Approved: March 19, 2009
Date

MINUTES OF THE HOUSE AGING AND LONG TERM CARE COMMITTEE

The meeting was called to order by Chairman Bob Bethell at 3:30 p.m. on March 17, 2009, in Room 711 of the Docking State Office Building.

All members were present.

Committee staff present:
Norm Furse, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Judith Holliday, Committee Assistant

Conferees appearing before the Committee:
Michael Strouse, Ph.D., CEO, Community Living Opportunities, Lawrence
Monte Coffman, Executive Director, Windsor Place, Coffeyville
Tom Akins, Vice President, Development and Planning, Brewster Place, Topeka
Bill McDaniel, Commissioner, Program and Policy, Kansas Department on Aging

Others attending:
See attached list.

Chairman Bethell brought the minutes of the March 10 and March 12 meeting before the Committee. Representative O'Brien made a motion to approve the minutes, seconded by Representative Furtado. The motion carried.

Chairman Bethell brought bills previously heard before the Committee for action:

HB 2310 - Long-term care partnership program; exchange of policies.
Representative Myers made a motion to pass **HB 2310** favorably and asked to be put on the consent calendar. Representative Hill seconded the motion. The motion carried.

HB 2366 - All-inclusive care for the elderly (PACE) program.
Representative Donohoe made a motion to pass **HB 2366** favorably and asked to be put on the consent calendar. Representative Horst seconded the motion. The motion carried.

HB 2323 - Adult care homes, home health agencies; employees; criminal history information.
Chairman Bethell asked Revisor Staff to explain the balloon amendment, which essentially changed the title of the bill from "adult care home and home health agencies" to "providers of care services; relating to employment of persons by such providers."

Representative Hill made a motion to adopt the amendment and pass it favorably. Representative Williams seconded the motion. The motion carried.

Representative Hill made a motion to pass **HB 2323** as amended. Representative Williams seconded the motion. The motion carried.

Michael Strouse, Ph.D., CEO, Community Living Opportunities (CLO), appeared before the Committee on the issue of telehealth and telemedicine. (Attachment 1) Mr. Strouse reported advances in CLO's "HomeLink" remote support program, which brings remote monitoring from a central location center 'on demand' into homes of persons with disabilities.

CLO is seeking grants to prepare the HomeLink program for use on a fee-for-service basis to provide support for people in home settings and, over a period of time, possibly in nursing facilities. The type of monitoring is based on predetermined agreements, including responding to help requests and alarms in the home, constant live viewing and supervision, evacuations in disasters, and contacting 911 to dispatch emergency help. Motion detectors, sound detectors, pressure sensors, door sensors and glass breaking sensors can also be activated to monitor individuals. HomeLink can also monitor without intrusion to observe behaviors, download to a

DVD, and share in a clinical setting to determine the best at-home plan for the individual.

Monte Coffman, Executive Director, Windsor Place, Coffeyville, appeared before the Committee on the issue of telehealth. (Attachment 2) Mr. Coffman's handout compared Kansas Medicaid Long-Term Care services in nursing facilities with Home and Community Based Services (HCBS). Medical clinical care is the one component missing from HCBS. Telehealth would fill this need and allow seniors to stay in their homes longer.

Mr. Coffman told the Committee the measurement technologies for telehealth application are centered around a small 'TeleStation' which asks the patient simple health questions, with the responses communicated to the clinical software. These questions are on blood pressure and pulse; glucose (blood sugar); pulse oximeter, which spot checks oxygen saturation and pulse within seconds; ECG/Rhythm wristband with snap-on connectors; and a low-step scale with a wide platform, large digital display and voice announcement for weight reading. Other readings can be added manually or through wireless transmission if programmed.

The TeleStation will transmit the readings it receives from each device via a toll-free number and send to a secure, password-protected website so the telehealth nurse can see them, usually within 15-20 minutes after the first measurement is taken. Family members can also access this website in order to keep informed of their family member's health.

