Long Term Care Commission

Testimony of The Honorable

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Independent Living Systems, LLC

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Independent Living Systems

- Assists Health Plans in administering Managed Long Term Care (Capitated) Programs
- Administers Member Centric Model of Care for Medicare and Medicaid Special Needs Plans
- Provides hospitals and Community Based Organizations (CBOs) with Care Transitions models such as Community-based Care Transition Programs (CCTPs) and others
- Provides nutrition for members with chronic conditions after discharge

LTC key success factors

- Break down silos: align financial incentives-global budgeting, capitation, integrated payment for duals.
- Facilitate partnerships among traditional providers, agencies and health plans.
- Incorporate strong social component in care coordination.
- Enhance participant engagement and empowerment throughout the system.
- Promote new facility and housing models for reducing hospitalizations. For example, nursing homes need to evolve to include Skilled Nursing/Assisted Living Facility hybrids, adult day care, respite, etc.
- Develop new payment models such as bundled payments, ISNPs, etc.
- Identify the appropriate quality of care measures for combined models of care.

Partnerships with Health Plans

Health Plans

- Managed care experience
- Capital to build programs and fund reserves
- Information Technology and analytics
- Ability to create new payment mechanisms and align financial incentives
- Principally experienced with acute care
- Not well understood by participants

Traditional Providers and Agencies

- Experience with aged, blind and disabled populations
- Better understanding of social factors and needs
- Ability to bring other community resources and funding
- Presence in low income communities with “feet on the ground”
- Established trust with special populations

