care, (March 24, 2005), <https://www.communitycarenc.com/PDFDocs/Mercer%20SFY04.pdf> (accessed July 21, 2008).

¹⁸ E.T. Momany, S.D. Flach, F.D. Nelson et al., "A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program", *Health Service Research* 41, pt 1 (2006): 1357-71.

recognition of the enhanced services (care management, care coordination, patient education and same-day access to appointments), physicians would receive a per member per month fee in addition to the regular fee-for-service payments. Under the policy option, the projected net cumulative savings to national health expenditures is \$60.0 billion over five years and \$193.5 billion over 10 years. Most of the savings were derived from a decrease in hospital and physician expenses as a result of higher-quality and more-efficient care delivered by medical homes.

Challenges Facing Implementation of the Patient-Centered Medical Home

Successful implementation of the patient-centered medical home must overcome many challenges, but two in particular require immediate attention – our current reimbursement system and the capacity of our current clinical workforce to staff medical homes.

Many medical home services (such as care coordination or care management) and infrastructure (health information technology or registries) are reimbursed either inadequately or not at all in the current fee-for-service system. Current reimbursement is biased in favor of procedures (such as surgical operations or imaging) and does not adequately pay for time spent with patients to take their medical history, conduct an examination or follow-up before or after the next appointment. In their June 2008 report, the Medicare Payment Advisory Commission summarized the problem: “In consideration of the devaluation of primary care services, the Commission is concerned that these services risk being underprovided, as physicians view them as less valued and less profitable. Yet, primary care services and – perhaps more importantly – primary care clinicians, are critical to delivering more coordinated, high-quality care to the Medicare population.”¹⁹ Further, many technical procedures become more efficient, or take less time, with improvements in technology. If reimbursement levels stay constant, then payment effectively increases. However, similar efficiencies are rarely realized in primary care, since less time with patients might mean compromising patient-centered care.

Another challenge is a shortage of primary care physicians to staff medical homes. Due to lower reimbursement, the average medical or surgical sub-specialist makes almost twice the annual salary of the average primary care physician, and the primary/specialty

¹⁹ Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Reforming the Delivery System, June 2008, Pg..27.

care income gap is growing over time.²⁰ This income disparity has led to declining numbers of medical students to select residencies in primary care. Other factors are perceived to exacerbate the decline in primary care physicians. For example, subspecialty physicians are perceived to enjoy a better lifestyle – more regular hours, less on-call responsibilities – than their primary care colleagues. For the Medicare population, a dwindling workforce could threaten access to primary care services for elderly Americans.

Intense National Interest in the Patient-Centered Medical Home

The patient-centered medical home is not just a pipe dream derived from survey results or econometric models. The evidence showing the quality and cost gains from stronger primary care through medical homes has galvanized a broad array of stakeholders. In addition to the four primary care specialty societies, the medical home has been endorsed by large employers, including IBM and WalMart; labor and consumer organizations, including AFL-CIO and AARP; and is being tested in several demonstrations by major private health plans, including Blue Cross Blue Shield and Aetna.

Public payers have also recognized the potential value of stronger, well-coordinated primary care and authorized new payment models to promote the patient-centered medical home. As you know, The Tax Relief and Health Care Act of 2006 instructs the Centers for Medicare and Medicaid Services to develop an 8-state demonstration of the medical home under Medicare.²¹ The recently passed Medicare Improvements for Patients and Providers Act of 2008 provides an additional \$100 million dollars to augment that demonstration.²² I commend the Congress for its willingness to test this promising approach.

The states have been equally active on the topic of medical home. In Pennsylvania, Governor Rendell and the legislature have begun a statewide “roll-out” (not a demonstration) of the patient-centered medical home model.²³ And in Massachusetts, a bill was introduced last week that would permanently restructure financing of Medicaid plans to provide a supplemental fee to primary care practitioners working in qualified

²⁰ T. Bodenheimer, R. Berenson, and P. Rudolf, “The Primary Care-Specialty Income Gap: Why It Matters”, *Annals of Internal Medicine*, 2007; 146:301-306.

²¹ Tax Relief and Health Care Act of 2006 (Dec. 20, 2006) Division B, Section 204.

²² Medicare Improvements for Patients and Providers Act of 2008 (Jul. 15, 2008) Part 1, Section 133.

²³ Chronic Care Management, Reimbursement and Cost Reduction Commission, “Prescription for Pennsylvania, Strategic Plan”, February 2008; <http://www.rxforpa.com/assets/pdfs/ChronicCareCommissionReport.pdf> (accessed July 21, 2008).

medical homes.²⁴ Under a Commonwealth Fund grant to the National Academy for State Health Policy, a survey of Medicaid and SCHIP directors revealed that 23 states have efforts underway to test the patient-centered medical home in state Medicaid programs.²⁵

The Commonwealth Fund is actively engaged and closely monitoring many of the national and state medical home activities around the country. We are supporting a demonstration with safety net clinics, the further development of measures to qualify a primary care practice as a medical home, evaluations of several medical home demonstrations and the development of policy and payment options. Of course, the patient-centered medical home cannot fix all of the quality and cost problems of our health system. Through our evaluations, we will learn the impact of the medical home on clinical quality, patient experience and health care costs. It will be years before we have any answers, since it takes time to achieve both practice transformation and a positive return on investment. However, the Commonwealth Fund's substantial investment in the medical home demonstrates our commitment to the approach as central to establishing a strong foundation for primary care that can help the United States health care system achieve higher performance.

Policy Options for Congressional Consideration

As the committee considers legislative and regulatory strategies to encourage person-centered care for older citizens, there are a number of steps Congress could take. They are:

Ensure transparency of the Medicare medical home demonstration

Demonstrations take several years to get underway, be completed and publish results. Congress' interest in careful implementation of the CMS Medicare medical home demonstration is evidenced by your recent passage of the Medicare Improvements for Patients and Providers Act of 2008 in which you allocated \$100 million dollars to allow the Secretary to expand the demonstration. In light of the keen interest from numerous state and commercial payers to test and expand the model, regular reporting to Congress and the public about the progress and early lessons from the Medicare medical home demonstration can inform similar initiatives around the country. Routine updates could also encourage timely release of evaluation results, which will shape future program implementation. I am not suggesting interference with Medicare's operation of the demonstration,

²⁴ Commonwealth of Massachusetts Senate, Bill No. 2526, Section 44 (proposed).

²⁵ N. Kaye, M. Takach, Preliminary State Scan Summary Results, Unpublished data (1/25/08).

but rather recommending a mechanism for public review and discussion of the Medicare medical home experience to help shape policy and practice.

Direct the Centers for Medicare and Medicaid Services to join commercial and state public payers in the Medicare medical home demonstration.

Several commercial payers are willing to change payment rates to primary care practices to test the patient-centered medical home. Although there are examples of partnerships between state Medicaid and commercial payers on current medical home demonstrations (e.g., Rhode Island, Colorado), there is no active collaboration between commercial payers and Medicare. With explicit encouragement from Congress, there is an opportunity to facilitate such a partnership.

Pursue intermediate and incremental financing changes to promote medical home components, such as care coordination.

Two options include:

- Authorize a separate payment for discrete services associated with key care coordination functions, such as discharge planning, which could help reduce unnecessary hospital readmissions. The physician or clinical care team's role could be clearly defined – preparation of discharge summary, medication reconciliation, a post-discharge status update with patient and patient's family – and verified with documentation.
- Increase payment levels for evaluation and management services provided by primary care clinicians to help support care management and care coordination. The Medicare Payment Advisory Commission made a similar recommendation in their June 2008 report, suggesting “The Congress establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary care-focused practitioners.”²⁶

Implement scholarships or educational loan forgiveness programs to encourage medical students to choose careers in primary care.

Increasing tuition expenses and lower salary projections contribute to fewer medical students choosing careers in primary care. Tuition assistance – in the

²⁶ Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Reforming the Delivery System, June 2008, Pg..27.

form of debt forgiveness or medical school scholarships – could reduce the financial burden and enable more students to enter the field of primary care.

Thank you for this opportunity to participate in today's hearing and to address questions of the Committee.



Achieving Person-Centered Primary Care: The Patient-Centered Medical Home

44

Charts to accompany written testimony

**Melinda Abrams, M.S.
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Senate Special Committee on Aging
July 23, 2008
mka@cmwf.org**

Figure 1. Strong Public Support for “Medical Home”: Accessible, Personal, Coordinated Care

When you need care, how important is it that you have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need?

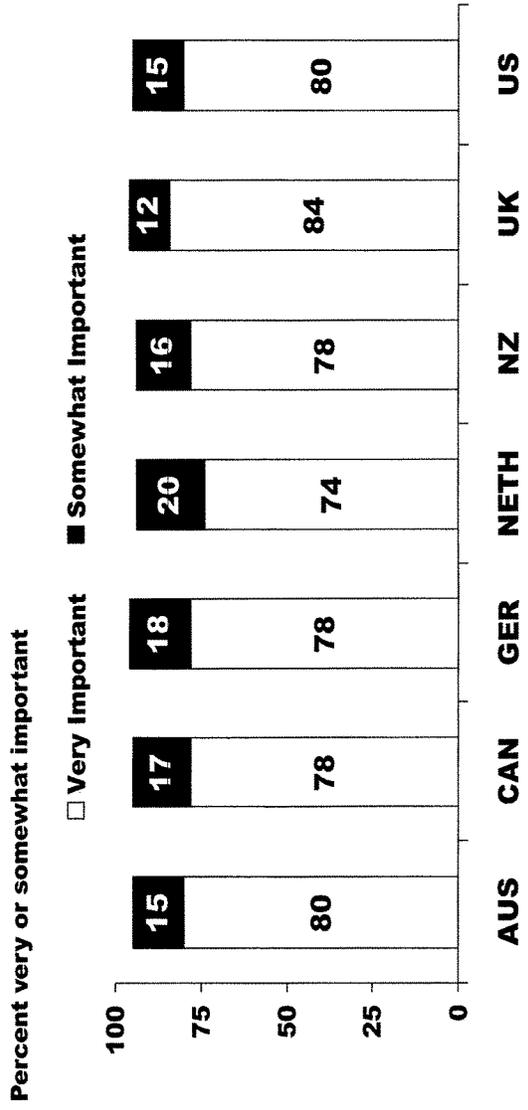
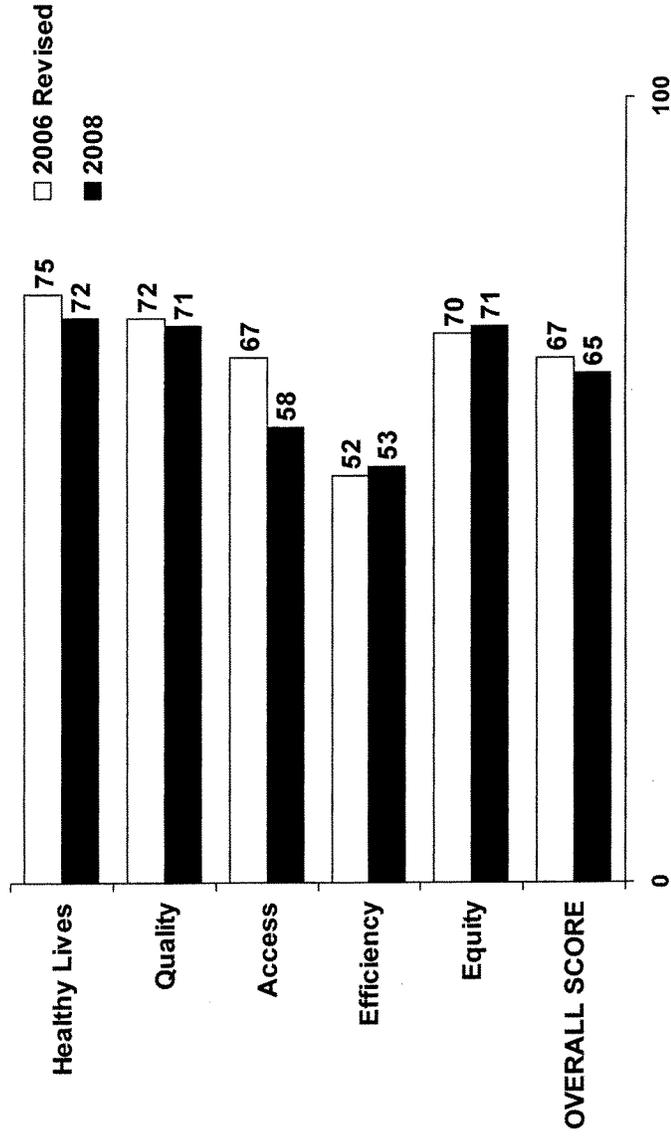
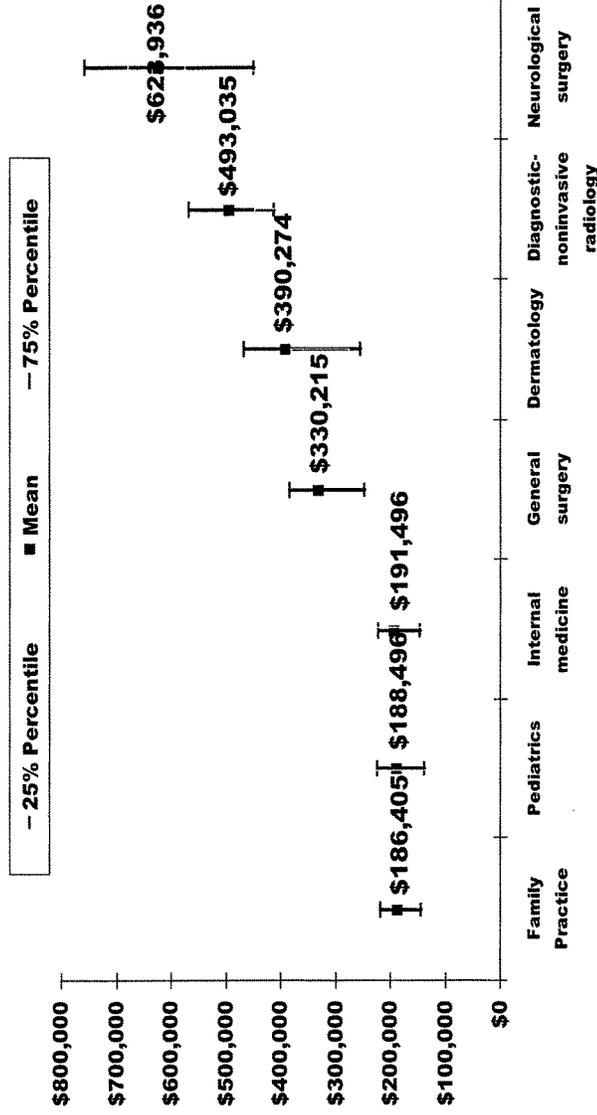


Figure 2. Scores: Dimensions of a High Performance Health System



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

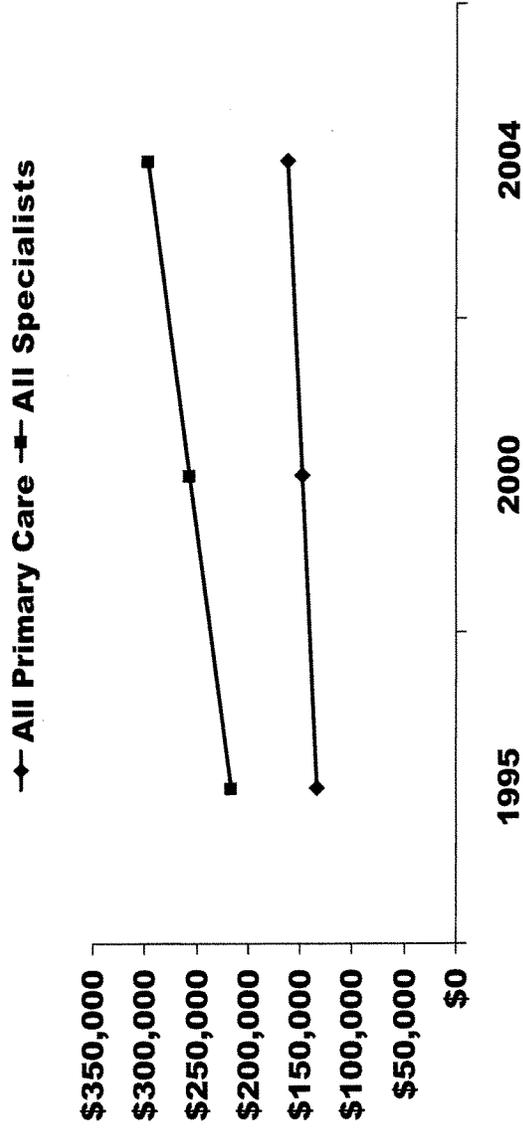
Figure 3. Average Medical Specialty Salaries



Source: Reprinted with permission from the Medical Group Management Association, 104 Inverness Terrace East, Englewood, Colorado 80112-5306; 303.799.1111. www.mgma.com. Copyright 2006

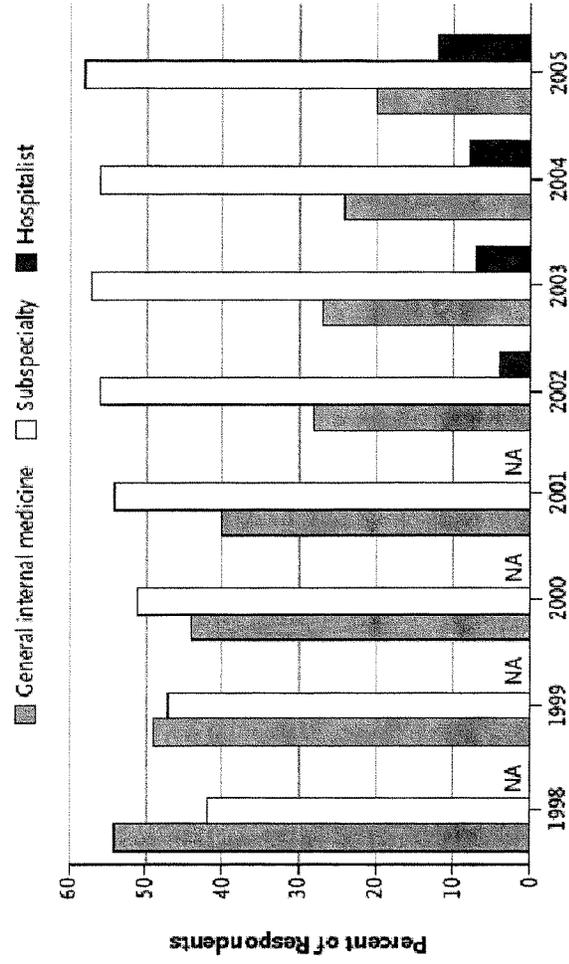
Figure 4. The Primary Care-Specialty Income Gap is Widening

Median Pretax Compensation of physicians, 1995-2004



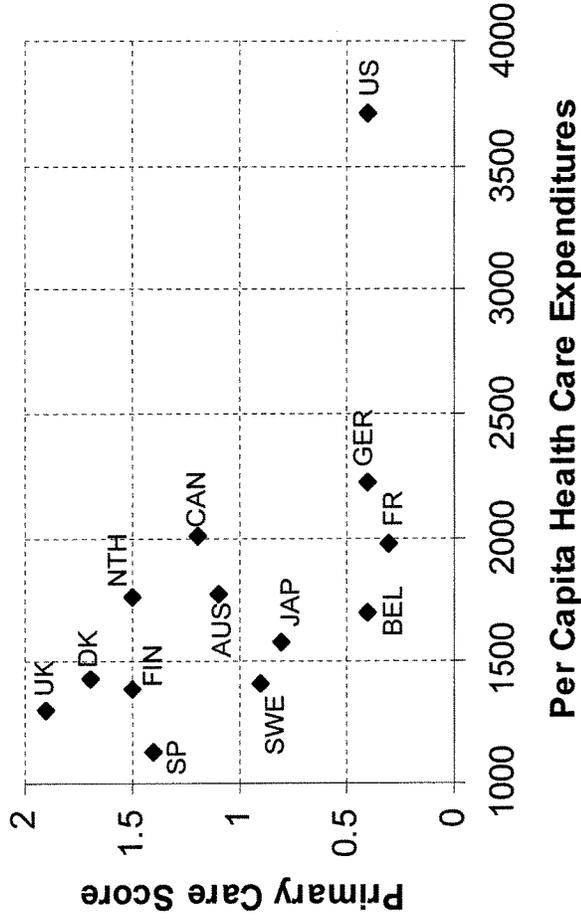
Source: T. Bodenheimer, R.A. Berenson and P. Rudolf, "The Primary Care- Specialty Income Gap: Why It Matters", *Annals of Internal Medicine*, Feb. 2007;146(4):301-306.