The four primary reasons seniors have to leave their homes are diabetes, congestive obstructive pulmonary disease (COPD), congestive heart disease, and hypertension.

The cost savings opportunities to the State's Medicaid programs would amount to approximately $12 million annually if 500 Kansas elders could be deferred from nursing facility placement and receive telehealth through HCBS. If 500 Physically Disabled consumers could be averted from nursing facilities, the savings would be $8.7 million or more.

Tom Akins, Vice President of Development and Planning, Brewster Place, appeared before the Committee supporting telehealth. (Attachment 3) Brewster Place developed a new concept in November 2009 called Brewster at Home. This membership-based program provides a 'passport' to Brewster Place activities, trips, programs, and discounts for handyman services, home health, nutrition, housekeeping, meals, move management, computer training, and much more. The most important service is the telemonitoring service, which includes:

- Sensors that detect and notify the care giver if a person is potentially unsafe, i.e., has fallen, did not get out of his chair, or turn off the stove;
- Health technologies that monitor blood pressure, weight, glucose and other conditions in real time which enables notification of care givers immediately of significant changes and reduces the need for doctor visits;
- Medication dispensers that provide medicines when appropriate and remind a person to take them, with immediate notification to the care giver if a dosage is missed.

The telemonitoring services are in keeping with the Kansas Department on Aging's efforts to:

- Support health;
- Support independence;
- Manage chronic disease;
- Minimize visits; and
- Be accessible across care settings.

Valid data is missing to help establish outcomes and demonstrate to taxpayers and insurance companies that a front-end investment in technologies that keep elders safe, independent, and in their own homes will actually save money. At present, marketing for this technology is focused on the private pay market; if you can afford it, you can get it. At present, there is no reimbursement from insurance carriers or the State for these sensors.

Mr. Akins stated that there are partners who are willing to collaborate on projects with the State that will provide this important data so that determinations about the long-term public policy implications of

telemonitoring can be made.

Mr. Akins stated that the State should insist on the following data for any demonstration project it supports:
- Which telemonitoring systems will aid in managing chronic disease?
- Which telemonitoring systems will help our elders remain in their homes?
- What staffing patterns will be necessary to support telemonitoring systems?
- Can the use of telemonitoring systems save money?

A pilot program by the State of Pennsylvania has successfully utilized Medicaid waivers to provide reimbursement for home telemonitoring for adults ages 60 and older under approval from the Centers for Medicare and Medicaid Services (CMS). This initiative includes a telemonitoring reimbursement policy to cover home health, pharmacies, durable medical equipment providers, and hospitals through contracts with local county Area Agencies on Aging. Pennsylvania officials expect this program to alleviate the workforce shortage by increasing the number of persons that can be served through HCBS.

Mr. Akins urged the Committee to seek ways to support demonstration projects such as telemedicine through policy changes and financial support.

Bill McDaniel, Commissioner, Program and Policy, Kansas Department on Aging, appeared before the Committee regarding telemedicine programs. (Attachment 4) Mr. McDaniel stated that for seniors, health care is delivered through the acute care system (hospitals, doctor's offices, emergency rooms), and long-term care (nursing homes, HCBS).

Recent trends in health care have shown an increasing number of providers marketing telehealth and telemedicine products as ways of maintaining independence. While the marketing strategy is aimed at seniors who desire to remain in their homes, this approach is market driven, rather than data driven.

Mr. McDaniel summarized the telemedicine long-term payer options. Medicare pays for some of these monitoring services in hospitals, with some doctors, and in skilled rehabilitation facilities; Medicaid pays a lesser amount for remote monitoring for chronic care management; and long-term care insurance pays a lesser amount for some HCBS services.

Mr. McDaniel told the Committee that more data is needed in the following areas:
- the types of devices that help seniors remain at home;
- which devices help manage chronic disease;
- which devices perform better than others;
- what level of staff is needed to support the technology;
- what savings can be realized; and
- who are the most suitable product users.