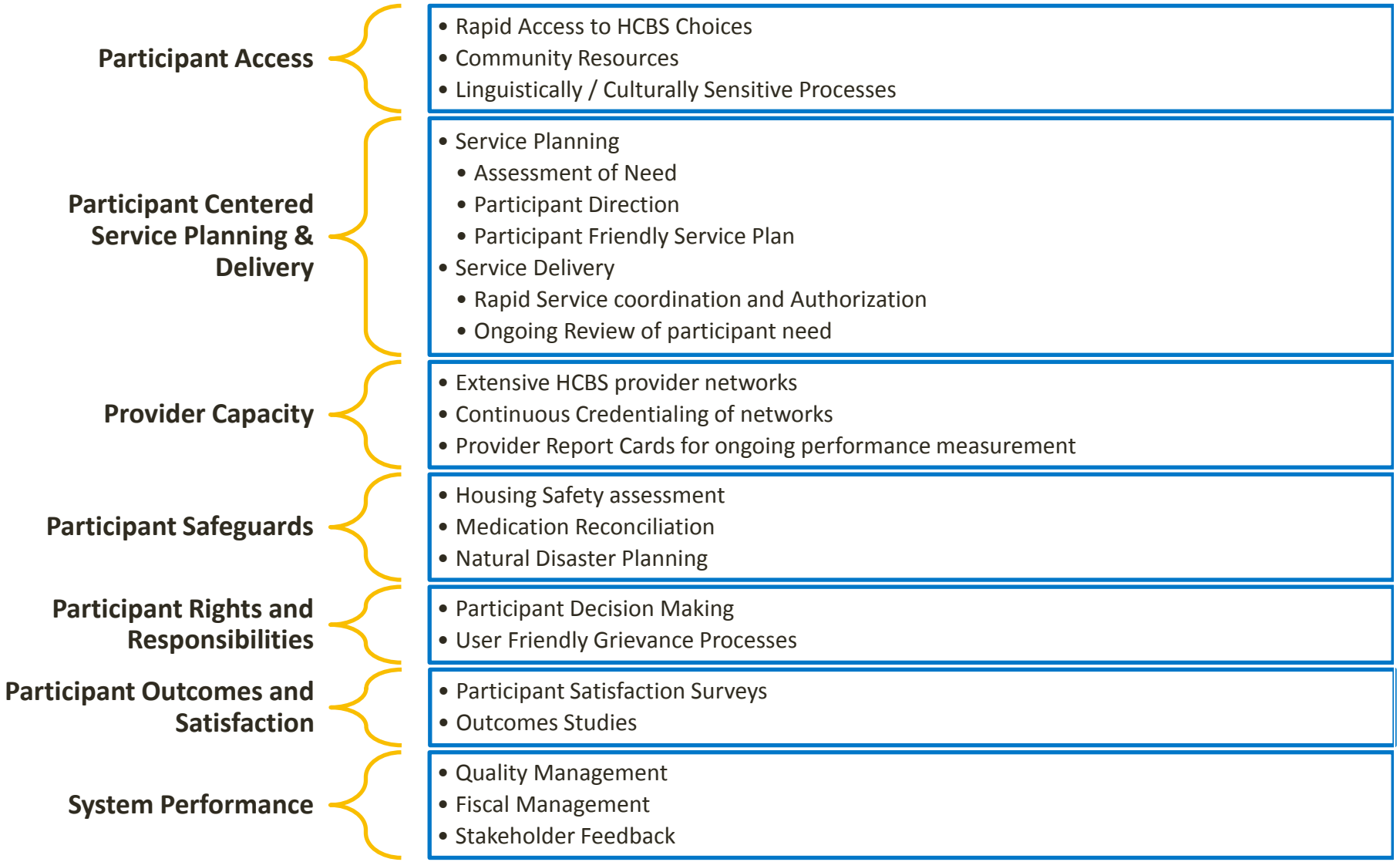
Social factors

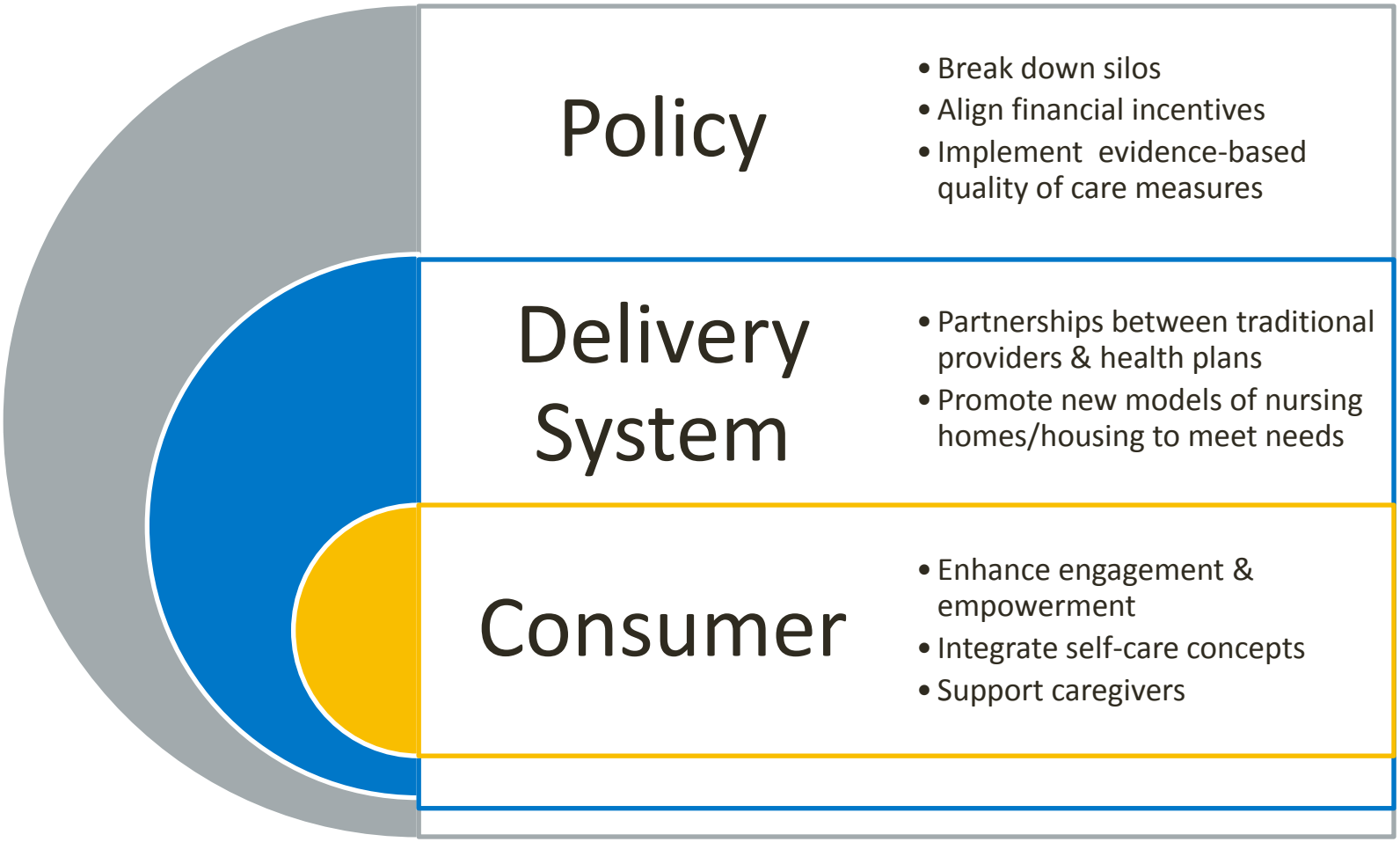
- Functional capability (Activities of Daily Living/ADLs)
- Presence/role of caregiver
- Income and financial resources
- Housing
- Transportation
- Access to Medical Home
- Ethnic/cultural influences
- Need comprehensive assessment
- Individualized plan of care
- Personal case manager and care coordination
- Special consideration for persons at highest risk
- LTC point of entry in community

Participant/Family Engagement

- Self reported conditions during assessment
- Understanding and participation in plan of care
- Assignment to medical home with regular primary care visits
- Care coordination telephonic follow up
- Access to disease and multiple chronic conditions management
- Nutrition management, nutrition assessment, home delivered meals & supplements
- Medication management
- Participant directed care options

Quality Outcomes




Policy
• Break down silos
• Align financial incentives
• Implement evidence-based quality of care measures
Delivery System
• Partnerships between traditional providers & health plans
• Promote new models of nursing homes/housing to meet needs
Consumer
• Enhance engagement & empowerment
• Integrate self-care concepts
• Support caregivers

THANK YOU

Josefina Carbonell

Served as Assistant Secretary for Aging 2001-2009 at the U.S. Department of Health & Human Services, Administration on Aging

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