Figure 5. Proportions of Third-Year Internal Medical Residents Choosing Careers as Generalists, Subspecialists, and Hospitalists



Source: T. Bodenheimer, "Primary Care—Will it Survive?" *New England Journal of Medicine*, Aug. 2006; 355(9):861-864.

Figure 6. Primary Care Score vs. Health Care Expenditures, 1997



Source: B. Starfield, *Why More Primary Care: Better Outcomes, Lower Costs, Greater Equity*, presentation given at the Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, (October 2006).

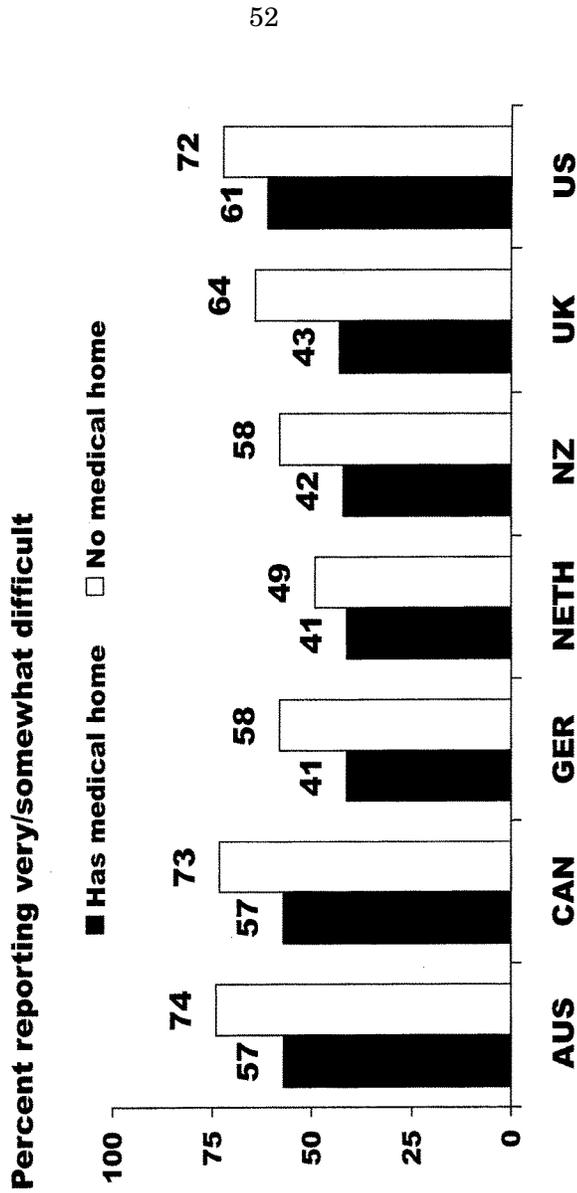
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Figure 7. 2007 International Survey Indicators of A Medical Home: U.S.

Indicator	Percent
Patient has regular doctor or place of care	90
Doctor/staff know important information about patient's history	74
Place is easy to contact by phone during regular office hours	57
Doctor/staff help coordinate care received from other doctors/sources of care	50
All four indicators of Medical Home	50

Source: 2007 Commonwealth Fund International Health Policy Survey

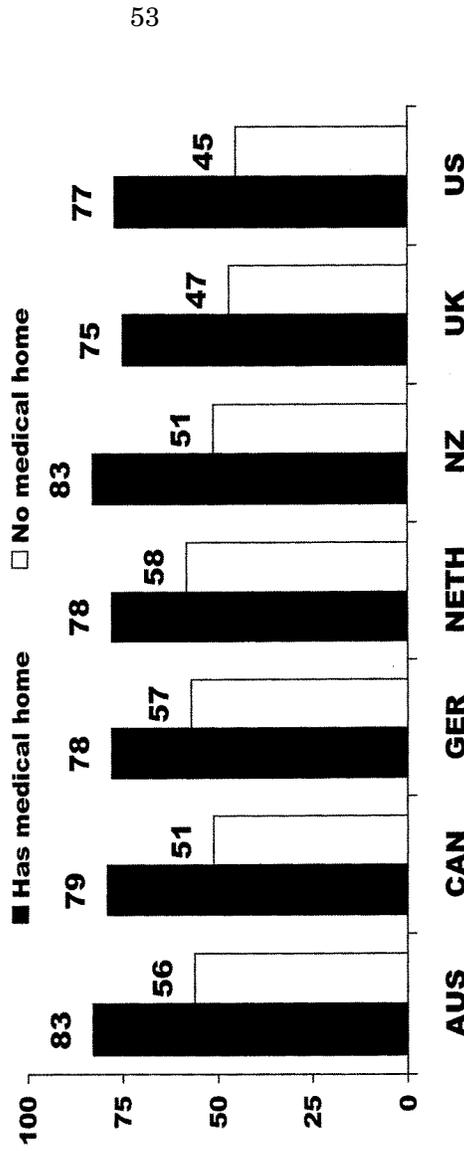
Figure 8. Access: Patients with a Medical Home Less Likely to Report Difficulty Getting Care on Nights, Weekends and Holidays Without Going to the ER



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
 Source: 2007 Commonwealth Fund International Health Policy Survey
 Data collection: Harris Interactive, Inc.

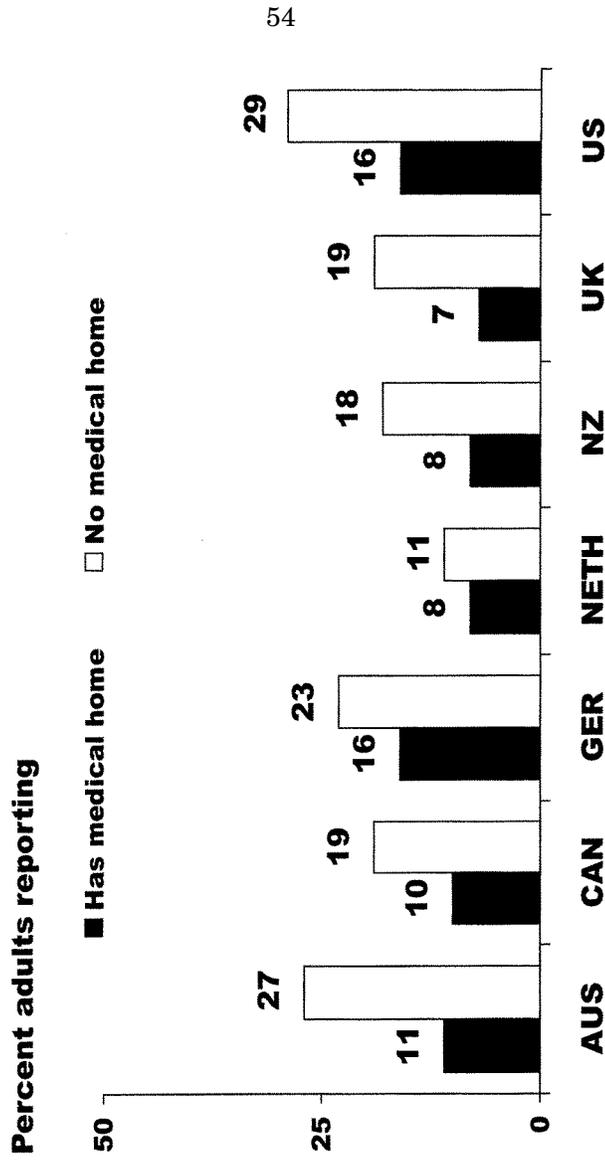
Figure 9. Communication/ Decision Making: Doctor Always Explains Things, Spends Enough Time With You, and Involves You in Decisions, by Medical Home

Average percent of adults with a regular doctor or place of care reporting “always” across three indicators of doctor-patient communication



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
 Source: 2007 Commonwealth Fund International Health Policy Survey
 Data collection: Harris Interactive, Inc.

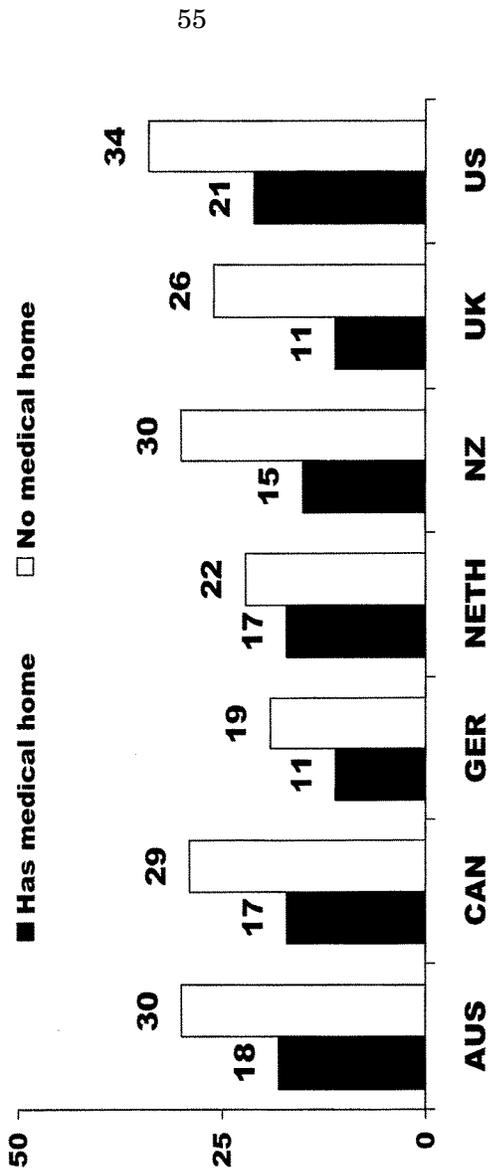
Figure 10. Coordination: Medical Records Not Available During Visit or Duplicative Tests, by Medical Home



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
 Source: 2007 Commonwealth Fund International Health Policy Survey
 Data collection: Harris Interactive, Inc.

Figure 11. Safety: Any Patient-Reported Error

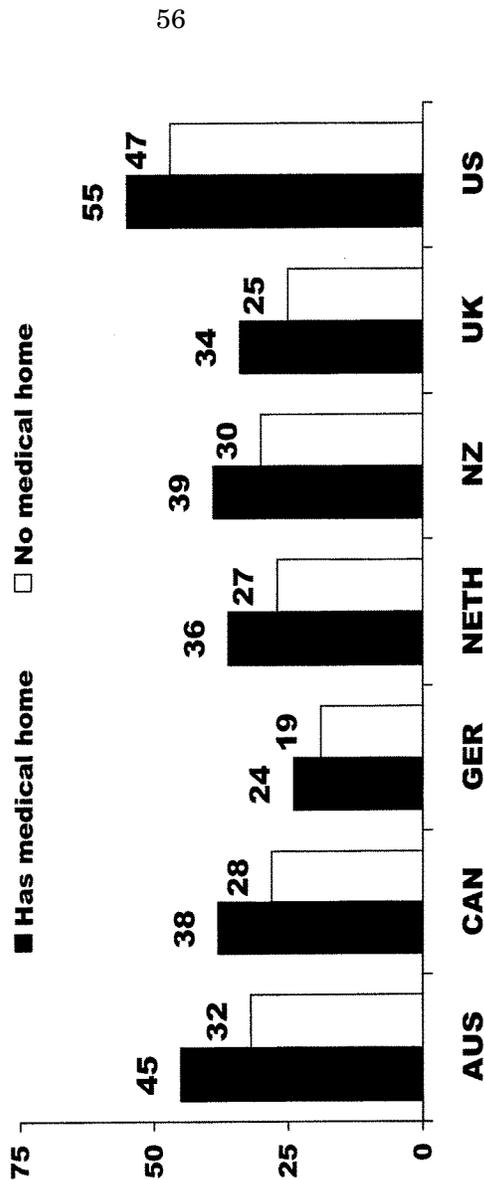
Base: Adults with chronic condition
 Percent any medical, medication, or lab error



Note: Errors include medical mistake, wrong medication/dose, or lab/diagnostic errors. Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
 Source: 2007 Commonwealth Fund International Health Policy Survey
 Data collection: Harris Interactive, Inc.

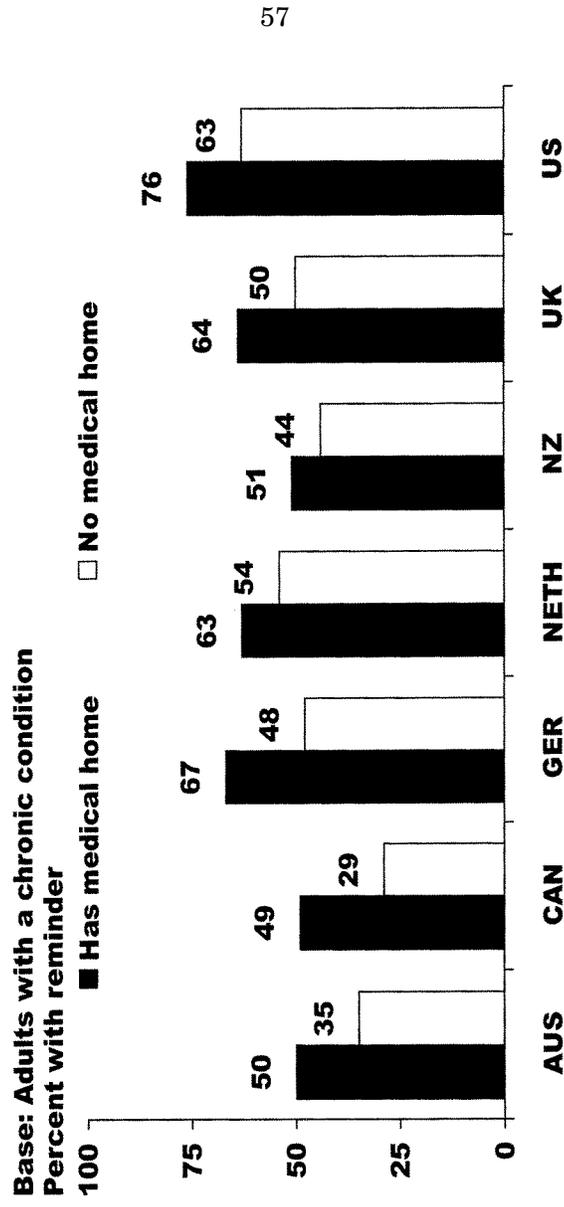
Figure 12. Chronically III: Doctor Gives You Written Plan for Managing Care At Home, by Medical Home

Base: Adults with chronic condition
Percent with care plan



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
Source: 2007 Commonwealth Fund International Health Policy Survey
Data collection: Harris Interactive, Inc.

Figure 13. Receive Reminder for Preventive/Follow-Up Care, by Medical Home



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
Source: 2007 Commonwealth Fund International Health Policy Survey.
Data collection: Harris Interactive, Inc.

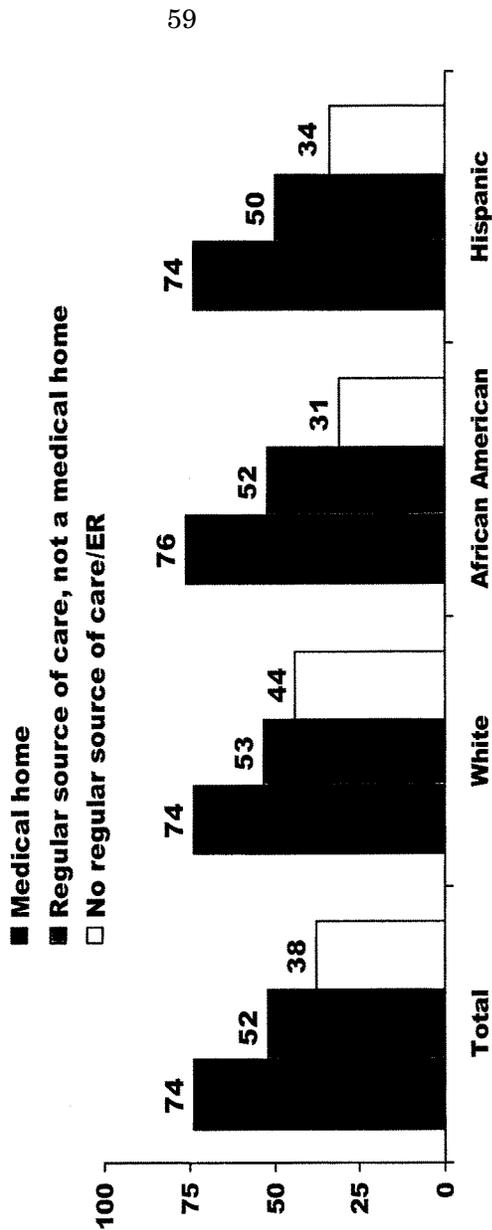
Figure 14. 2006 Fund Quality of Care Survey
Indicators of a Medical Home
(adults 18–64)

Indicator	Total		Percent by Race			
	Estimated millions	Percent	White	African American	Hispanic	Asian American
Regular doctor or source of care	142	80	85	79	57	84
<i>Among those with a regular doctor or source of care . . .</i>						
Not difficult to contact provider over telephone	121	85	88	82	76	84
Not difficult to get care or medical advice after hours	92	65	65	69	60	66
Doctors' office visits are always or often well organized and running on time	93	66	68	65	60	62
All four indicators of medical home	47	27	28	34	15	26

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 15. Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

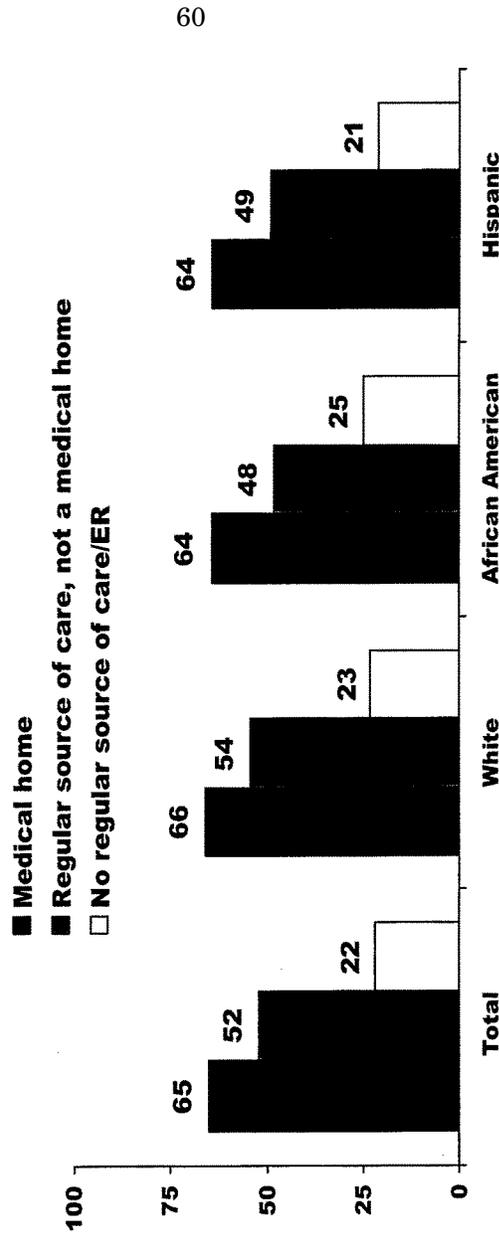
Percent of adults 18–64 reporting always getting care they need when they need it



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time. Source: Commonwealth Fund 2006 Health Care Quality Survey.