Chairman Bethell asked if there were additional comments from the audience. Debra Zehr, President, Kansas Association of Home and Services for the Aging (KAHSA), came forward to address the Committee. (No written testimony) Ms. Zehr told the Committee that there are studies on the national level dealing with telemedicine and directed the Committee to visit the website www.agingtech.org. She commented that there is a bill in Congress providing that costs for telemedicine would be picked up by Medicare, and expressed hope that our Kansas Congressmen would sign onto the bill as cosponsors.

Monte Coffman commented that the CMS would not fund telemedicine programs until there were results of a study of 1,000 or more.

Chairman Bethell told the Committee that they would continue discussions on telemedicine at the next meeting, as well as action on bills previously heard.

The meeting was adjourned at 4:45 p.m. The next meeting is scheduled for March 19, 2009.

HOUSE AGING & LONG TERM CARE COMMITTEE

DATE: 3/17/09

NAME	REPRESENTING
Jim Beckwith	KCAP
Tom Higgins	Brewster Place
Monte Dyer	Windsor Place
Charles Smith	Wesley Plaza
Larry & Jean Bowman	Observer
Bill McDaniel	KDOA
Nicki Norden	Capitol Strategies
Deb Merrill	KHPA
Barb Conant	KDOA
Chad Austin	KHA

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March 17, 200_

CLO's HomeLink Technologies

...Technology that is virtually here today

Chairman Bethell and members of the Committee, thank you for the opportunity to testify today about our technology efforts at CLO.

Breakthrough Technologies... Most improvements in service quality are measured in degrees or inches. Advances come in bits and fits fueled by hard work across time. Every few decades, though, something happens so amazing it creates a whole new way of doing things.

This is exactly the case with CLO's "HomeLink" remote support program. CLO's remote monitoring and support program is a major breakthrough in support technology that has been created to bring "on demand" support directly into the homes of persons with disabilities to maximize or preserve their independence.

Imagine:

- Knowing when people in a home or apartment need support during the day or at night and providing that support on demand;
- Remotely supervising up-at-night staff across town, across a region, or from Kansas to California to make sure that they are up, supported, and that persons served are safe and receiving the care they need;
- Bringing a certified behavior analyst into a home to provide support when needed, or evaluating a behavioral concern in its natural setting--but without disturbing the natural setting;
- Providing a family in a rural Kansas setting remote "super nanny" earbud coaching for a child with significant needs;
- Remotely collecting health vital data and then providing a way for a nurse or even a doctor to make multiple house calls to check in on a person served, or to help provide training or advice to a staff person or family member supporting a person with a special need;
- Knowing exactly when, to the minute, a person is incontenent, has fallen out of bed, or has a seizure; or imagine
- Having someone immediately available to help assist a staff person who is dealing with an emergency, call 911, warn someone about an intruder, remind a new staff person how to properly provide CPR, or even verbally guide a fireman to the window of a smoke filled room where a person is sleeping.

If this technology were available, wouldn't everyone sleep better and feel safer in their home? Couldn't this technology help preseve someone's independence and prevent their move to a more restrictive setting or prevent the need for intrusive night support or continuous staffing? This may sound futuristic, but in truth, CLO is providing much of this technology right now and working on the rest. And while this technology never replaces people, it does completely leverage and help monitor and supervise direct support staff to ensure that support is as affordable as possible, available "on demand" when needed but unobtrusive when it is not, and most importantly, highly effective.

CLO is seeking grants and raising social investments to prepare its HomeLink Technologies program for use on a fee for service basis that will provide significant support at tremendous savings for supporting people with developmental disabilities as they seek to maximize their independent community life.

For more information contact:

Michael Strouse, Ph.D.
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913-341-9316

How does it work?

CLO's *HomeLink Technologies* creatively combines high security and smart home technologies along with specialized training and ongoing support, allowing CLO to remotely monitor and support multiple homes and people from a centralized monitoring center located in Lawrence, Kansas.