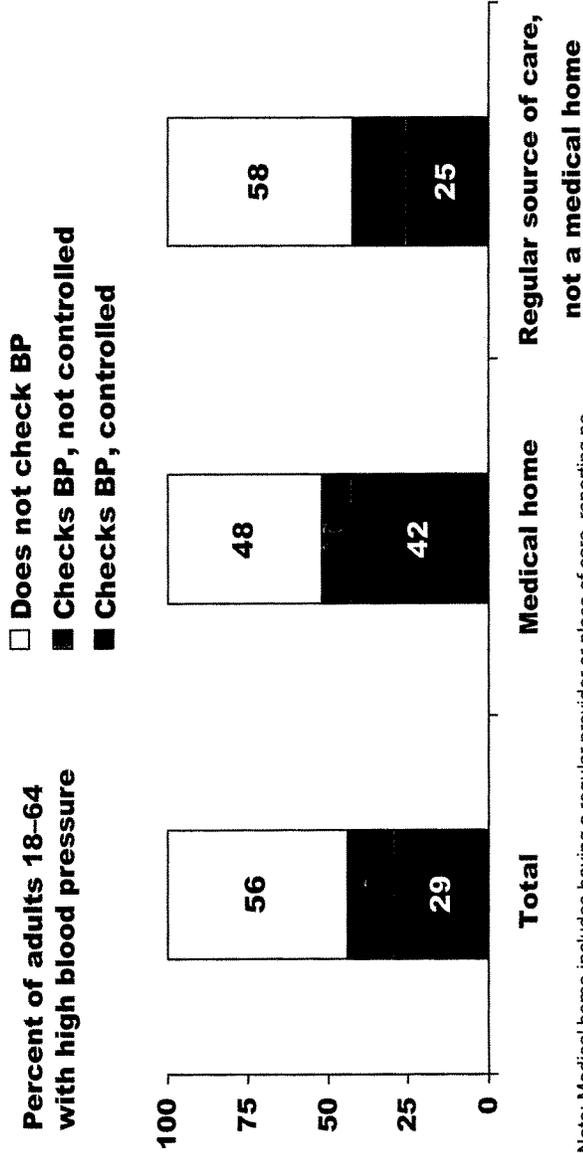
Figure 16. When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits

Percent of adults 18–64 receiving a reminder to schedule a preventive visit by doctors' office



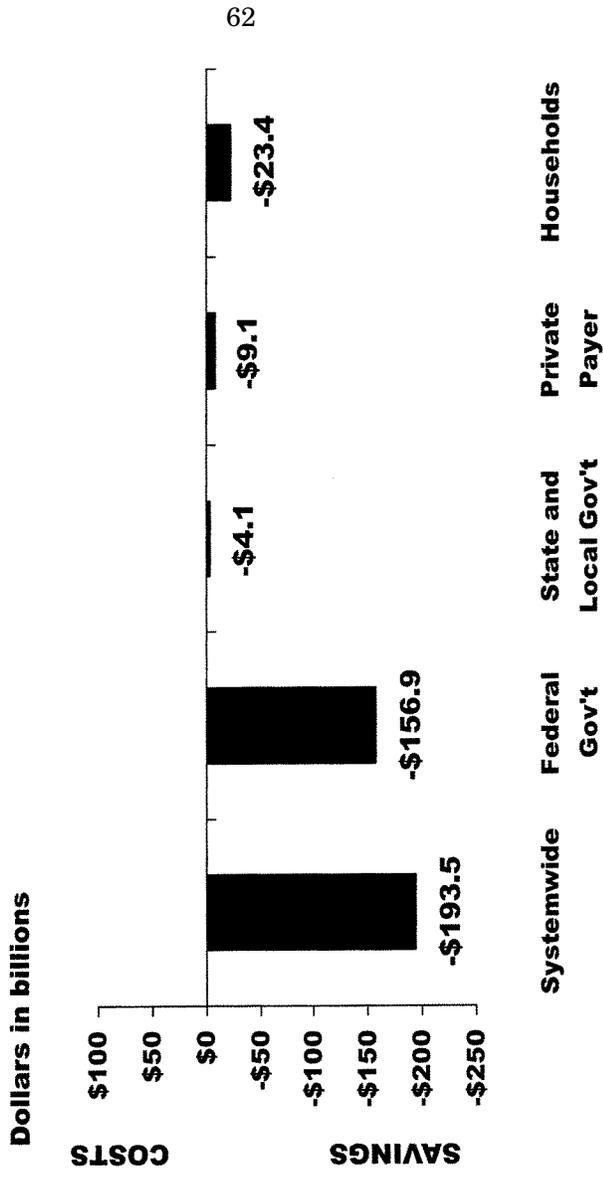
Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time. Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 17. Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control



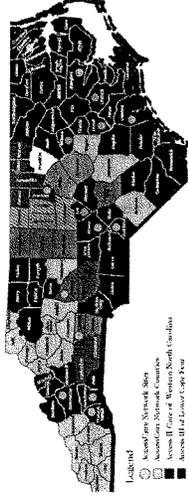
Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
 Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 18. Estimated Distribution of 10-Year Impact on Spending from Strengthening Primary Care and Care Coordination

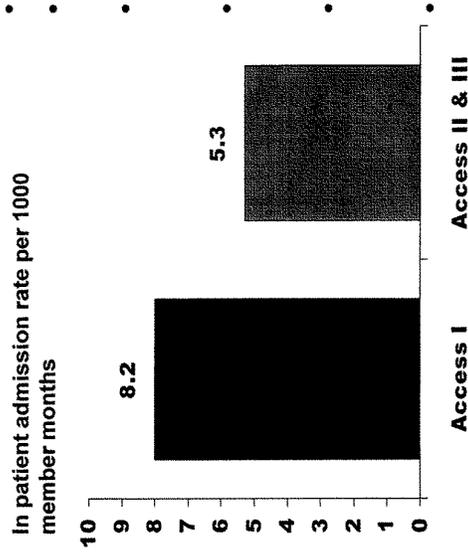


Source: Based on estimates by The Lewin Group for The Commonwealth Fund, 2007.

Figure 19. Community Care of North Carolina: Medical Homes Can Save Health Care Costs



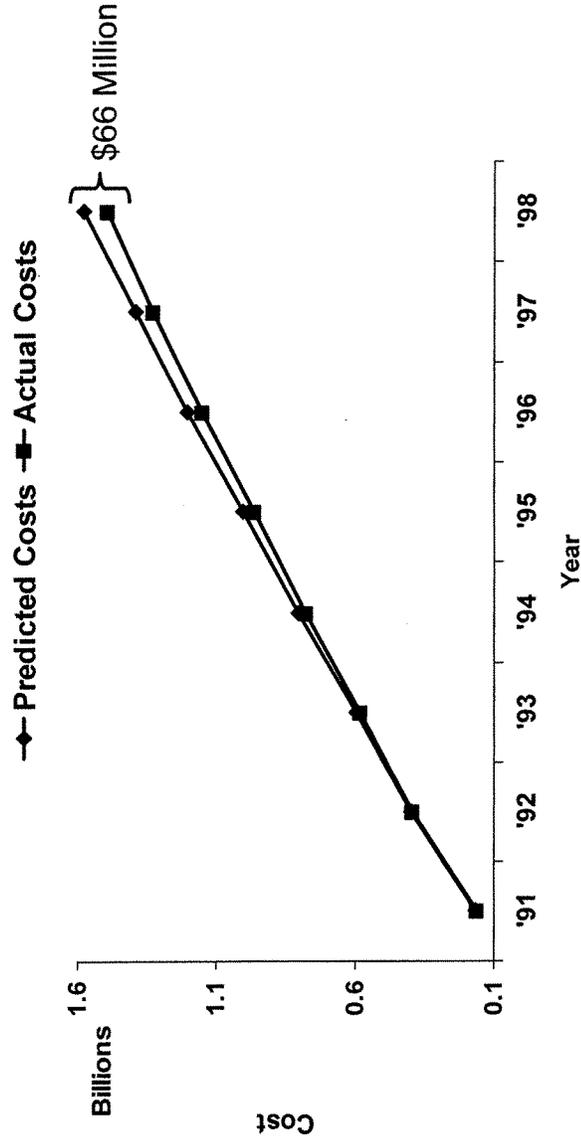
Asthma Initiative: Pediatric Asthma Hospitalization Rates (April 2000 – December 2002)



- 14 networks, 3,200 MDs, >800,000 patients
- \$3 PMPM to each network
- Hire care managers/medical management staff
- \$2.50 PMPM to each PCP to serve as medical home and participate in disease management
- Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more!
- Case management: identify and facilitate management of costly patients
- Cost (FY2004) - \$10.2 Million investment; Savings: \$124M compared to FY2003 and \$225M compared to Medicaid FFS (Mercer Consulting)

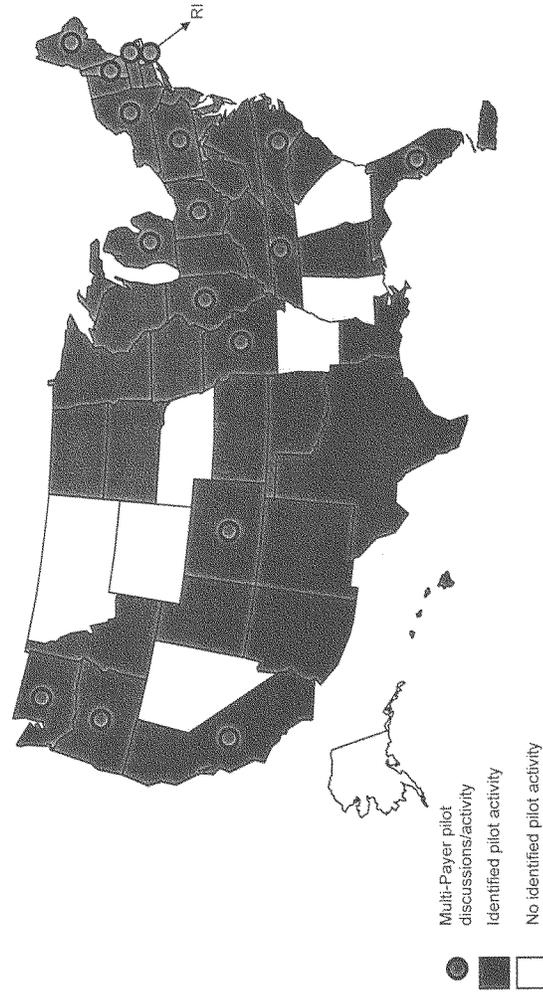
Source: L. A. Dobson, Presentation to ERISA Industry Committee, Washington, DC, Mar. 12, 2007 (Updated June '08).

Figure 20. Iowa Medicaid Saved \$66 million (1991-1998)



Source: E. T. Momany, S.D. Flach, F.D. Nelson et al., "A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program", *Health Service Research* 41, pt 1 (2006): 1357-71.

Figure 21. Overview of Current Pilot Activity and Planning Discussions of the PCMH (as of July 2008)



Source: Patient-Centered Primary Care Collaborative, July 16, 2008.

Senator CASEY. Ms. Abrams, thank you very much.

Finally, we have Dr. Eric Coleman. Dr. Coleman is a Professor of Medicine and Director of the Care Transitions Program at the University of Colorado. He is also executive director of the Practice Change Fellows Program, designed to build leadership capacity among healthcare professionals who are responsible for geriatric programs and service lines. He is a board-certified geriatrician.

Dr. Coleman, we appreciate your willingness to be here and look forward to your testimony.

STATEMENT OF ERIC COLEMAN, M.D., MPH, DIRECTOR, CARE TRANSITIONS PROGRAM, UNIVERSITY OF COLORADO, AURORA, CO

Dr. COLEMAN. I thank the leaders of the Committee for inviting me to participate in this important hearing on person-centered care.

This morning, we have heard how the Green House model and the medical home can offer great promise for assuring person-centered care in long-term care settings and outpatient settings, respectively. I would like to submit before this Committee that these models are particularly suited for persons whose medical conditions are in a steady state.

Inevitably, many of these people will experience an exacerbation of their medical condition or a sudden traumatic event, and this will require a transfer to a place such as an emergency department or a hospital. These transfers are often referred to as “transitional care” or the handoff of care across settings.

Transitional care poses challenges that distinguish it from other types of care. Many transitions are unplanned, and they result from exacerbations of medical problems that can occur at all hours of the day, the night, and on weekends. They often involve clinicians who have never met this person before.

To better illustrate the challenges of transitional care, I offer the case of Mrs. Sanchez. She is 84 years old. She has high blood pressure, diabetes, and is in the early stages of Alzheimer’s disease.

One morning, she awakened with a stomach virus that caused her to lose her appetite. Because she had taken her morning diabetes medication but had not eaten all day, later that afternoon, she became light-headed. After this, she lost her balance. She fell, and she fractured her right arm.

She was admitted to the hospital, where she underwent surgery to stabilize the fracture. Late on a Friday evening, she was discharged home to the care of her daughter. Three o’clock in the morning on Saturday, however, she woke up in excruciating pain, and it was then that her and her daughter realized they didn’t have an adequate supply of pain medication to last through the weekend.

The daughter could not reach the on-call orthopedist. She spent hours making phone calls and looking to find a 24-hour pharmacy to finally obtain the pain medication. Mrs. Sanchez further was not prepared for her self-care. She did not receive advice for how to keep from becoming constipated from her pain medication. Five days later, she was readmitted to the hospital with severe abdominal pain.

Poorly executed care transitions can confound our best attempts to provide person-centered care. As illustrated by this case, they also contribute to our rising healthcare costs. The excellent care provided by a Green House or by a medical home can quickly unravel as the person is transferred to a new, unfamiliar care setting.

Yet the challenges to providing person-centered care during these care transitions can be overcome. The Care Transitions Program that I direct recognizes that often by default patients and their family caregivers perform a significant amount of their own care coordination without the preparation, the tools, or the support.

With generous funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation, we developed the Care Transitions Intervention to provide true person-centered care during these care transitions.

What is the Care Transitions Intervention? Well, during a 1-month program, recently hospitalized older patients and their families work with a transitions coach to learn transition-specific self-management skills that will ensure that their needs are met during this vulnerable time of the handoff from hospital to home.

What is the evidence that the model is effective and reduces cost? Patients who received this program were significantly less likely to be readmitted to the hospital. What is more, the benefits were sustained for 5 months after the end of the 1-month intervention. Thus, rather than simply providing post hospital care in a reactive manner in the moment, investment in imparting self-management skills pays dividends long after the program ends.

Annually, a single transitions coach can manage 350 patients coming out of the hospital. During this time, the model produces a net cost savings of \$300,000 per coach. The Care Transitions Intervention is in the public domain (www.caretransitions.org). There are no licensing fees, and to date, 128 of the Nation's leading healthcare organizations have adopted this model.

How can this Committee further support person-centered care models such as the care transitions intervention? Well, the primary barrier to making the model available to all older Americans concerns the lack of financing mechanisms within the Medicare program that supports self-management. We now have some experience with self-management programs in the area of diabetes.

It is time for us to re-examine our approach to Medicare reimbursement and explore modifications for how to support self-care models like the Care Transitions Intervention that have been proven to improve outcomes, reduce cost, and promote greater person-centered care. I thank you for your attention.

[The prepared statement of Dr. Coleman follows:]

**"Person-Centered Models for Assuring Quality and Safety
During Transitions Across Care Settings."**

Written Testimony to the
United States Senate
Special Committee on Aging
Senator Herb Kohl, Chair

Hearing Title: "Person-Centered Care: Reforming Services and
Bring Older Citizens Back into the Heart of Society Approaches."

July 23, 2008

Eric A. Coleman, MD, MPH
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www.caretransitions.org

Good morning. My name is Dr. Eric Coleman and I am a professor of medicine and a practicing primary care geriatrician based at the University of Colorado. I thank you for inviting me to participate in this important hearing dedicated to promoting greater person-centered care.

We have heard earlier in this hearing how the Green House model and the Medical Home model offer great promise for assuring person-centered care in long-term care and in outpatient care respectively. I would like to submit before the Committee that these models are particularly suited for persons whose medical conditions are primarily in a stable or steady state. Inevitably, many of these persons will experience a worsening or exacerbation of their medical conditions or a sudden traumatic event that requires a transfer to settings such as an emergency department or a hospital.

These transfers are often referred to as transitional care, the area of health care that is primarily concerned with the relatively brief time interval that begins with preparing a patient to leave one setting and concludes upon being received in the next setting. Transitional care poses challenges that distinguish it from other types of care. Many transitions are unplanned, result from unanticipated medical problems, can occur at all hours of the day or night as well as on weekends, involve clinicians who may not have an ongoing relationship with the person, and happen so quickly that even the most dedicated health care professionals and family caregivers are not able to respond in a timely manner. As a result, these persons are largely unprepared for what transpires and are often uncertain about their role.

Poorly executed care transitions can confound our best attempts to provide person-centered care. The excellent care provided by a Green House or Medical Home can quickly unravel as the individual is whisked out the door to an unfamiliar care setting. Despite our professional advantages, many of us in this room today have unfortunately learned from personal experience that health care delivery has become increasingly fragmented and lacks effective mechanisms to ensure continuity and coordination of care across settings.

As director of the Care Transitions Program I have devoted my career to ensuring quality and safety for persons at the time of care transitions or the "hand-offs" that occur as persons transfer from one care setting to the next. These settings may include hospitals, skilled nursing facilities, outpatient clinics, assisted living facilities and private residences. Over the past decade, we have learned three key lessons that are particularly relevant to our proceedings this morning:

1. Care transitions occur with astounding frequency and variability. For example, a nationally representative sample of Medicare beneficiaries discharged from the hospital experienced 46 unique care patterns in just 30 days.

2. Care transitions represent a highly vulnerable time for errors that compromise quality and safety. Our research has found that over 40 percent of older adults transferred out of the hospital experience at least one medication discrepancy.
3. By default, patients and their family caregivers have become the silent care coordinators, performing a significant amount of their own care coordination with no specific preparation, tools, or support.

Yet the challenges to providing person-centered care during care transitions can be overcome. With the generous support of the John A. Hartford Foundation, our Care Transitions Program has developed and disseminated the Care Transitions Intervention model to 128 of the nation's leading health care organizations.

What is the Care Transitions Intervention?

During a 4-week program, patients with complex care needs and family caregivers receive specific tools and work with a "Transition Coach," to learn self-management skills that will ensure their needs are met during the transition from hospital to home.

What is the Evidence that the Model is Effective and Reduces Health Care Costs?

Patients who received this program were significantly less likely to be readmitted to the hospital, and the benefits were sustained for five months after the end of the one-month intervention. Thus, rather than simply managing post-hospital care in a reactive manner, the investment in imparting self-management skills pays dividends long after the program ends. Annually, a single Transitions Coach can manage at least 350 chronically ill hospitalized adults. During this time, the model produces a conservative net cost savings of \$300,000 per Transitions Coach. In keeping with the goal of promoting true person centered care, participants who received this program were more likely to achieve self-identified personal goals around symptom management and functional recovery.

What Makes the Care Transitions Intervention Unique?

In contrast to traditional case management approaches, the Care Transitions Intervention is a self-management model. The Care Transitions Intervention represents a truly person-centered care model as it was developed with direct input from patients and family caregivers who contributed to the overall design. Using qualitative techniques, the Care Transitions Program worked directly with older adults and their families to identify the key self-

management skills needed to assert a more active role in their care. Next a Transition Coach was introduced to help impart these skills and help the individual (and the family caregivers) become more confidence in this new role. Although critics are quick to point out that this is only applicable to highly educated or motivated patients, our experience has shown that most patients and family caregivers (including those from diverse backgrounds) are able to become engaged and do considerably more for themselves during transitions. In essence, the model is about making an investment in helping older adults and family caregivers more comfortable and competent in participating in their care during care transitions. Five months after the Transition Coach signed off, these patients continued to remain out of the hospital, demonstrating a sustained effect from investing in a self-care approach.

What Are the Four Pillars?

The intervention focuses on four conceptual domains referred to as pillars, which were directly informed by qualitative studies of older adults and their family caregivers:

1. Medication self-management
2. Use of a dynamic patient-centered record, the Personal Health Record
3. Timely primary care/specialty care follow up
4. Knowledge of red flags that indicate a worsening in their condition and how to respond

Who Supported the Development of the Model?

The John A. Hartford Foundation and The Robert Wood Johnson Foundation

Where Can I Learn More About the Model?

The Care Transitions Intervention is in the public domain and there are no licensing fees. Please visit www.caretransitions.org where you can learn more about the model and its evidence base and to access patient tools, performance measures, medication safety tools and much more. You may contact Eric Coleman, MD, MPH, via email Eric.Coleman@uchsc.edu.

What Are the Barriers to Further Dissemination?

Although demand for the Care Transitions Intervention continues to grow, the primary barrier to making this model available to all Americans with chronic and complex care needs concerns the lack of financial support for self-management. We must realign our approach to Medicare reimbursement to support new self-care models that have been proven to improve outcomes, reduce health care costs, and promote greater person-centered care.

Two Innovative Approaches to Promoting Greater Person-Centered Care

Next I would like to highlight two additional innovative approaches to promoting greater person-centered care through greater support of family caregivers. Family caregivers are often the first and last line of defense when it comes to ensuring patient quality and safety. They are the “glue” that keeps care from unraveling and they are frequently the ones who complete tasks left undone by health care professionals. One cannot consider person-centered care or transitional care without prominently underscoring the essential but largely unrecognized contributions of family caregivers.

United Hospital Fund’s “Next Step in Care”

Family caregivers are often responsible for coordination of a loved one’s care after hospital or nursing home discharge, and when formal home health care services end. Yet they are rarely trained to provide care or included in transition planning. Next Step in Care is a multi-year campaign created by the United Hospital Fund in New York City under the leadership of Carol Levine that will launch in the Fall of 2008. The goal of Next Step in Care is to change professional practice and improve patient transitions by helping family caregivers and health care professionals work more effectively together. The program stresses careful planning, clear communication, and ongoing coordination as patients are admitted to and discharged from hospitals, rehabilitative settings, and home health care agencies. The Next Step in Care program offers free, easy-to-use, web-based practical guides, checklists, and other materials for both family caregivers and providers. For example, the new website, nextstepincare.org, will have guides to medication management, hospital discharge planning, home care, and rehabilitation, as well as a unique tool for family caregivers to assess their own needs after discharge.

National Family Caregivers Association’s Comprehensive Care Benefit

The National Family Caregivers Association (NFCA), under the leadership of Suzanne Mintz, has issued a policy statement outlining a comprehensive care coordination benefit that targets the most expensive Medicare’s beneficiaries and their family caregivers. NFCA maintains that family caregivers and their loved ones must have affordable, readily available, high quality and comprehensive services that are coordinated across all care settings. NFCA has termed transitions “no-care zones”. The most complex and expensive of Medicare’s beneficiaries need the services of a patient/family advocacy and navigator team. Although there

is no consensus on the definition of navigator as it applies to healthcare, the NFCA envisions this team being comprised of nurses, social workers, and others as deemed appropriate, that are assigned to patients and their primary family caregiver who meet certain established criteria. The team would stay with the patient and their primary caregiver as long they continue to meet the established criteria so they may assist that patient/caregiver during periods of crisis, transition, and also stasis to help ward off further crises

Person-Centered Care Requires Greater Accountability On Behalf of Professionals.

The majority of my testimony has focused on innovative strategies for supporting patients and family caregivers become more active participants in their health care towards achieving better outcomes. However, investing in such approaches does not obviate the responsibility of health care professionals to become more responsive to the needs of persons undergoing care transitions. Greater alignment of financial incentives through bundled payment approaches as described by the MedPAC commission is an important step in this direction. Further, health care professionals need to be more engaged in the process of defining and assuring accountability for persons undergoing transitions. The ABIM Foundation, in partnership with nine physician professional organizations has launched a national effort entitled, "Stepping Up to the Plate" that has made real progress in this regard.

Senator CASEY. Dr. Coleman, thank you very much.

We will move to questions now, and I want to welcome Senator Blanche Lincoln from the State of Arkansas for her presence here. We will move to questions.

I will start, and I will be brief and try to come back maybe. But I wanted to thank Chairman Kohl for his leadership and for allowing us to gather here today and for allowing me to chair this hearing. It doesn't happen very often when you can become the chair of any hearing this early in a Senate term.

Dr. Thomas, I wanted to start broadly, I guess, on two areas. One, let us not talk about how difficult it will be to get where we want to get to. We will do that second. We will have the challenge second.

The first thing I wanted to ask you, though, is just—if you could just outline, you did some of this in your opening, but some of it you could reiterate, but also amplify, which is to talk about the vision you have for this concept of patient-centered care. Where do we need to get to? Not some ideal that is not achievable, but where do we need to get to?

Then the second part of the question, if you could answer, is what are the challenges and what advice can you give us, as Members of Congress, but also give others who are struggling with this issue?

Dr. THOMAS. Thank you, Senator.

I would say, first off, where are we going and how does patient centeredness get us there? Patient centeredness is really a bridging concept that helps us take the healthcare system we have today, which we all can describe and we know, and helps us cross over to the healthcare system we ought to have.

In other words, to think of it in sort of pendulum-type terms, that pendulum swing toward a technology provider-focused approach to healthcare is starting to swing back—with the aid of concepts like the medical home and patient-centered care, starting to swing back into a system that creates partnerships between people with expert knowledge and people who need access to that knowledge.

I thought Dr. Coleman's remarks were really spot-on in terms of commenting on the terrible wastefulness of a provider-centered system because, you know, our healthcare system is not and should not be set up to run at the convenience of the providers. It should be run and set up to establish good outcomes for patients. So that is the first thing.

I guess I would argue to the Committee that patient centeredness is a way of aligning our healthcare system with our ideals, and that is important work that is going to take years to accomplish. But that is where it needs to go.

In terms of how can we—what can be done to help swing this pendulum back to a better place, I think, No. 1, we need more elbow room for innovators to be able to put together new approaches that challenge the orthodoxy.

We were chatting earlier about the Commonwealth of Pennsylvania's desire to kind of put together a new strategy for long-term care. Well, you know there are a lot of providers out there who are hesitant to take those kinds of risks, and we need to help put to-

gether a system that protects patients and allows providers to develop new approaches and programs.

The last point I would make in terms of what can help is there is a difference between the money you need to operate an established ongoing service and the money you need to jump across the creek to the other side and get it going in a new model. It is especially difficult in healthcare.

We can talk about this in manufacturing and services, but in healthcare, you have to operate the existing model at a high degree of efficiency while you are creating this new model at the same time. We need people like the people here in this room and the adopters of Green House and other models, they need help getting to the other side.

Senator CASEY. I am going to reserve some of my time for later, but I wanted to turn to Senator Wyden and our colleagues so they can get their questions in.

Senator WYDEN. Mr. Chairman, thank you, and you have arranged a terrific panel.

I only want to take a minute to kind of ring the alarm bell on what I think is a coming calamity in terms of the workforce to try to meet the needs of older people. You mentioned that, Ms. Abrams. But what is striking is you look, for example, at what has happened in Massachusetts. They are going forward with their efforts at providing universal coverage but they have bumped up against a huge calamity. Already they don't have enough primary care physicians just to meet the needs of the working age population, not to say anything about seniors and long-term care.

My sense is that given what we all want to do, and you all are the pioneers in this area, is have health care providers spend more time with patients and more time with families. To achieve this we are going to need a huge increase in the number of people who are trained in geriatrics. I was in fact, appreciative of your comment, Ms. Abrams, that it is fine to call it a health home rather than a medical home. The primary reason we call it a health home in the Healthy Americans Act is to try to get more professionals into the act, that we would get more nurses and physician assistants and others providing this care for patients.

My question to all of you is what are your ideas for increasing the number of people going into the field, particularly without breaking the bank? One of the areas we are looking at in the Healthy Americans Act is the idea of redoing job training programs in this country, many of which now seem to be training people for jobs that are going to go overseas in a few years.

We would like some of those dollars go, for example, to train people as nurses, physician assistants, and others to do exactly the kind of work you are talking about. That would give us a chance to stretch existing funds that are now spent on training in an area that could pick up on some of your good ideas.

With your indulgence, Mr. Chairman, one question before I do an introduction of a witness on behalf of Senator Smith. I'd like to get your thoughts on what we could do to expand the workforce in the geriatric area particularly, without breaking the bank.

Dr. Coleman, you have been nodding your head. So I guess I am making you a glutton for punishment and starting with you. Your thoughts, workforce?

Dr. COLEMAN. Critical question. As you know, the Institute of Medicine just released a report on the need to retool our country's workforce for the aging population. I had an opportunity to testify before that committee. One of the points that I made had to do with not only how do we attract people to the field, but also looking at their workflow, their daily professional lives, et cetera.

One of the phrases that jumps to mind is "all assessed up and nowhere to go." We spend a disproportionate amount of time assessing our patients, which leaves very little time for actually taking care of them. This is true in home care and in nursing home care among others.

Senator Casey used the term earlier "relationships." Those of us who chose to go into primary care, as opposed to specialty care, did so because we wanted to have meaningful relationships with our patients. We knew where the salaries were going to be lower. We knew the time expended per week was going to be greater. We chose this to have the meaningful relationships.

The advanced medical home offers an opportunity for building these relationships. But as I look through each of the different initiatives, I see a lot of discussion, focused on how the practice is going to change, what the requirements are going to be in order to be certified as a needed home. We don't hear as much about how this type of approach or any approach is going to improve the time for face-to-face, meaningful relationships with our patients. I think that is the hook that makes people want to come to primary care and what keeps them in primary care.

Senator WYDEN. Any other witnesses? Perhaps even for the record because this may be something you want to talk about. This is an area that we are making a special focus with our group of 16 Senators, 8 Democrats and 8 Republicans. Because I think this is a showstopper.

We don't have enough providers to meet the needs of our country today. However, we are going to add 47 million uninsured people as part of a universal coverage effort and we want to be sensitive to the thoughtful points that you are making. We are going to have to find some creative new ways to get folks trained and on the front lines.

Do any of you want to add anything for now? Yes, sir?

Mr. JENKENS. Yes, thank you, Senator Wyden.

One of the critical aspects of the Green House model is to create a job that nurses and direct care workers want to have and make them want to come to work in the morning. I think one of our biggest problems in long-term care is that we haven't valued those jobs, and we haven't made those jobs very pleasant jobs to be in. That is more than just the hourly wage that we pay. As a matter of fact, I think you will find that the hourly wage is a very small piece of the dissatisfaction with long-term care jobs.

So the Green House project focuses on giving direct care workers power and authority and then valuing them. The reason we call direct care workers in The Green House homes "Shahbazim" is that we didn't want them to be called care attendants or nurse aides be-

cause there is such a negative connotation associated with those terms.

What we found in the Green House is that when you give nurses and you give direct care workers an environment and an organizational structure that really values them and lets them do the job and create the relationships they came to long-term care to have, they stay in those jobs. People who said they would never be in those jobs come to those jobs. So you expand the pool of people who are willing to do that work.

You will hear from a Shahbaz, Edna Hess from Pennsylvania, and a family member from Lincoln, NE, about this very thing. We have two Shahbazim in Lincoln, NE that also demonstrate this expansion. One was a bartender who had left long-term care. She had been an LPN and she came back to be a Shahbazim, she left long-term care because she said she couldn't take it anymore in the old system, but she wanted to be part of it in the new green house homes.

Senator WYDEN. Ms. Abrams?

Ms. ABRAMS. I mentioned—I just want to affirm everything you said in terms of the calamity and the concern over the workforce. I originally had a lot longer comment about workforce and cut it, so I appreciate that opportunity to mention it.

I did mention—the piece that I was focusing on was the number of physicians choosing primary care, which is what has come up a little bit in Massachusetts. So I did mention the idea of loan forgiveness programs for physicians that go into primary care or scholarships for medical students who go into primary care.

But another real issue is, and Dr. Coleman mentioned this, making it attractive. The way physicians are trained, there is the curriculum and then there is the hidden curriculum, and it is what is modeled in the academic health center. In that academic health center, most of their time is spent in a hospital. So they don't have enough time in primary care settings, community settings. They have very little exposure to how to actually work effectively in a team, in a multidisciplinary team.

I think that because of our reimbursement system, we are biased toward surgical procedures, and we don't value and we underinvest so that physicians or clinicians have time to take a medical history and to really help do medication reconciliation and spend time to kind of come up with a care plan. The reason I mention that as well is because I think if we can come up with ways to make primary care more attractive, both in terms of reimbursement—I mean, primary care physicians make about half of what specialty care physicians make.

There is this huge income gap, and none of us should feel sorry for how much primary care physicians make. It is just that in your medical work, if you are worried about primary care workforce, it is not that they are poor, it is just more that we want them to also be going into primary care to take care of and do the care coordination for older Americans.

So part of it is about the training, and the training is in the place and the training is also with teams. I am not an expert on IME and DME, you know, payments from Medicare, but my understanding is the way that those are funneled is it is very much in

the interest of the hospital to hold onto those resources. So another possibility is to think about kind of maybe it would be a grant program.

I don't know if it is a grant program that would allow to some of these academic health centers or residency training programs that actually do come up with models that are patient-centered and multidisciplinary and team-based care. Because that is also how we are going to be more efficient and not use the physician's high-scale time for some other things that could be used with other kinds of professionals and help to expand the workforce.

Senator WYDEN. Your ideas are very helpful, and you can see all the heads nodding on this side of the dais. I will look forward to following up with the four of you.

Chairman Casey has given me a lot of time. I just want to note on behalf of Senator Smith and myself that on the next panel, we will have Dr. Diana White, the Senior Research Associate of the Institute on Aging at Portland State. She has been one of the pioneers, as you know, in this area. Senator Smith and I are very pleased that she is going to be here. We want to thank Chairman Casey for inviting her.

Senator CASEY. Thank you, Senator Wyden. We appreciate your work in so many of these areas and especially the work on healthcare broadly and in particular on our long-term care workforce.

Senator Whitehouse has spent—and I will be introducing Senator Lincoln in a moment as well. But Senator Whitehouse has spent a lot of time on the issue of healthcare in the 18 months that we have been in the U.S. Senate, especially in the area of having the infrastructure in place for information technology and other ways to deliver quality healthcare to as many people as possible in a better way.

We are grateful for his leadership on those issues and his willingness to participate in today's hearing.

Senator Whitehouse?

Senator WHITEHOUSE. Thank you, Chairman Casey.

You have predicted my question, which is that whether we follow the various models that have been mentioned here today, a system specializing in chronic care that is patient centered, a Green House model, the medical home model, or the care transitions model, it strikes me that we are lacking an underlying infrastructure support that would enable and empower all of those models, and particularly in the area of health information technology—electronic health records, personal health records, electronic prescribing, interoperable health records, and so forth.

I would just like to ask each of you, first of all, do you agree with that? Second of all, if you agree with that and you think there is a goal we should achieve, a baseline of infrastructure to support these various modalities, are we close to it? If not, how far off are we, and what steps should we be taking to enable that kind of infrastructure to develop?

Why don't we start with Mr. Thomas, go the other way this time so Dr. Coleman is not always being picked on first.

Dr. THOMAS. I know, from his work, he is going to have a lot to say, Dr. Coleman is. Well, here is the thing. The information tech-

nology revolution that has changed virtually every part of our society except healthcare, I used to—I think it remains—pretty much remains true. I used to say—

Senator WHITEHOUSE. I am told by the—just to interrupt for a second, I am told by The Economist magazine that there is actually one other industry that is even behind the healthcare industry in terms of information technology, and that is the mining industry.

Dr. THOMAS. Oh, mining. Yes, OK, so we are there with the mining industry.

Senator WHITEHOUSE. Then it is healthcare, and then it is everything else in the world.

Dr. THOMAS. Yes. OK, yes. Well, you know, a typical nursing home, as it stands today, has less technology available to the people than is available to the guy who drives a FedEx truck. I mean, that is awful.

I like the proper application of information technology, especially in long-term care, because chronic care generates a huge amount of information. I still have a bump on my hand from my years in practice of handwriting notes hours and hours a day. Somewhere around America, there are rooms stuffed full of the handwritten notes that I took over the years, entirely useless, and my handwriting wasn't quite that bad even.

But we need to move into this system so we can gain efficiencies in how we handle data so that we can enable the development of the relationships. That is the win here. It is not just, "Well, now we have a computer system." Well, great. So what?

It is now we have a computer system that moves this information efficiently, and now we can concentrate more time, energy, and training on relationship-based healthcare.

Mr. JENKENS. We push very hard for The Green House adopters to implement a whole variety of technology, including electronic medical records, and monitoring technology. The Green House in Lincoln has a marvelous technology even beyond the doors of the house, allowing people with dementia to go outside safely.

The challenge that we see is really twofold. One is the cost of implementing the technology. I think people are willing, but the training and the technology itself is outside of what they can (eek spelling) out of usually thin or nonexistent margins associated with a heavy Medicaid population.

The second is trust. I think trust is an area that we are addressing with the workforce in many areas. We have Shahbazim who we trust with the most intimate and complicated tasks of someone's daily life, someone we love, but many organizations that we talk to will not trust them with an email account or web access. They can't communicate with each other. One of the greatest benefits of technology is to allow people to share what they have learned.

We run 11 forums through the Green House Project for people to share information, every position within the Green House, and our biggest challenge is that the Shahbazim don't have access to email and the Internet to participate in those discussions.

Senator LINCOLN. They do not?

Mr. JENKENS. They do not.

Senator WHITEHOUSE. Is that HIPAA at work?

Senator LINCOLN. Why?

Mr. JENKENS. Typically, they can't afford to have a personal account, and the organizations either don't feel that they need it, don't feel they can afford it, or, very often, don't trust them to have it.

Senator CASEY. I am just going to jump in for one second. Just for purposes of definitions, my staff did a good job here about the definition of Shahbaz and Shahbazim.

Mr. JENKENS. Yes.

Senator CASEY. I am told it is a Persian word meaning "royal falcon" or "king's falcon," the mightiest, the bravest, the fastest, the most courageous of all falcons, right? OK. Which is we are talking about the direct care workers.

Mr. JENKENS. Yes,

Senator CASEY. I wanted to read that for the record. I am sorry for cutting into Senator Whitehouse's time.

Ms. ABRAMS. I want to start by saying that I completely agree that we are lacking the infrastructure that we need to and that with health information technology. We need to consider it. There was a paper not that long ago that said we would never consider a cardiologist appropriately trained and prepared unless they knew how to do catheterizations.

To think that in primary care and long-term care that we should be sending providers out into the field without the skills and the tools to provide that care well, I think that we have to kind of rethink the competencies of our providers and the competencies that they need both to work in teams, but also to provide better quality care.

Senator WHITEHOUSE. You are referring to a coordination of care competency?

Ms. ABRAMS. Right.

Senator WHITEHOUSE. OK.

Ms. ABRAMS. A care coordination competency. Yes, I mean, I guess it doesn't make sense to have a health information technology competency for the reasons that Dr. Thomas mentioned because it is really just a bunch of wires. So, it is about how you use that hardware and that software that are so important. So I think that we are lacking that infrastructure.

You asked about, well, is there a baseline, and are we close to it? I think that there are pockets of innovation around the country such as either in health systems or in communities where they have really begun to use health information technology in a way that is incredibly productive and in a way that has helped to improve quality of care, such as Group Health Cooperative out in Seattle, Washington. Or there is the Mid Hudson Valley Region in New York, where they are implementing a lot of EHRs, and it is also creating a health information exchange where all the data is being aggregated.

I think that so when we also think about the health information technology, it is what do we need at the practice level? What do we need at the community level so that we can do better management of population health? Then also thinking and part of the question is, well, what is the role of Government, to some extent, in this both in terms of trying to promote the adoption, but also the standards?

Because at some point because our system is public and private and a lot of the vendors are private, there are different templates, and it is inoperable. It seems daunting. But I believe that the Agency for Healthcare Quality and Research has been doing an enormous amount of work in trying to set some of those standards and trying to have standards for both interoperability and for some of those templates.

But I think that is some of the goals. That is really the goal. So that if you are sick in Nebraska and you live in New York, that someone can pull up your record.

Senator CASEY. Dr. Coleman, I am sorry to pinch you off, but we are over time. So if you have anything to say—

Ms. ABRAMS. Oh, sorry.

Dr. COLEMAN. I will be brief.

Senator CASEY [continuing]. If you could kind of shorten it so that I am not treading too badly on Senator Lincoln's time.

Dr. COLEMAN. Sure. I am a strong believer in the potential for information technology to improve person-centered care. In fact, one of the four pillars of our Care Transitions Intervention is a personal health record, encouraging folks to take ownership over their own health information.

Last year, we completed a detailed study for the Assistant Secretary for Planning and Evaluation in HHS on health information exchange. We spoke with experts. We did site visits to the exemplar programs, some of which were already mentioned.

The main take-home points were, first, there are places that are doing this well. However, it is often just the hospital and the clinic that share information. Nursing homes, home care agencies are not even invited to the table.

Second, it is really all about workflow. The technology solutions are here. It is about having healthcare professionals understand how not to do, as Dr. Thomas described, endlessly writing down information and transferring it somewhere else.

Third, it also comes down to relationships again. This has become a common theme for this hearing. We saw healthcare professionals actually going around the technology because they wanted to connect with their professional colleagues. So a hospital discharge planner has an electronic system in place to make transfers to a nursing home but sidesteps the electronic system to telephone her friend because that relationship was more important in some respects than ensuring the patient's transfer went well.

There is reason for hope, and I will just finish by shining a positive light on the State of Indiana, where they have a program called "Docs for Docs," Documents for Doctors. If I am practicing in Indiana and I have the patient's unique patient identifier, I can look up all of their lab results, all of their radiology results, all of their hospital discharge summaries, procedures, et cetera, no matter where in the State this took place.

So we do have examples that I believe we can learn from. Thank you.

Senator WHITEHOUSE. Thank you all very much.

Thank you, Chairman.

Senator CASEY. Senator Whitehouse, thank you very much.

We have Senator Blanche Lincoln, who has long been a great advocate for people at both ends of the age scale, the children in the dawn of life, as Hubert Humphrey said, and older citizens and not to mention all of rural America.

We are grateful for her presence here and, Senator Lincoln, thank you very much.

Senator LINCOLN. Thank you, Mr. Chairman.

Thank you so much for encouraging this hearing, which I think really does focus on so much of what we need to do. Obviously, some of the things we have gotten right. But without a doubt, the enormous list of tasks that we have before us.

Dr. Coleman, just to your last point, the Documents for Docs, is that just very similar to a physician's ability to write prescriptions? I mean, do you have an access where you can then access those documents through a physician code or a physician licensing?

Dr. COLEMAN. That is right. There is a portal that any physician in the State can use provided you have that individual's personal identifier. This becomes the rub and not all American citizens are comfortable with this approach of having a unique patient identifier. The State of Indiana was willing to accept the risks and the benefits.

Senator LINCOLN. Right. We have that problem with privacy here. I mean that has been one of our bigger challenges and hurdles. But it is interesting to look at that opportunity of access to information.

Two points that I would just like to bring up and certainly get any of your comments on. I have been working on coordination of care for quite some time, and it really came from my own personal experience with my dad. My dad was diagnosed with Alzheimer's at an early age, and we made a very long journey as a family with his multiple chronic diseases plus dementia and the real need for having a coordination of care in order to see the kind of loving care we wanted him to receive.

I grew up in a very small community within walking distance of all my relatives, my grandparents. I didn't know I was a caregiver at the age of 16 just because I took dinner up to my grandparents every other night. But it was. It was a huge part of their needs in terms of caregiving, but it was a wonderful part of my growing up and learning from them, learning about what it means to care for individuals, learning how hard that work can be and how important it is.

So the bill that I have got, S. 1340, mainly focuses not necessarily on a medical home for the whole spectrum of care, but when you look at acute and chronic and long-term and all of that, but specifically on chronic conditions, one of those including dementia, and making sure that we are working to create that coordination of care that is going to provide both efficiencies that lowers our costs, but more importantly, the quality of care that we want our seniors to have.

I think that is so important. It is difficult because we are in an environment where we have created over the last 50 years healthcare delivery that is focused on acute care. It is not focused. I mean, our whole system is designed for acute care. So we are going to have to create some real social changes here in the culture

and the mindset of individuals about their own prospective healthcare as aging adults, but also what they are predicting for their aging parents and grandparents and what have you.

In our coordination of care, Ms. Abrams, we have the doctor, and the doctor does get an increased reimbursement as the overall guidance for that team. But the patient can choose who their care manager will be. So if they are more comfortable with the nurse practitioner or somebody else, then that can be their care manager.

But it makes sure that that entire team is communicating and coordinating that care based on the multiple chronic diseases that that patient is dealing with. There is no doubt that training is a huge part of that.

My husband is a physician. I asked him what he went through in terms of medical school and residency and the things that he learned, as we cared for both my father and then his mother, and he said, you know, it is just not there in terms of what physicians are learning particularly in medical school about how to organize, work with that team.

His father was a surgeon, and it was unbelievable, when his mother was hospitalized before she passed away, the lack of coordination in that care. I had two physicians right beside me. So, it is—there is just so much we need to do, I think, to get to the ultimate goal of the kind of quality of care that we want for seniors.

So I guess my question to you, Ms. Abrams, or to anybody, the way that the medical home is currently defined with the word “physician” being used rather than “primary care provider,” and the fact that what you mentioned, which we have a lack of primary care physicians. There is certainly a shortage there, and the medical home seems consistent with the kind of care that advanced practice nurses currently provide. Do you think the definition could use some—do we look at that in terms of both the shortage that exists and certainly the care that folks are wanting to have in their coordinated care effort and in their team, the actual team perspective of how we go through that?

Ms. ABRAMS. Thank you, Senator Lincoln.

I do. I think that the patient at a medical home, the joint principles that I referenced in the beginning of my statement, they were endorsed and released by the primary care specialty societies, by physicians. So it is their belief and their opinion that the model is physician directed.

Senator LINCOLN. Right. Ours is physician directed.

Ms. ABRAMS. But I have to tell you that it is my position, I think that advanced practice nurses and independent nurse practitioners could also lead a healthcare home and a medical home.

Senator LINCOLN. Right.

Ms. ABRAMS. Again, we can call it a healthcare home, and it is really more about the functions and keeping the patient at the center and having the other pieces in place. So I—and many nurse practitioners, they provide care under the supervision, even though loosely defined, or under the supervision many of them with a physician. But I think there is—and I think it could work under that model. I think that it could also work with advanced practice nurses, as you mentioned.

Senator LINCOLN. Well, we just have to realize that that the shortages not only exist now, but we are training less academic physicians, which means we not only have less practicing physicians. We have less physicians that are there in the medical schools to train particularly geriatrics and geriatric training. So I think—

Ms. ABRAMS. Right. The other thing we also have to remember, too, is that a lot of nurse practitioners, they begin to specialize as well. So it becomes an issue—

Senator LINCOLN. We have got another bill—

Ms. ABRAMS [continuing]. About encouraging people to go into geriatrics.

Senator LINCOLN. Right. We have got another bill to encourage particularly nursing students to take a subspecialty or some type of a specialty part in their training in geriatrics.

Dr. Thomas, absolutely if you want to answer that, but I have got another accolade for you.

Dr. THOMAS. I just want to say—oh, well, thank you so much. I do want to add to what Ms. Abrams was saying is that you are really seeing the contours of a problem with prestige. Our system is set up to throw the greatest prestige toward the most subspecialized technocratic providers, and our society needs a system that gives prestige to people who do that work that your father-in-law and your family needed.

Senator LINCOLN. Right.

Dr. THOMAS. So that is not—I don't think the Senate can solve that issue. But when you are thinking about what is the problem, it is a—we have a misallocation of prestige in our system.

Senator LINCOLN. But what we can do and what Government's responsibility is is to create an environment where those social changes can happen, so that those who need that prestige are being reimbursed for the kind of hard work that they are doing, so that there is an appreciation level and a prestige that comes with that.

There is no doubt that we can help create that environment in a better way than what we are doing. I just want to thank you, Dr. Thomas, for your vision and collaboration with so many dedicated individuals. In Arkansas, we are proud that Arkansas Green House Project called the Northwest Senior Services—

Dr. THOMAS. Yes.

Senator LINCOLN [continuing]. Is both the first Green House in Arkansas, but it is also the first Green House in the country that is partially funded with low-income housing tax credits, which we try in every which way we know how in Arkansas to be innovative because we do have a disproportionate share of our population that are elderly.

Disproportionately, they live in rural areas, where all of that technology is important if we are going to get them the kind of medical care they need.

But they are also disproportionately low income on very restrictive fixed incomes. So, we have got a large portion of our older adults and so many low income that reside in these rural areas. But you might even comment a little bit on that if you get a chance, focusing on affordability of these types of facilities and whether tax credits and other incentives and other creative ac-

counting that we can put together with different programs to help produce more.

Senator CASEY. Doctor, can you be really, really—

Dr. THOMAS. I will be so brief. I would say Mr. Jenkins was responsible for, I think, a lot of that creative thinking, and it is part of what we need to do through the whole system is take all the pieces apart and put them together in new and creative ways.

Senator LINCOLN. Robert Wood Johnson has been fabulous in Arkansas. So we appreciate it.

Thank you, Mr. Chairman.

Senator CASEY. Senator Lincoln, thank you very much.

We want to thank this panel. We have to move to our second panel. I know I am over time now to get to our second panel. But we are grateful for your presence here, for your testimony.

We will be—I know I will, but I am sure other members of the Committee will be submitting questions in writing that you could make your answers then would be part of the record. Thank you very much.

We are going to move now to our second panel. Zoe Valentine Holland, Edna Hess, and Dr. Diana White, who will be coming up next. Thank you very much.

Well, thank you very much. We are going to move right to our witnesses. I will start with Zoe Valentine Holland, who is the daughter of a former Green House resident in Lincoln, NE. It is an honor to have you here and to speak of your own personal experience.

Then I will introduce each of our witnesses as we go forward, and I know we are moving kind of quickly, but we had to make a quick transition. This room is being—we are going to get a little extra time, but this room is being used for another purpose. So we are almost out of room time, and I don't make those decisions. So I will move rather quickly.

Thank you very much.

**STATEMENT OF ZOE HOLLAND, DAUGHTER OF A FORMER
GREEN HOUSE RESIDENT, LINCOLN, NE**

Ms. HOLLAND. Senator Casey and fellow Committee members, thank you for inviting me to testify this morning.

My name is Zoe Holland. My assignment this morning is to tell you a story, to speak to your imaginations and your hearts. On March 26 in 1906, a red-haired baby girl was born on a small farm in Minden, NE, to Andrew Boicourt and Elizabeth Boicourt, and they named their sixth child Mary Josephine. She was my mother, and this is her story.

Mary left her home as a young woman for Omaha, the big city, to fulfill her dream of becoming a nurse, which she did. She later married a physician and surgeon, and they raised two children.

Fiercely independent, Mary returned to Nebraska in her 90th year to set up home in a high-rise apartment. She was on the top floor with an amazing view of clouds and sky and trees. She was so grateful and so happy to be there, and she made many new friends.

Suddenly, in 2002, Mary suffered an illness that required treatment and care only available in a nursing home. I think Dr. Cole-

man's reference to the difficulty in transitioning and getting that 24/7 care really illustrated our family's situation and experience. Her illness coincided with my knee replacement surgery and the reality that her daughter was aging. I no longer had the strength to care for my mother, and we were both very sad.

After exploring several possibilities, she and we chose Tabitha Healthcare Services in Lincoln. She moved into a little room. There was no room for her treasures. Good-bye to the art, the music, the pretty shoes, the clothes, and the mementos of a rich and fulfilling life.

She had worked in nursing homes as a nurse, and she knew what was to come. She was angry at me and what was happening to her. Who could blame her? She had always disciplined herself to exercise daily, move around. There was no room, and it was so dark and so small in there.

Visits of family and friends gradually tapered off. There was only space for one person at a time in her room, while others waited in the hall. We took turns. As the days went by, we watched the light that had burned so brightly for so many years grow very dim. Mother spent much of her time in bed, sleeping as much as she could because she had nothing to do and nowhere to go.

She always reminded me of how much she appreciated the care of the staff and told me that they were doing the very best they could in the environment they were working in and with the resources they had.

We began planning her 100th birthday party nearly a year in advance to lift her spirits, knowing that family and friends were coming from Washington, Oregon, Colorado, New York State, and Glasgow. This was a grand and glorious event, and she received many gifts. But the greatest gift of all was her selection to be one of the first elders to be in the Green House in Lincoln, NE.

Suddenly, to Mary Valentine, my beautiful mother, life mattered again. With light flooding through her bedroom window, she sent us scurrying after her lost treasures.

She could sleep as late as she pleased in the morning and still have breakfast. A Shahbaz would attend to her hair and nails and clothing for the day. Monica took a dress home and ironed it so her dress would not be wrinkled on one occasion. Every night, a Shahbaz would tuck her in bed lovingly and tell her good night.

She also received at the Green House the coordinated care that I think you were discussing. There was, all of a sudden, a smaller staff and a closer connection to the doctors and nurses. It was a really tight relationship, very good.

During the day, she could sit in her tiny recliner that fit her tiny body and hold a tiny Chihuahua, Tupac, who belonged to a staff member. They were a good fit. She was convinced that Tupac wanted to be wrapped in a silk scarf every day as he snuggled in her lap.

The year 2006 belonged to Mary. The Green House itself was the scene of many celebrations, dinners, and parties, and many of them were ours. For the first time in many years, my husband Mike and I felt free to travel, knowing Mother was secure and comfortable and, oh, so happy. We could contact her caregivers daily and expect an accurate and thorough report.

Her 101st birthday has been recorded and documented. Mary sitting on the Green House porch with Tupac and her margarita and her celebratory cigarette, and they used their technology to send that all over the country. All of the people involved in the Green House project, "Oh, you are Mary's daughter. We saw her picture." It made that relationship very real.

April 17, 2007, was a soft and gentle spring day, almost perfect and was to be the last day of Mary's life on Earth. Attended by a beautiful red-haired young nurse, with Shahbaz Monica present, she died with the gentle grace and the quiet beauty that had exemplified her life on Earth in the arms of her beloved granddaughter Ann.

In my announcement of her death, I wrote, "The staff at Tabitha and the Green House loved her fiercely and are grieving mightily. Please pray for these angels on Earth." In May, her remains were buried beside her son on a hillside in Eugene, OR.

Later, a memorial was dedicated in her honor at Tabitha. On the porch, you will see a fountain with a big dog and a little toy, which welcomes all the visitors in the spirit of Mary.

In her last room at the Green House, there now lives a sweet, small redhead named Gwen. Once in a while, like Monday, I stopped in with a flower. She understands that sometimes I just need to be in that room.

On the anniversary of Mother's birthday, my husband Mike and I took some friends and had a little margarita party in the Green House. We had dips and chips, and all the elders came out, and we told Mary stories. We wanted these elders to know that when they were no longer here, someone would remember them, too.

That is one person's story, but that is not the end of our story. We have constructed in America a beautiful democratic system, which through its agencies works to provide sustenance and direction for all of its citizens almost, but not quite, across their life spans. We have fallen just a wee bit short.

It is time for us to cover that gap. How do we do it? "In small places close to home, so small they cannot be seen on any map," as Eleanor Roosevelt suggested, or just maybe build more places like a Green House.

Thank you again for the opportunity to testify and tell the story of my mother, Mary Valentine.

[The prepared statement of Ms. Holland follows:]

**Testimony before the Senate Special Committee on Aging
Wednesday, July 23, 2008**

**Zoe Valentine Holland
Family Member of GREEN HOUSE® Resident Mary Valentine
Lincoln, NE**

Senator Casey, Chairman Kohl, Ranking Member Smith, and fellow Committee members thank you for inviting me to testify this morning.

I am Zoe Holland, and I come to you from the Heartland of America to speak about a matter that is very close to us all. My assignment this morning is to tell you a story. To speak to your imaginations and hearts.

On March 26, 1906, a red haired baby girl was born to Elizabeth and Andrew Boicourt on their small farm in Minden, Nebraska. They named this child, who was their sixth, Mary Josephine. She grew to love all fragile helpless creatures, and music and science and art and poetry as well. She was my mother and this is her story.

Mary left her home for Omaha, to fulfill her dream of becoming a nurse. Her life exemplified the noblest qualities of this profession. This beautiful, soft-spoken and gentle redhead became the wife of a physician and surgeon, Dr. L.F. Valentine. She was at his side from the time he was a country doctor in Nebraska through the later years of his medical practice in Santa Monica. They raised two children.

Fiercely independent, Mary returned to Nebraska in her 90th year to set up home in a hi-rise apartment. She was on the top floor, with an amazing view of trees and clouds. She created lovely rooms, and enjoyed flowers, her French Impressionists, music and small cheese and wine gatherings, as well as family birthday parties and holiday celebrations. She was so grateful and happy to be there and made many new friends.

Suddenly, in 2002, Mary suffered an illness that required treatment and care only available in a nursing home. This coincided with my knee replacement surgery, and the

realization that I was also a senior, and no longer strong enough to provide for her health care needs. We were both very sad.

After exploring several possibilities, she and we chose Tabitha Health Care Services in Lincoln. My daughter helped me sort out her things... all those lovely treasures for which there would be no room where she was going to live. Goodbye to the art, the music, the many books, shoes, clothes, and mementoes of her rich and fulfilling life. No place for the photos of dear ones. Her imagination would need to hold them close.

For the first time since I was a kid and she caught me smoking, she was angry with me. For several days, when I would approach, she turned her back to me and faced the wall and would not speak. I know she felt betrayed by the one person for whom she had given so much.

And who could blame her? She had always disciplined herself to exercise daily. Now there was no room. She shared a very small room with a curtain partition. She was near the door and the bathroom with no window to look out. She was nearly blind and her space was very dark. One of her problems was incontinence, and sharing a bathroom with a constipated person was not helping that situation.

Visits of family and friends gradually tapered off. I attribute this to the depressing environment. There was only space for one person at a time in her room, while others waited in the hall. After she was moved to the second floor, she could no longer wander independently outdoors.

As the days went by, we watched the light that had shone so brightly for so many years grow very dim. Mother spent as much time sleeping as possible because there was nowhere to go. Flowers brought to her room withered and wilted overnight and we were watching her do the same thing. She was most appreciative of her care, reminding me that the staff – Linda, Lisa, Tammi and Julie – were doing the best they could. There was no one consistent staff person we could contact about the way she had spent her day. She did have several falls, fractures, while at Tabitha. The dining area was very crowded, with tight places for servers around wheel chairs. Granddaughter Liz, when

she came to play her violin, had to perform in the hallway and no one could see her. And there was no piano for her great granddaughter Emily. Emily did find a way to be close to Mary, who was nearly blind and deaf. She brushed her hair and fixed her nails, and would sit snuggled very close to her on her bed.

Family members faithfully sent her cards, little gifts and messages of encouragement, reminding her that she was still important to our lives. We began planning the centennial birthday party nearly a year in advance. It did lift her spirits, knowing friends and family were coming from Washington, Oregon, Colorado, New York state, and Glasgow. This was a grand and glorious event, with candles, balloons, piano, violin, pipes and drums, toasts and tributes. But the greatest gift of all was her selection to be one of the first elders to move into the new GREEN HOUSE® Home at Tabitha.

"Sometimes our light goes out but is blown into flame by another human being. Each of us owes deepest thanks to those who have rekindled this light." – Albert Schweitzer

To each and every one in the Green House who rekindled our Mother's light, our deepest thanks.

Suddenly, to Mary Valentine, life mattered again. With light flooding through her window, her brand new furniture and bedspread, she sent us scurrying to recover her lost treasures. Out came the china tea cups, the glass of Oregon sand with the sea shells, the photos of her husband, son, grandchildren and great grandchildren. The French Impressionists were back, and she once again began to plan for entertaining guests in her home. Remembering how she had always been a lady of fashion and style, she turned her attention to her closet. Soon my sewing machine was humming. A person who had always lived in the service of others was living a full life again. She could sleep in as late as she pleased in the morning and still have breakfast. A Shahbazim, like Monica, would attend to her hair, nails, and clothes selection for that day. Monica once took a dress home with her to iron so Mary would not be wrinkled. Every night she donned a soft floral night gown and was lovingly tucked into bed.

During the day she could sit in her tiny recliner that fit her tiny body and hold a tiny Chihuahua, Tupac, who belonged to a staff member, Thomas. They were a good fit. She was convinced that Tupac preferred to be wrapped in a fine silk scarf when he was held on her lap.

That year of 2006 belonged to Mary. The Green House itself was the scene of many celebrations, dinners, and some of them were ours. Granddaughter Liz played her violin on several occasions. Family and friends arrived throughout the year from Hawaii, Seattle, Long Beach, New Mexico, and Mother could play the gracious hostess, one of her favorite roles. I would often take our Newfoundland, Argus, to visit Mother, Tupac, and the elders.

For the first time in many years, my husband Mike and I felt free to travel, knowing Mother was secure and comfortable, and oh, so happy! We could contact her caregivers daily and expect an accurate and thorough report. They also called us if they had a special concern.

Mary's 101st birthday has already been told, retold, recorded, documented, as it was observed on the porch with Tupac in his silk scarf on her lap as she smoked her celebratory cigarette and toasted the good life with a Margarita.

Framed on Mother's Wall:

"These many beautiful days cannot be lived again, but they are compounded in my own flesh and spirit. And I take them in full measure toward whatever lies ahead." – Daniel Berrigan, S.J.

April 17, 2007 was a soft and gentle spring day, almost perfect... and was to be the last day of Mary's life on earth. I had been recovering from a hip replacement and had not seen her for ten or more days. Mike called on her and they sat on the porch and had a pleasant visit. Later Monica walked with her, and told me how astonished she had been when Mother stated that she had heard a dove singing, since Mother was quite deaf. Monica then saw the dove. Later that evening, she fell and was taken to the hospital.

Attended by a beautiful red-haired young nurse, with Shahbaz Monica present, she died with the gentle grace and quiet beauty that had exemplified her life on earth... in the arms of her beloved granddaughter Ann. In my announcement of her death I wrote this, "The staff at Tabitha and the Green House loved her fiercely and are grieving mightily. Please pray for these angels on earth." In May, her remains were buried beside her son on a hillside in Eugene Oregon.

Afterward

On September 29, 2007, a memorial was dedicated in her honor at Tabitha. On the porch of the Green House in Lincoln, a fountain with a statue of the big dog standing on his hind legs with his paws on the bowl welcomes all visitors. Balloons were released with loving thoughts of Mary attached to dog biscuits. There were cookies and drinks and stories and laughter. Thomas was there and so was Tupac. But the big black Newfoundland had been called to dog heaven that morning.

In Mother's last room, lives now a sweet small redhead, whose name is Gwen. She is a former music teacher, and the room looks so much the same as when Mother was there. Gwen also likes floral and feminine fragile things. Gwen has a daughter who visits her, and once in a while I stop in with a flower.

She understands that sometimes I just need to be there.

March 26, 2008. Mike and I took a couple of friends, one who shared a birthday with Mother, and had a little Margarita party with chips and dip. Nearly all the elders and Shahbazim gathered in the living area and we told Mary stories. We also want each of these elders to know that when they are no longer there, someone will be remembering them, too.

And that is one person's story. But it is not the end of our story.

What Can this Success Mean for America?

"Where, after all, do universal rights begin? In small places, close to home... so close and so small that they cannot be seen on any map of the world... unless those rights have meaning there, they have no meaning anywhere." – Eleanor Roosevelt

We have constructed a democratic system which – through its agencies and institutions – works to provide sustenance and direction for all its citizens, almost, but not quite, across their life spans. We have fallen just a wee bit short.

It's time for us to cover that gap. How do we do it? "In small places, close to home, so small they cannot be seen on any map," as Eleanor Roosevelt suggested... or, just maybe, build more places like Green House. And why?

Because it works. There are observable, measurable and quantifiable data to support our storytelling.

Because place matters... To quote Bill Thomas, "LIFE MATTERS"

And that is the heart of the matter.

Thank you again for the opportunity to testify before you today and tell the story of my mother, Mary Valentine.

Senator CASEY. Ms. Holland, thank you very much for your testimony. It was poignant and moving and an important personal reflection.

We often have testimony here in these hearings that is data driven. It is important. But very rarely do we get the chance to listen to someone who has had the kind of experience and, as you say, speaks from that experience. But it especially speaks from the heart.

You said in your testimony that you weren't sure you had the strength to care for your mom, and it is readily apparent that you did and your strength is enduring.

Ms. HOLLAND. We, our family is so grateful because we had the Green House there and the Tabitha there and the transition. We didn't have the strength, but it was there. We are a team with the Shahbazim. They are family to us.

Senator CASEY. Well, you are giving important testimony to the importance of this patient-centered approach, and we are grateful that you took the time to testify and to tell that story about your own mother and your own life experience, but also to travel the distance you did.

So thank you very much. If I have time, I will ask you a question. But we are going to move to our next witness.

Edna Hess, I had the chance to meet earlier today, this morning. She is a Shahbaz. Am I saying that right?

Ms. HESS. Yes, you are. You are saying that correctly.

Senator CASEY. I want to commend her for her work. I have spent a good deal of time on the issue of what happens to and what are the programs and strategies that support direct care workers. So, Edna, we are grateful for your work, and we are especially grateful for you taking the time to be with us today.

I also wanted to take this opportunity to announce that, as Mrs. Hess knows, there will be a congressional staff visit to the Lebanon Valley home in early October of this year. For those of you who don't know, that happens to be in the State of Pennsylvania, where we are proud of that.

But I wanted to have Edna testify now, and then we will go to our last witness.

**STATEMENT OF EDNA HESS, SHAHBAZ, LEBANON VALLEY
BRETHREN HOME, PALMYRA, PA**

Ms. HESS. Thank you, Senator Casey.

Senator CASEY. Oh, the microphone?

Ms. HESS. Thank you, Senator Casey, Ranking Member Smith, and other members of the Committee for their kind invitation to appear before you this morning and to tell you my experiences as a Green House Shahbaz. It is a privilege and an honor to share that story with you.

This year marks my 30th year as a nursing assistant. Like many of my colleagues, I became a nursing assistant just because I needed a job, and it turned into a lifelong calling. I have always felt that the care provided by myself and the rest of the staff at Lebanon Valley Brethren Home was of the highest quality. Our residents were clean, well tended, well fed. Still, there was something missing that I could not put my finger on.

Looking back on it now, I realized that while we offered our residents excellent care, that did not always translate into highest quality of life. When the Green House concept was first introduced by my employer, I was skeptical. After nearly 30 years as a nursing assistant, it was difficult to think about providing care in a new way.

Still, the description of the Green House lifestyle was very appealing. I decided to apply for a Shahbaz position and was fortunate to be selected as one of the first Shahbazim to be trained.

It has now been 9 months since my house, the Hostetter House, first opened its doors. The 10 elders who live in my house were transferred from the existing nursing units at the Brethren home. So I already knew many of them.

I cannot believe how much better they are all doing in the Green House setting. The most noticeable improvement I have witnessed is the amount of socialization that occurs in our house. Several of my elders were hardly ever out of their rooms in the traditional nursing units. Now they are frequently seen chatting in the living room, out on the patio, or lingering at the dining room table. Very seldom do they want to go to their room.

The second biggest improvement is in the dining experience. Every meal is home cooked in our open kitchen, and the elders experience all the smells and sights of the meal preparation. They really chow down at mealtime. When we first moved into the house, four of my ladies were receiving daily nutritional supplements like Ensure, and now, none of them.

The living conditions in our Green House homes are much better than in the traditional nursing home units. It is much calmer because you don't have the background noises of intercom announcements, alarms to deal with. There are no medication carts, laundry carts, housekeeping carts, or food carts to obstruct the walkway paths for our elders.

There is no gathering of wheelchairs around a crowded nurses station. Our elders now congregate in front of the fireplace or out on the patio.

One of the things that I now realize was missing in the traditional nursing home was the ability to make choices. Our residents were given very few opportunities to make choices that were important to them, like what time to wake up in the morning or what activity to attend.

All that is different in our Green House. We no longer awaken our elders. We wait for them to wake up when they want to. We make them breakfast when they get up, whether that is 6 o'clock in the morning or 10 o'clock. As far as activities, they are now individualized. Sophie, she likes to do puzzles by the fireplace. George, he watches TV in his room at times. Bill putters on the patio with gardening, and Gertrude loves to go bowling with our newest toy, Nintendo Wii game system, which I want to add I like, too.

I can honestly say that I love being a Shahbaz and so do my fellow Shahbazims. We have not had a single Shahbaz resign in the 9 months that our house has been open. This compares favorably with the national average for turnovers for nursing assistants, which is over 70 percent.

The working life we now enjoy is very demanding because we do cooking, cleaning, and activities, in addition to nursing care, but it is so much more fulfilling. I no longer feel like I am working on an assembly line. There are two Shahbazims on my shift for just 10 elders, so we feel like there is plenty of time to provide the person-centered care that is truly needed.

One of the greatest things about the Green House homes is the consistency of staffing. I always work in the Hostetter House, and so the elders feel very secure and comfortable because they know me and I know them. This helps to provide better care. A few of my elders were chronically incontinent in the nursing home, but now we know them so well that we can anticipate their toileting needs.

I often think of one of our elders that has since passed on. This gentleman and his wife were both elders in the Hostetter House, and they shared adjoining rooms. Though he was terminally ill with cancer, the gentleman was always more concerned with his wife's welfare than with his own. Over many decades of marriage, he had always taken great care to make sure that his sleeping wife had a covering blanket on top of her to keep her warm.

When the couple was in our traditional nursing unit, the husband always worried that the staff would forget the covering blanket. Sometimes they did because the staff changed regularly and not everyone knew the ritual. After a short time in our Green House, we realized how important it was for the covering of the blanket to Mr. P, and we never forgot it. I believe it gave him great peace that he knew his wife would be cared for in the same attentive way that he had done.

In conclusion, I feel very lucky to be a Shahbaz and to work in a Green House home. In talking with many of my fellow Shahbazim, we all agree that we feel spoiled by our Green House experience in the sense that none of us would want to ever go back to the traditional nursing home setting again.

Senator Casey, other members of the Committee and your staff, I encourage all of you to personally visit a Green House, our Green House, and see firsthand what a difference it is making in the lives of the resident elders. With Green Houses, seeing is believing.

Thank you once again for this opportunity to present this testimony.

[The prepared statement of Ms. Hess follows:]

Testimony before the Senate Special Committee on Aging
July 23, 2008

Edna Hess, THE GREEN HOUSE® Shahbaz
Lebanon Valley Brethren Home
Palmyra, PA

Good morning. I would like to thank Senator Casey, Chairman Kohl, Ranking Member Smith, and the other members of the Committee for their kind invitation to appear before you this morning, and to tell you about my experiences as a Green House Shahbaz. It is a privilege and an honor to share that story with you.

This year marks my 30th year as a nursing assistant. Like many of my colleagues, I became a nursing assistant because I needed a job, and it turned into a life-long calling. I have worked in a variety of facilities, both personal care homes and nursing homes, and in both for-profit and non-profit settings. For the last twelve years I have had the good fortune to be employed as a Certified Nursing Assistant in the skilled nursing center of the Lebanon Valley Brethren Home in Palmyra, PA. Despite the negative feelings that most people have about nursing homes, I have found it personally rewarding to be helpful to the residents and family members that I have cared for.

I have always felt that the care provided by myself and the rest of the staff of the Lebanon Valley Brethren Home was of the highest quality. Our residents were clean, well-tended, and well-fed. Still, there was something missing that I could not put my finger on. Looking back on it, now, I realize that while we offered our residents excellent nursing care, that did not always translate into a high quality of life.

A Certified Nursing Assistant in a traditional nursing home is a very busy person. We typically are assigned full responsibility for the total care of seven, eight or even more elderly residents for our eight-hour shift. These residents are usually very frail. Many of them are incontinent, and many of them have dementia. The work day feels very much like working on an assembly line, as we progress nonstop through a series of tasks such as giving baths, changing bed sheets, providing assistance at mealtimes, pushing wheelchairs, and dressing and re-dressing our assigned residents. If we manage to finish all the care routines, there is still the paperwork challenge of documenting all of our actions in the medical records.

When The Green House® concept was first introduced by my employer, I was very skeptical. After nearly 30 years as a nursing assistant, it was difficult to think about

providing care in a new way. Still, the description of The Green House lifestyle was very appealing. I decided to apply for a Shahbaz position, and was fortunate to be selected as one of the first Shahbazim to be trained. The training lasted three full weeks, and included one full week of instruction in cooking skills by a chef from a local community college.

It has now been nine months since my House, the Hostetter House, first opened its doors. The ten elders who live in my House were transferred from the existing nursing units at the Brethren Home, and so I already knew many of them. I cannot believe how much better they are all doing in The Green House setting. The most noticeable improvement I have witnessed is in the amount of socialization that occurs in our House. Several of my elders were hardly ever out of their rooms in the traditional nursing units; now they are frequently seen chatting in the living room, out on the patio, or lingering at the dinner table. Even the elders who have dementia are engaged in the activities and conversations around them, though they clearly don't understand everything that is going on. The second biggest improvement is in the dining experience. Every meal is home-cooked in our open kitchen, and the elders experience all the smells and sights of the meal preparation; they really chow down by the time the meal is served! When we first moved into the House, about four of my ladies were receiving daily nutritional supplements, like Ensure, because of their poor eating habits; after a few months in our House, those supplements were discontinued because everybody was gaining weight.

One of the things that I now realize was missing in the traditional nursing home was the ability to make choices. Our residents were given very few opportunities to make choices that were important to them. Breakfast was served by 6:30 AM, so most of the residents were awakened by staff at 5:45 AM. Activities, mostly for large groups of residents, were organized around regular calendar times and days. All that is different in our Green Houses! We no longer 'awaken' our elders, we wait for them to get up when they want to. Some of my elders are still early risers, but others can often be found sleeping until 10 AM or even later. We make them breakfast when they get up, whether that's 6 AM or 10 AM. As for activities, they all pretty much do what they want. Sophie likes to do puzzles by the fireplace, George watches TV in his room or entertains the ladies with tales of his WW2 adventures, Bill putters on the patio with gardening. Gertrude loves to play with our newest toy, a Nintendo Wii game system that simulates the bowling games she played all of her life. Occasionally, our elders will go 'visiting' at the Castagna House across the street to play Bingo with those elders.

We hold meetings with The Green House elders on a regular basis to talk about how things are going, and to offer them more choices about their daily lives. One of the more popular customs that has evolved is the elder's option to choose the menu (and dessert) on their birthday. This is something that we couldn't do in the traditional nursing home

because of the large numbers of residents, but it is relatively easy to do when you are only caring for ten elders.

One of the neat things about being a Shahbaz is that we get to make a lot of the decisions about how our House operates. For example, in the traditional nursing home the dining tables were often pre-set (for greater efficiency) by the dietary staff. When a resident came to the table, their appetizer, drinks, and dessert were already at their place setting. In actual practice, this didn't work very well because many residents would eat their dessert immediately and then refuse the rest of the meal. When we opened the Hostetter House we continued this same practice because it was the way we had always done it. Eventually we experimented with holding the dessert back until later in the meal; this has worked great because the elders now eat the healthy part of the meal first. The Shahbazim in our House also discovered that if we delayed the dessert service a bit, the elders filled the time delay by starting conversations with their neighbors. More socialization!

I can honestly say that I love being a Shahbaz, and so do my fellow Shahbazim. We have not had a single Shahbaz resign in the nine months that our Houses have been open. This is a big improvement over my facility's 23% annual turnover rate for nursing assistants, and an even bigger improvement over the national turnover rate for nursing assistants, which I understand to be slightly over 70% per year. [Source: American Association of Homes and Services for the Aging, Washington, DC] The working life we now enjoy is very demanding, because we do cooking, cleaning and activities in addition to nursing care, but it is so much more fulfilling. I no longer feel like I am working on an assembly line. There are two Shahbazim on my shift for just ten elders, so we feel like there is plenty of time to provide all the care that is needed. We are now able to do all of the "extras" that we rarely had time for in the traditional nursing home. We can let an elder linger in a luxurious whirlpool bath because there is no time pressure to get onto the next bath. We can sit with the ladies and do manicures, or just chat on the patio with them while enjoying afternoon iced teas.

One of the great things about our Green House® homes is the consistency of staffing. I always work in the Hostetter House, and so the elders feel very secure and comfortable because they know me and I know them. This helps to provide better care. A few of my elders were chronically incontinent in the traditional nursing home, but now they are mostly or completely continent. We know them so well that we can anticipate their individual toileting needs, and it is certainly a lot easier and more dignified to take an elder to the bathroom before they have an episode of incontinence. This same familiarity helps in dining, as well, as we get to know their personal food preferences and dietary restrictions.

I often think about an elder in my House who has since passed on. This gentleman and his wife were both elders in the Hostetter House, and they shared adjoining rooms. Though he was terminally ill with cancer, the gentleman was always more concerned with his wife's welfare than with his own. Over many decades of marriage, he had always taken great care to make sure that his sleeping wife had a covering blanket on her to keep her warm. When this couple was in our traditional nursing unit, the husband always worried that the staff would forget the covering blanket, and sometimes they did because the staff changed regularly and not everyone knew the ritual. After a short time in our Green House, we realized how important the covering blanket was to Mr. P and we never forgot it. I believe it gave him great peace to know that we would care for his wife in that same attentive way after he was gone.

The living conditions in our Green House® homes are so much better than in the traditional nursing home units. It is much calmer because you don't have the background noises of intercom announcements and call bell alarms to deal with. There are no medication carts, laundry carts, housekeeping carts, or food carts to obstruct the walking paths for our elders. There is no gathering of wheelchairs around a crowded nursing station. Our elders now congregate in front of the fireplace, or out on the patio. The beauticians and physical therapists come to our House to conveniently provide their services. On occasion, our elders will choose to be transported to the campus Community Center for a worship service, concert, or important meeting.

The Green House® homes have also been very popular with the families of the elders. In my opinion, they seem happier because they see that their loved ones are happier. The family members get involved in the life of the House, as there are more things that they can do in a Green House home. They help set the table, participate in activities, bring in DVD's for everyone to watch, and sometimes take drink orders for anyone sitting in the living room area. From time to time, they stay to enjoy a meal with their loved one. Some of them bring their dogs in for an occasional visit.

In conclusion, I feel very lucky to be a Shahbaz and to work in a Green House home. In talking with many of my fellow Shahbazim, we all agree that we feel "spoiled" by our Green House experiences...in the sense that none of us would ever want to go back to working in a traditional nursing home again. As part of our initial Shahbaz training, we collectively composed a "Shahbazim Code of Ethics" to guide our behavior, and to set a measuring stick for holding one another accountable to the Green House principals. The first two principals are: (1) We will keep the Elder at the center of the home, and (2) We will protect, sustain, and nurture our Elders and each other. If we can keep to these principals, our Elders and The Green House homes will both flourish.

Senator Casey, other members of the Committee, and your staff, I encourage all of you to personally visit a Green House and see firsthand what a difference it is making in the lives of its resident elders. With Green Houses, seeing is believing. I hope, too, that this Committee will do what it can to support efforts that put elders at the center of their own care, and give them the opportunity to maintain a high quality of life.

Thank you once again for the opportunity to present this testimony.

[ATTACHMENT]

Lebanon Valley Brethren Home

Shahbazim Code of Ethics

- *We will keep the Elder at the center of the home.*
- *We will protect, sustain, and nurture our Elders and each other.*
- *We will maintain standards of excellence regarding Elders and decision making.*
- *We will show dignity, compassion, respect, and patience towards all.*
- *We will minister individual physical, spiritual, emotional and social needs under our care.*
- *We as a team will contribute to the goal of providing the highest quality of care.*
- *We will continue to learn and grow.*
- *We will monitor ourselves and others to prevent Institutional Creep.*
- *We will carry ourselves with a positive and professional attitude.*
- *We will be accommodating and flexible towards each other, our Elders and their families.*
- *We will be sincere in engaging in a life worth living.*
- *We will be punctual in arriving at work and reliable in completing our tasks as assigned.*
- *We will be truthful and honest in our interactions with one another.*
- *We will practice effective communication with each other, our Elders and their families.*

Senator CASEY. Well, Edna, thank you very much.

Ms. HESS. Thank you.

Senator CASEY. When you referred to your own lifelong calling, now I think those of us in the room who didn't know your story before understand why it has been such a calling for you. We appreciate that. We will visit not only because you said it and asked us to do it in public, but that helps. [Laughter.]

We will be submitting questions to you.

Finally, and I know because we have to give up our room shortly, I wanted to make sure that Dr. Diana White, who is the Senior Research Associate at the Institute on Aging at Portland State University in Portland, OR, I wanted to make sure that Dr. White had an opportunity to testify.

She has done extensive research into person-centered care and has tremendous expertise on the most recent developments around the country and in her home State of Oregon. Dr. White, thank you very much for being here.

STATEMENT OF DIANA WHITE, PH.D., SENIOR RESEARCH ASSOCIATE, INSTITUTE ON AGING, PORTLAND STATE UNIVERSITY, PORTLAND, OR

Dr. WHITE. Thank you, Senator Casey.

It is an honor for me to be here and an honor to be representing all of my colleagues in Oregon. I have been working in this area since 2001, and for most of that time, I worked for the Oregon Health and Science University's Hartford Center of Geriatric Nursing Excellence, and I am continuing that at Portland State.

The Hartford Center partnered with the State's unit on aging and 10 long-term care facilities to develop person-centered care practices, many of which we have heard talked about today. In 2003, the partnership expanded when Oregon received a Better Jobs Better Care demonstration grant. We were one of five, and Pennsylvania was one of our fellow demonstration grantees.

Our partners included eight provider organizations, the long-term care trade associations, the Oregon State Board of Nursing, and many, many others. Through Better Jobs Better Care, we worked to improve living and working environments for direct care workers and residents, both, through person-centered care practices. I was the local evaluator of that project.

One of our first challenges was to clarify and define what we meant by person-centered care. Everybody has their own vision of what that is. We went through a rigorous and systematic process to create a definition and then a measurement tool we could use in our evaluation. As our own thinking and experience evolved, we began to use the term "person-directed" rather than "person-centered" because we wanted to emphasize that residents, even those with severe cognitive and physical disabilities, needed and were able to guide their care.

Person-directed care is a way of thinking about care that honors and values the person receiving support. The elements comprising person-directed care we identified are personhood, knowing the person, choice and autonomy, comfort and relationships. I have attached definitions of each of these elements.

To implement these practices, we found organizational systems must be in place. For all levels of staff, this means adequate education and training, the ability to be an advocate for residents, the ability to make care decisions with residents, having the time to work with residents, teamwork, skilled supervisors, and adequate staffing.

I would like to give one example of some of the work that emerged and that was done. At Rogue Valley Manor, which is a nursing home in Medford, OR, a nursing assistant meets with each new resident to learn how and when they like to get clean. If the person is used to showers at night, they continue to get showers at night. If they prefer a bath in the morning, they can get that, too.

If bathing or showering is painful or frightening, a towel bath might be a comforting solution. The CNA also learns what kinds of soaps and shampoos and lotions and ritual routines are preferred, whether their hair should be washed during their bath or shower or at a different time.

Sometimes residents with dementia can't describe their preferences or routines. The CNAs get what information they can from the resident. They ask family members. They talk to each other. Most importantly, they pay a lot of attention to the behaviors of the resident to figure out the rest.

During this process, workers also identify what kind of music or conversation, if any, would be pleasurable to the person to help put them at ease. The shower or bathing schedule is then built around resident preferences, and then staff have the flexibility to go with the flow. If a resident does not feel like following their routine on a particular day or they request a different one, that can happen, too.

At many other facilities throughout Oregon, person-centered practices have not stopped with bathing programs or the many dining programs that have been developed. Each led to new activities, as staff and residents experienced successes and saw different areas that needed a person-directed approach. For example, with flexible dining and bathing schedules, residents now get up and go to bed when they want. Some residents go to breakfast in their pajamas if that was their routine in the past.

Some facilities have started therapeutic gardening programs, and almost all are really working to build teams and leadership skills among the direct care staff. Many have experimented successfully with worker-directed teams who make their own assignment to residents, mentor new staff, and do their own scheduling.

Although exciting and rewarding, the process is not easy, even when organizations are committed to these changes. We would like to see more investment in organizations that are working toward person-directed care practices.

An example is a partnership between Oregon's seniors and people with disabilities and 12 nursing homes using civil penalties money. We are also experimenting with educational programs directed at nursing students, direct care workers, people who are in the field, to make sure that the training starts at the very beginning of this process.

Person-directed care practices continue to evolve in Oregon, and I will leave here the philosophy statement that has been developed by key stakeholders, including Government and provider organizations, and information about several ongoing person-directed care activities.

Again, I thank you for this opportunity to share our experiences and our hopes to transform long-term care.

[The prepared statement of Dr. White follows:]

Dr. Diana White

Senior Research Associate
Institute on Aging
Portland State University
Portland, Oregon

Before the

Senate Special Committee on Aging

Hearing on

**Person-Centered Care:
Reforming Services and Bringing Older Citizens Back to the Heart of Society**

July 23, 2008

Good morning Senator Casey, Ranking Member Smith, and members of the Committee; I very much appreciate the opportunity to participate in this hearing on person-centered care. I have been participating in efforts to create more person-centered long-term care practices since 2001. For most of that time I worked for the Oregon Health & Science University's Hartford Center of Geriatric Nursing Excellence and I am continuing that work at Portland State University. The Hartford Center partnered with the State's Unit on Aging, Seniors & People with Disabilities, and 10 long-term care facilities (nursing homes, assisted living, residential care) to develop person-centered care practices. In 2003, the partnership expanded when Oregon received a Better Jobs Better Care Demonstration grant from the Robert Wood Johnson Foundation and Atlantic Philanthropies. Our partners included 8 provider organizations (nursing homes, home care, assisted living, residential care), the long-term care trade associations (Oregon Health Care Association, and the Oregon Alliance of Senior and Health Services), the Oregon State Board of Nursing, and many others. Through BJBC, we worked to improve living and working environments for direct care workers and residents through person-centered care practices. I was the local evaluator of that project.

One of our first challenges was to clarify and define what we meant by "person-centered care." We went through a rigorous and systematic process to create a definition and then a measurement tool we could use in our evaluation. As our own thinking and experience evolved, we began to use the term "person-directed" rather than "person-centered" because we wanted to emphasize that residents, even those with severe cognitive and physical impairments, need to be in charge of their care. **Person-Directed Care** is a way of thinking about care that honors and values the person receiving support. Well-being and quality of life are what the person receiving services says they are. Supporting people the way they want to be supported is more important

than completing a list of care tasks. The elements comprising person-directed care are: personhood, knowing the person, choice and autonomy, comfort, and relationships. Definitions of each of these elements are attached to this statement. I should note that developing consensus on the definition of person-centered and person-directed care is an ongoing process in the field. To implement these practices, organizational systems must be in place. For all staff, this means:

- adequate education and training
- ability to be an advocate for residents
- ability to make decisions about care with residents
- having the time to work with residents
- teamwork
- skilled supervisors
- adequate staffing

I would like to provide some examples from two nursing homes who participated in the BJBC project as well as the earlier project. At Mennonite Village, a nursing home in Albany, Oregon, residents go to a dining room of their choice at any time of day and order from a menu, which is different every day. If they don't see something they like, they know they can request a sandwich or eggs, or some other favorite food. Certified Nursing Assistants, or CNAs, have food handler permits, so dining hours are extended to all hours of the day or night. If someone wants a hamburger at 1:00 AM, they can get it. Food waste has almost been eliminated, residents are no longer parked dozing in the hallways waiting for meals, the dining areas are quieter and more conducive to conversation, resident and family satisfaction with food has increased, and direct care staff point to this program with pride.

At Rogue Valley Manor in Medford, Oregon, a nursing assistant meets with each new resident to learn how and when they like to get clean. If the person is used to showers at night, they continue to get showers at night. If they prefer a bath in the morning, they can get that, too. If bathing or showering is painful or frightening, a towel bath might be a comforting solution.

The CNA also learns what kinds of soaps, shampoos, or lotions are preferred, whether hair should be washed during the bath or shower or at a different time. Sometimes a resident with dementia can't describe preferences or routines. The CNAs get what information they can from the resident, they ask family members, they talk to each other, and, most importantly, they pay a lot of attention to the behaviors of the resident to figure out the rest. During this process, they also identify what kind of music or conversation would be pleasurable to the person to help put them at ease. The shower or bathing schedule is then built around resident preferences. Staff have the flexibility to "go with the flow" if a resident does not feel like following their routine on a particular day or requests a different routine. This person-directed bathing practice has resulted in reduced stress and increased pleasure for staff and residents.

At both these and at many other facilities throughout Oregon, person-centered care practices have not stopped with dining or bathing programs described here. Each led to new activities as staff and residents experienced successes and saw different areas that needed a person-centered approach. For example, with flexible dining and bathing schedules, at both of these facilities, residents get up and go to bed when they want, some residents go to breakfast in their pajamas if that was their routine in the past. Some facilities have started therapeutic gardening programs, and almost all are experimenting with ways to build team and leadership among direct care staff. Many facilities have experimented successfully with worker-directed care teams. These teams make their own assignments to residents, mentor new staff, and do their own scheduling. Building renovations are occurring, beginning with eliminating nursing stations to create living room areas. All of the organizations most engaged in these activities report more satisfied and vibrant elders, and more satisfied and empowered staff.

We have learned that the ability of organizations to develop and sustain person-directed care practices is related to four areas: first, an organizational culture compatible with a person-centered care philosophy is necessary. We found that those who were most successful in making changes were open to doing things differently and considered this work to be core to their mission rather than a project to be completed. Second, top management must be engaged and committed, but able to delegate leadership to others. Support from corporate leaders is critical. Third, all staff must be a part of the change and committed to making things work. They must have a real voice and meet regularly to plan and evaluate their activities. Many organizations need help in learning how to lead effective meetings and hold one another accountable for following through on team decisions. Finally, successful organizations create person-directed care practices that make sense for their settings, the residents or clients receiving support, and for the staff who work there. As a result, details vary, but new practices are more likely to become integrated into operation of the organization. A DVD on transforming dining practices recently produced in Oregon provides an example. Four facilities radically changed dining practices, but all did it differently, including family style, buffet, and 2 different restaurant-style approaches.

Although exciting and rewarding, the process of culture change is not easy, even when organizations are committed to making these changes. Long-term care has many challenges, most associated with limited resources of time, staff, and funding. We would like more investment in the organizations that are working toward person-directed care practice changes. An example is a partnership between Oregon's Seniors & People with Disabilities and 12 nursing homes using civil penalties funds. We would like a formal certification program that recognizes those organizations that meet specific benchmarks reflecting person-directed care practices. The magnet program managed by the American Nurses Credentialing Center and

North Carolina's NOVA program provide models. The ability to implement and grow person-directed care practices depends on a strong and stable workforce. I echo the recommendations provided by Robyn Stone, John Rowe, and others to this committee last April on "Impending Shortages of Health Professionals." Education of the workforce needs to emphasize person-directed care principles. The trade associations in Oregon prominently feature culture change at their annual conventions. The ECLEPs project educating nursing students, and Better Jobs Better Care and the Jobs to Careers initiatives for direct care workers are other examples as is development of universal workers that allows flexibility in staffing. Most regulations governing long-term care do not contradict person-directed care practices; however, review mechanisms are needed to assure that they support both safety and person-centered care practices. In all of these efforts, we need to continue to clarify what we mean by person-centered or person-directed care and continue to develop ways to define, measure, and sustain these practices. More research can inform us about best practices for implementing culture change activities and determine the extent to which they help the people they are meant to serve. We need to learn directly from residents how well these changes are meeting their own needs, values, and preferences, and the extent to which they feel honored, respected, and part of their communities.

Person-directed care practices continue to evolve in Oregon. I will leave you with a Philosophy Statement that has been adopted by key stakeholders, including government and provider organizations, and information about several ongoing person-directed care initiatives. All involve statewide coalitions composed of multiple partners. Again, thank you for this opportunity to share our experiences and our hopes to transform long-term care.

Domains of Person-Directed Care

Developed for the Oregon Better Jobs Better Care Demonstration Project

Person-Directed Care is a philosophy of care that requires thinking about and planning with and for people who require assistance in their daily lives and providing that assistance in such a way that the person is honored and valued and is not lost in the tasks of caregiving. The emphasis of care is on well-being and quality of life as defined by the person. Six domains comprise person-directed care; 5 address care and support issues directly and the sixth addresses systems needed to support person-directed care

1. Personhood. Each person has inherent value, and is therefore worthy of respect and honor regardless of disease or disability. Care centers on the individual (in contrast to the provider or caregiver) through a) consideration of strengths, abilities, possibilities, and the social contributions of the person in the present; and b) sensitivity to the person's perspective about his/her care experiences and meanings the person has constructed about his/her situation.

2. Knowing the Person. Each person is unique with his/her own life story, cultural experiences, personality, and pattern of daily living—or daily habits, values, needs, preferences. Knowing the person includes knowing what is important to that person. Care involves supporting continuity between who the person has been and who the person is now by providing care in a manner consistent with that person's biography. Knowing the person is essential to understanding the meaning of behavioral symptoms in persons with dementia or other cognitive impairment.

3. Autonomy/choice. Care is supportive of personal or mastery; it assumes that independence enhances competence. Care emphasizes a balance between freedom and choice on the one hand with safety on the other. The right of individuals to take risks and, in some case, to make poor decisions is emphasized. With PCC, individuals have maximum control over their own care and environments.

4. Comfort. Physical and emotional care needs are attended to using highest standards of practice (e.g., pain control, alternatives to restraints, appropriate medications, exercise, bathing, dressing, eating, toileting, skin care, wheelchair seating, appropriate touch).

5. Relating to others. Each person lives and function within a web of relationships: (e.g., person-family, person-care provider, person-family-provider, person-peer, person- external community, care provider-supervisor). Intentional relationships between care providers and the person (and family) emphasize and promote communication, consistency, trust, attachment, friendship, and partnership, and minimize isolation and conflict.

Supportive Environment. The ability to provide PDC is dependent upon characteristics of the system in which care is provided. These include the resident's environment (e.g., personalized living space, interesting activities, pleasurable places that are accessible, privacy) and the organizational environment. Organizational environment includes support for staff to work with residents (e.g., adequate information, advocacy role, problem solving, policies and procedures that support worker autonomy). It also involves structural characteristics such as staffing, workload, training, supervisory support, and teamwork.

White, D. L., Newton-Curtis, L., & Lyons, K. S. (2008). Development and initial testing of a measure of person-directed care. *The Gerontologist*.

BJBC Policy Goal: Better interpretation of Oregon Revised Statutes regarding Seniors and People with Disabilities ORS 410.020

Oregon citizens can be justifiably proud of the system of care that has developed over the past twenty-five years. The number of community based care choices, and the availability of home care, hospice and other services have been at the forefront of national efforts to develop a diversified system. However, recent fiscal challenges have slowed system development efforts and the state now faces the looming challenges of a growing population of elders and disabled citizens and an environment of limited resources. To continue to improve the system of care and the ability of that system to recruit and retain front line workers, a coalition of 19 organizations sought and received funding as a Better Jobs Better Care (BJBC) demonstration project from the Robert Wood Johnson Foundation, Atlantic Philanthropies, and the Northwest Health Foundation. BJBC has focused significantly upon policy development to continue to promote Oregon's system development and to promote the culture change to a person-centered care model which has emerged as a key underpinning of the project's efforts.

The language of Oregon Revised Statutes focused on interpreting state policy may be interpreted as supportive to the philosophy of person-centered care and with the values of independence and personal responsibility (e.g. 410.020 Section 2. "Assure that older citizens and disabled citizens retain the right of free choice in planning and managing their lives... maximize self care and independent living within the mainstream of life." Section 10. "Involve older citizens and disabled citizens in the decision making process for programs affecting their lives." Section 16. "Recognize that older citizens who retire should be able to do so in honor and dignity.") However, the state policy for seniors and persons with disability as enacted in Oregon Revised Statutes, while not inconsistent with the culture change now occurring in long-term care, does not speak directly to some important concepts.

The opportunity now exists to better interpret state statutes to reflect this culture change of person-centered services and personal responsibility. Oregon's Department of Human Resources has assembled a Task Force on Long-Term Care, which is a public policy forum endorsed by the Governor, to examine and recommend system change. The BJBC coalition believes that the goal of a fully-integrated long-term care system in the future should be the product of a public-private partnership and should reflect person-centered care and personal responsibility. If this common goal can be agreed upon by the members of the Task Force and the public and private partners in the BJBC coalition, it can lead to statutory and administrative rule changes that promote person-centered services. The development of workforce competencies related to person-centered care will also be crucial to this policy change.

Definitions

A fully developed system of care is a continuum of services including: family education and support; case management; personal capacity building; in-home care; community based care services (day services, foster care, residential care, assisted living); intermediate and skilled nursing.

Person-Centered Care (PCC). PCC is a philosophy recognizing the inherent value of each individual and is focused on supporting strengths and abilities; capacity for social

contribution; unique values, preferences and living habits; and autonomy and choice. Quality is measured in terms of both physical and emotional care. PCC recognizes that quality of care is built on healthy relationships and strives to create systems that support relationships between care receivers and direct care workers. It requires an intentional approach of relationship building between people giving and receiving services and recognizing the importance of direct care workers to these relationships. It requires organizational commitment to the adaptation of treatment plans, organizational protocols, and policies and practices to enhance relationship and autonomy so that decision making can occur to meet individual needs and goals. It necessitates the adaptation of both living and treatment environments and staff orientation and training.

Person-Directed Care (PDC). A philosophy of PDC strives to implement and support the choices that the person being assisted makes and to keep all decision-making as close to them as possible. It recognizes that some individuals lack the physical or cognitive abilities to tell us with words what their wishes are, but that within their past choices and present behaviors lies the key to what will most honor their current wishes. In these cases, those who work with them on a daily basis (the family or other direct caregivers) need to have the ability to adapt routines to fit their expressed and implied wishes. It recognizes the inherent value of each individual focused on supporting their strengths and abilities, capacity for social contribution, unique values, preferences and living habits, promoting autonomy and choice.

Promotion of Personal Responsibility – Helping people to maximize their knowledge, skills and abilities in order to foster independent lives and decision making ability; bolstering support systems which promote the capacity to continue to operate with as much autonomy and self sufficiency as possible.

Public Private Partnership – A philosophy of collaboration of governmental, private for profit and not for profit providers of service, foundations, philanthropists, advocates and faith based organizations to develop resources, programs and facilities to achieve agreed upon social goals.

Policy Proposal

The BJBC coalition recommends that the state and its partners *develop and sustain a private public partnership to fully develop a system of care with an emphasis on person centered and person directed care and services and promotion of personal responsibility.*

To implement the proposed partnership DHS should include person centered care and workforce development in current planning efforts regarding the Future of Long Term Care in Oregon. DHS should collaborate with private providers, long term care workers, advocates, consumers, philanthropic and faith based organizations to develop and promote common goals for person-centered care, person-directed care, personal responsibility and capabilities, and family support. Collaborative efforts should focus on workforce development and training.

Partnerships should be strengthened and this statement endorsed through other organizations such as Acumentra Health, MOVE, the Oregon Alliance for Senior and Health Services, Oregon

Health Care Association, AARP, Home Care Commission, colleges and universities, and labor unions.

Roles

While all partners shall seek to develop and mutually fund innovative services to fully develop the continuum of care, specific roles for public and private sector partners merits clarification.

Public Sector:

- Develop and implement regulatory standards reflecting PCC and PDC values.
- Develop policies balancing health and safety concerns within a context promoting personal responsibility, independence and individual choice.
- Allocate resources to support staff training and development regarding PCC and PDC.
- Allocate resources to fund concrete services to assist elders and disabled Oregonians to remain autonomous.

Private Sector:

- Develop the continuum of housing options, services and care system for elders and disabled Oregonians within the PCC and PDC standards.
- Develop proactive strengths based early intervention and support services that foster elder and disabled friendly communities and promote PCC and PDC goals.
- Implement workforce development strategies and programs to assure competency in delivering PCC and PDC services.
- Provision of health promotion, planning assistance, education and fitness services to clients to support the goals of individual planning and personal responsibility.
- Solicitation of private philanthropy and resources to further the implementation of the continuum of care and PCC and PDC innovations.

Educational Sector:

- Conduct research to establish evidence-based best practices consistent with PCC and PDC goals in long-term care.
- Facilitate translation of research into practice.
- Educate and train the long-term care workforce.
- Incorporate PCC and PDC concepts into educational curricula.

Philanthropy, Advocates, Consumers and Faith Based Community:

- Active participation in planning and development of PCC and PDC service innovations and service development that fosters personal responsibility.
- Financial participation in program and project development.
- Participation in qualitative assessment of efforts to implement system improvements.

Labor:

- Promote education and implementation of programs promoting PCC and PDC standards and workforce issues for individuals represented by organized labor.

Culture Change & Person-Directed Care Initiatives in Oregon

1. **M.O.V.E.** stands for *Making Oregon Vital for Elders*, and is a network of organizations and individuals committed to facilitating and supporting culture change in long-term care. Members are dedicated to reexamining current practices and policies in health care delivery regardless of setting and assuring a person-directed, value-based system. M.O.V.E. holds quarterly educational meetings featuring leaders in the culture change movement from all over the country. MOVE also develops resources to support organizations on their culture change. An example is a DVD, “Transforming Your Dining Services,” that features four facilities that have successfully implemented four different types of person-centered dining practices, developing the programs to meet the needs and preferences of the residents served. For more information, www.orculturechange.org
2. **CCMU Culture Change Teams.** The State Unit on Aging (i.e., Seniors and People with Disabilities) has developed partnerships with 12 nursing homes. Using civil penalty funds, each nursing home established a culture change team that includes direct care workers. A state surveyor, who does not have responsibility for surveying that particular facility, is an outside team member. The surveyors are resource persons for the facility. They can emphasize that the survey requirements are consistent with person-directed care, debunk myths about what can’t be done, and offer suggestions for how to accomplish what the team wants to accomplish for residents within the regulatory requirements. Through this process, surveyors are also learning about person-directed care and sharing that information with their colleagues. A geriatric nurse practitioner, who is a leader in person-directed care practice has been contracted with by the State to provide coaching and consultation to these 12 teams.

- 3. Nursing Home Collaborative.** The Hartford Center of Geriatric Nursing Excellence at Oregon Health & Science University is one of 5 Hartford Centers participating in the Collaborative to address quality care for frail older adults in nursing homes. Funded by the Atlantic Philanthropies, nurse leaders in geriatric nursing are working together to find a research-based professional nursing practice model that can be widely implemented and translated to a national standard. The Hartford Centers are building on existing relationships; in Oregon this includes MOVE.
- 4. Enriched Clinical Learning Environments through Partnerships in Long-Term Care (ECLEPs).** This project builds capacity for long-term care (LTC) facilities to be excellent clinical learning sites for nursing students in the Oregon Consortium for Nursing Education (OCNE). Through community-academic partnerships, this model training and support program provides LTC staffs with essential knowledge and skills to enhance their practice setting and support students' learning. This project is developing four enriched LTC clinical education sites for nursing students, including nursing facilities and assisted living. The program will be available for replication by other schools and LTC facilities throughout Oregon and the Northwest. This project is funded by the Northwest Health Foundation (NWHF).
- 5. Jobs to Careers,** is a work-based learning project targeting direct care workers in assisted living settings. The grantee is Portland Community College and funding comes from the Robert Wood Johnson Foundation. This project is governed by multiple partners. Five assisted living facilities are participating. Trainers have been trained and are teaching incumbent and new workers 26 modules that will help workers meet occupational competencies to be residential care assistants. Person-centered care

practices have been built into the modules and stressed at train-the-trainer sessions. Completion of all modules will result in college credits and opportunities for career advancement.

6. **Leading Edge** was a partnership led by Oregon's Quality Improvement Organization for the CMS 8th Scope of Work which included person-centered care initiatives. Tools to assist nursing homes map their person-centered care journey were developed through that project (see <http://www.acumentra.org/healthcare-settings/nursing-homes/index.htm>).
7. **Advancing Excellence**. Oregon is participating in this national campaign. To date, the group has focused on training to create person-centered work environments to retain direct care staff, and on improving care transitions between hospitals, home, and nursing facilities to reduce risk and incidence of pressure ulcers. Attached is a summary of the staff retention training teleconference series held last spring.
8. The Oregon Health Care Association, the Oregon Alliance for Senior & Health Services, as well as multiple other professional organizations have sponsored training on person-directed care practices for their members. Attached is a partial list of content covered in their conferences and conventions. Resources also are highlighted in their newsletters.

Senator CASEY. Thank you, Dr. White.

I want to thank our witnesses. We are out of time for the room. We are about 15 minutes over time. But we are grateful that each of you made the trip to be here, that your testimony—if you didn't get to all of it, the full testimony will be made part of the record.

But we are grateful for your leadership. We all have to run, but we are certainly grateful that you are here today.

Thank you very much.

[Whereupon, at 12:50 p.m., the hearing was adjourned.]

US Senate Special Committee on Aging Hearing July 23, 2008
Reforms to Establish Person-Centered Care for Older Citizens

Testimony submitted by Assisted Living Federation of America (www.alfa.org)

Mr. Chairman,

My name is Richard Grimes, the President and CEO of the Assisted Living Federation of America (www.alfa.org). Thank you for giving me the opportunity to submit testimony on the need and value of person-centered long term care for American seniors.

Assisted living is, by definition, a person-centered (resident-centered) alternative to institutional care. Assisted living is home for almost one million seniors in 38,000 assisted living communities. These residents are frail seniors who need some assistance with activities of daily living and can no longer (or choose not to) live in their family home—but do not need 24/7 nursing care. Assisted living is a *philosophy of care* that embraces choice, independence and the opportunity for seniors to live enriching lives with dignity, respect and privacy. It is for these reasons that assisted living is the fastest growing long term care option in the United States.

Because assisted living is resident-centered, it supports the *resident's* decision on how and where a person should live. The communities are as varied as the lifestyle choices of our residents. They range from high rise urban communities to bucolic country settings with lush gardens and pleasant fishing ponds. Consumer surveys, including those conducted by state regulatory agencies, repeatedly show an astonishing satisfaction rate of more than 90 percent. *We are convinced that our success is linked to our resident-or person-centered focus on consumer need and preferences.*

Aging in America has changed. Thanks to advances in pharmacology and health care and the benefits of our affluent society, people are living longer than they ever imagined. The US Census bureau reports that the fastest growing demographic in our nation are the very old. Seniors are not only living decades longer than their parents and grandparents but

they are healthier and more active. Study after study show that older Americans want to remain in their communities as they age and stay near friends, family and the familiar. Virtually no one wants to go into an institutionalized setting.

The typical assisted living resident is an 85-year old widow who needs some help with the activities of daily life, such as bathing or dressing. She likely takes almost as many medications as a nursing home resident but her medications enable her to manage chronic health conditions and live in her own room or apartment in an assisted living community. The community provides her meals and a variety of social and recreational activities from card games to book clubs. A van takes her to her doctor's office, to local entertainment events, and to the local mall for shopping trips. She lives surrounded by caring staff and friends and maintains control over her own life, deciding when to go to bed, when to get up, when to bathe and when to eat.

Frail seniors living alone at home often do not eat well or otherwise take care of themselves. Home care is a viable option for those who can afford it. But many seniors in need of care become depressed and isolated because of restricted mobility. Although many assisted living residents are reluctant to leave the family home for an assisted living community, our experience shows that the quality of life for frail residents dramatically improves after they move into an assisted living community. Sadly, the fear of institutional forms of care and ignorance about assisted living as a life-enriching alternative often intersect to immobilize frail seniors with sometimes tragic consequences.

While the long term care industry is no longer monolithic and nursing homes are not the only option, there is an understandable institutional bias against home and community based settings such as assisted living in government funded programs. That is because Medicaid and Medicare, the twin safety net programs for the poor and aging, were created by Congress long before the private assisted living industry existed in the United States. Assisted living is not looking for government funding but we are concerned about the ability of all Americans to afford the care they need and to have the means to choose

the type of care they want. With the population aging, this poses significant public policy questions for your committee.

Assisted living has proven to be cost effective. Assisted living costs half as much as nursing home care and is often a more appropriate choice for a senior who might need some help with the activities of daily life but not round the clock nursing care. States, always the incubators of innovation, are showing the way in this respect. AARP recently conducted a study that reported a disproportionate amount of Medicaid long term care dollars go to nursing homes, some 75 percent. However, it also showed that spending on home and community-based services, which includes assisted living, is increasing at a faster rate than Medicaid spending for nursing homes. In other words powered by consumer preference, the trend is away from institutionalized care and towards the more resident-focused options.

Nursing homes will always play an important role in meeting long term care needs for many. The Green House model is an excellent example of a type of person-centered care that has proven to be a successful alternative to the traditional nursing home model. However, nursing homes are not the right answer for all Americans. We look forward to working with the Committee on continuing to expand long term care options and help ensure all Americans receive the services they need in the places they choose to call home.

The Assisted Living Federation of American is the largest national association serving companies operating professionally managed assisted living communities for seniors. ALFA is the voice for senior living and advocates for informed choice, quality care and accessibility for all Americans needing assistance with long term care. For more information visit www.alfa.org.



STATEMENT FOR THE RECORD
SUBMITTED TO THE
SENATE SPECIAL AGING COMMITTEE

ON

PERSON-CENTERED CARE: REFORMING SERVICES AND
BRINGING OLDER CITIZENS BACK TO THE HEART OF SOCIETY

July 23, 2008

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AARP commends the Committee for holding this important hearing on person-centered care. As the Congress begins to seriously consider reforming our nation's health care system, we have an opportunity to also change the way in which health and long-term services and supports are delivered. We must move away from a system that often doesn't recognize the wide ranging needs of the individual to one that makes the individual the center of care across the continuum.

In our current health care system, a patient's care is often delivered by multiple providers who are often not linked in any way. The patient often has little or no direct involvement in their own care decisions, errors can occur, and the outcomes can often be poor. In a patient-centered system, care silos are eliminated, providers coordinate and communicate, and individuals are active partners in the decisions about their health care. As a result, patient outcomes and quality improve and the delivery system as a whole becomes more efficient.

In fact, the recent report from the Institute of Medicine, ***Retooling for an Aging America: Building the Health Care Work Force***, finds that care needs to be patient-centered and that the use of interdisciplinary team care; care management; chronic disease self-management programs; pharmaceutical management; caregiver education and support; preventive home visits; proactive rehabilitation; and transitional care are common features of care models that

show the most evidence of success in improving care quality, health-related outcomes or efficiency.

Medical Home

One model of person-centered care worth exploring further is the medical home model. A medical home enables an individual to voluntarily select a clinician or clinical practice to assume responsibility for coordinating, integrating, and enhancing access to needed services, including self-management. Care is facilitated by health information technology (HIT), registries, and information exchange with providers in all settings.

The medical home model has the potential to improve the quality of care and care coordination, increase access to care, improve payments for primary care and care coordination, and possibly reduce costs in the long run. Results from a 2006 Commonwealth Fund survey of 2,800 American adults showed that uninsured and/or underserved patients, including minorities, who have a health care or medical home, where a regular physician or health care professional oversees and coordinates their care and to whom a patient has relatively easy access, are better able to manage chronic medical conditions and obtain important preventive and maintenance care, thus promoting greater health care equity and improving the quality of care received. Because patient-centered medical homes focus on wellness and prevention, they allow providers to

address health issues before they become too serious and, therefore, can reduce health care costs.

Most proponents view the medical home as a primary provider who is selected by patients to serve as their predominant source of routine care and to work with them to manage their care from various other providers, assure that they receive appropriate preventive measures, and facilitate appropriate care across settings. The primary provider is often the patient's primary care physician or non-physician practitioner, such as a nurse practitioner. In some cases, the primary provider may be a specialist for patients with known chronic conditions, such as an oncologist for a cancer patient. Medical home models are often based on an interdisciplinary team approach including a variety of supporting professionals such as a nurse, pharmacist, therapist, nutritionist, medical social worker, and medical assistant, depending on the needs of the patient.

Attributes of the medical home model include:

- voluntary patient selection of a primary provider or medical practice;
- ease of patient access and communication, including during non-business hours;
- periodic assessment of a patient's clinical needs based on evidence-based protocols when available, and assessment of social and support needs and resources of both patient and family caregivers, as needed;

- care management, often employing an interdisciplinary team approach, especially for patients with multiple chronic conditions;
- education and training for patients and their family caregivers in support of patient self-management;
- capacity to use data to identify patients with specified conditions and risk factors, compile patient registries, track referrals and test results, and follow-up with other providers, including community resources. Preferred approaches rely on HIT, such as interoperable electronic medical records and electronic prescribing; and
- capacity to collect necessary data to report standardized performance measures on cost and quality of care.

Medical home models are also testing a number of different payment arrangements to help compensate providers for the time and resources associated with serving as a medical home.

AARP supports rapid testing, expansion and adoption of medical home models that promise to be effective for improving care of patients, particularly those with chronic conditions. AARP supports changes in Medicare coverage and reimbursement to facilitate adoption of medical home models. We are pleased that the recently enacted Medicare Improvements for Patients and Providers Act (P.L. 110-275) allows the Secretary of Health and Human Services to expand the Medicare Medical Home Demonstration Project and provides additional

resources for the demonstration project. AARP is also pleased to be a member of the Patient-Centered Primary Care Collaborative, a broad group of stakeholders that includes medical professionals, consumers, employers, and payers that support the concept of a Patient-Centered Medical Home.

Many states are embracing the medical home model. According to a recent article in the *New York Times*, there are pilot projects testing this model involving about two million patients in approximately six states. Some states, including North Carolina, have reported reduced costs through a medical home project. Other states, such as Pennsylvania, are embarking on a medical home pilot program in one geographic area and expanding to other parts of the state. Several states, including Florida, Minnesota, New Hampshire, New York, Oklahoma, Oregon, Utah and Washington are embracing the medical home concept through recently enacted legislation and executive action.

Patient Care Transitions

Person-centered care bridges across the lifespan. Individuals need different types of services and care and receive them in different settings. As individuals move between different settings, such as home to hospital and hospital to home or skilled nursing facility, these care transitions are critical and require coordination between individuals, family, and providers across all settings – a relationship-centered approach. Gaps in care can often occur during these

transitions when continuity of care and communication are vital, especially for those with multiple chronic conditions. Lack of coordination and/or communication could lead to duplicative or unnecessary services; unnecessary hospitalization; incorrect use of medications; inadequate care; or other adverse events. These are the types of problems that occur when care is not relationship-centered.

Smooth transitions require a number of important steps. Providers across settings must communicate and share information about the individual beyond their traditional silos whether it is medical history, functional ability, treatments, medications, or adverse reactions. HIT and interoperable electronic medical records could help improve the flow of information and communication among providers. HIT could also help enable smoother transitions back home through the use of telemedicine, health monitoring technologies, or assistive technologies. An assessment and care plan for the individual is another critical step, as is an assessment of the needs of a family caregiver and the provision of needed supports. Preparation by providers prior to a care transition and education and training of individuals and their family caregivers, as well as follow-up after a transition, is also vital to help ensure a smooth transition for the individual.

Smoother and successful care transitions rely on a relationship-centered model and the features that the IoM identified for successful care models. Individuals

receiving services must communicate and share information with providers to help ensure continuity of care and take an active role in managing their health. Especially for individuals with multiple chronic conditions, family caregivers can play a crucial role in the coordination of care for their loved ones. Family caregivers interact with physicians, nurses, social workers, and direct care workers in hospitals, home health, nursing home, and other settings, providing continuity of care and essential information to both care recipients and the various providers. Given such a role, family caregivers need to be integrated as full partners into the care team.

AARP is pleased to be participating in a Transitions of Care Workgroup to assist the American Medical Directors Association in their development of a clinical practice guideline on Transitions of Care in the Long-Term Care Setting. Once completed, this guideline should be a useful resource to help improve transitions of care. Smooth transitions and coordination among providers, individuals and their caregivers are an important part of person-centered or relationship-centered care.

Person-Centered Care Influencing the Delivery of Long-Term Care

Person-centered care is influencing the provision of long-term services and supports (LTSS) in part through culture change -- transforming nursing homes into a more desirable long-term care option by:

- promoting greater consumer choice and control regarding the services residents receive,
- offering private rooms and apartments,
- improving wages and working conditions for direct-care staff, and
- using advanced technology to improve services and minimize injuries to residents and staff.

A growing number of facilities are embracing culture-change efforts to transform the settings into more pleasant places for residents and direct-care staff. A recent Commonwealth Fund report found that most nursing home facilities were aware of the culture change movement¹. The study found that residents in nursing facilities that adopted principles of culture change were more likely to be involved in decisions that impacted their facilities. Nursing homes that adopted the principles of culture change were more likely to experience higher occupancy rates and improved staff retention, giving them a better competitive position in the marketplace.

Green House Model

One example of culture change and the creation of a specific person-centered approach is The Green House ® model. The goal of the Green House Project is

¹ Doty, M., Koren, M. and Sturla, E., Culture Change in Nursing Homes: How Far Have We Come? Findings From The Commonwealth Fund National Survey of Nursing Homes, The Commonwealth Fund, May 2008

to transform nursing homes from institutions into small, home-like settings with private rooms and private bathrooms, with an emphasis on resident-centered care and staff empowerment. This national program has been funded by the Robert Wood Johnson Foundation to replicate small cottages providing skilled nursing and assisted living services throughout the country.

As the program describes it, "Green House® homes are residences for 6 to 10 elders who require skilled nursing care and want to live a rich life. They are a radical departure from traditional skilled nursing homes and assisted-living facilities, altering size, design, and organization to create a warm community. Their innovative architecture and services offer privacy, autonomy, support, enjoyment and a place to call home." Similar to the results from the Commonwealth study, early research on this model finds that Green Houses achieve clinical outcomes that are at least as good as traditional nursing homes while consumer satisfaction and quality of life is much higher and staff turnover rates are much lower².

AARP supports policies that will encourage and provide incentives for new, affordable models of long-term services and supports (LTSS) that emphasize resident-centered care, a home-like environment, a positive workplace culture, and opportunities for resident and family involvement in the community.

² R. A. Kane, T. Y. Lum, L. J. Cutler et al., Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program, *Journal of the American Geriatrics Society*, June 2007 55(6):832–39

Providers with existing facilities that need renovations to create private baths, kitchenettes and other improvements should have incentives for making such changes.

For example, AARP Arkansas was instrumental in the passage of legislation that allows the use of funds to create programs supporting Green House Projects or Eden Alternative Programs. AARP Wyoming was also instrumental in the passage of legislation to create an “alternative elder care home” category and a feasibility grant to fund the development of three Alternative Elder Care Homes – fully detached houses for no more than 10 residents providing the highest level of care permitted under Wyoming’s applicable health care facility rules.

Conclusion

Person-centered care across all settings improves the quality of care and quality of life for older adults. These are important elements for consideration as Congress contemplates improvements to health care, chronic care, and long-term services and supports. AARP looks forward to working with members of the Senate and House on both sides of the aisle to advance the concept of relationship-centered care across the care continuum.