It all begins with CLO's "state-of-the-art" central monitoring center, located in Lawrence. From here, a professionally trained HomeLink Technologies support team watches and monitors homes and programs, alarms, and communicates with and dispatches program/home staff, mobile staff, and links professional and community support to provide help when and how desired. The HomeLink team constantly monitors homes and programs according to pre-determined agreements, ranging from responding to alarms and automated help requests by the home; to checking in on a schedule determined by the program or home; to constant live viewing and supervision. The HomeLink Team can view the home and program and communicate to home and program staff or persons supported by live two-way conversations made possible by interactive microphones and speakers. HomeLink is "Onstar" like technology with eyes. And depending upon the needs of the person, home, or program, support is provided in a number of ways from alerting staff in the home, to waking sleeping staff, to directing mobile staff to help, to contacting 911 to dispatch emergency help, to directly communicating (talking) with persons supported or staff to provide the help needed.

Smart home and high security technology are designed for implementing individual home or program applications. A typical application in a home would include positioning multiple low/no light video cameras in a home so that a central site monitoring professionals can view commmon areas (halls, living areas, kitchen, exits, etc.) of a home. Motion detectors and sensors measuring pressure, door or window opening, smoke, carbon monoxide, movement, sound, moisture, or other types of sensors (including medical sensors) are tailored to meet the needs of the individuals in a home. These sensors will send signals/alarms to the central monitoring station the moment they are activated. Or a person served or staff can simply activate a "need help now" button/alarm in the home. The HomeLink Central Monitoring Team immediately responds to various different alerts in ways that are intended by the type of alert. Also, depending upon the need of persons served, central monitoring staff can complete security "eyes-on" checks of each home on an individually determined schedule.

Current or in Progress HomeLink Application Examples:

Remote Night Monitoring and Night Supervison

Are up at night staff up? Do sleeping staff wake up and help when needed? Do people with developmental disabilities without staff get the help they need when they need it? Do up-at-night caregivers respect privacy, not smoke in the home, and always engage in safe behavior? Do up-at-night staff provide a quiet, dark environment that is conducive of a good night sleep? Are people with developmental disabilities safe from abuse, neglect, or exploitation at night? In truth, the answer is at best "we don't know for sure." The night time workforce nationally is among the least stable with turnover often well in excess of 100%. A significant percent of all up-at-night or sleeping staff caregivers have other day jobs. When do they sleep?

Right now, CLO is using this technology to ensure that persons with developmental disabilities can rest peacefully. CLO remotely monitors over 45 living arrangements scattered across several counties in eastern, southern, and mid-Kansas. This Spring, CLO will be adding 9 more homes located across the Silicon Valley region of Northern California. From 9p to 7a our HomeLink Technologies team in Kansas conducts repeated tours of all homes monitored, and monitors all alarms that might activate. If someone

opens a door, gets out of bed, creates motion, presses a help button, or activates a speicalized sensor the HomeLink Technologies Team is there. Depending upon the needs of the program, the team independently checks in on the home visually every few minutes to see if there is a need independent of any alarm/sensor. If help is needed sleeping staff can be directed to help or staff moving between multiple homes or apartments in a complex are contacted and redirected. Specialized GPS equipped vehicles can be monitored by HomeLink Technologies staff to ensure that they are moving between homes as they are supposed to do and not where they are not supposed to be. Up at night staff are assisted and remotely supervised to ensure that they too are supported and focused upon providing the best care possible.

CLO's Virtual Villiage Semi-Independent Living "On-Depand" Support Program (In development in 2009)

Many people with developmental disabilities can be quite independent, and some live without staff support. Some, though, could live without significant staff support IF there was a way to be sure that they don't need help and to provide them the staffing they need on demand. HomeLink Technologies can fill this void through the daytime too. Are daily routines completed correctly? Are medications taken on schedule? Are person served in an a semi-independent apartment program engaging in safe cooking practices? Are only approved guests in the home and visting during appropriate times? Do people need help at unpredictable times? How do you know that the independent living skills taught during structured teaching sessions are used when no one is there?

HomeLink Technologies can create a "Virtual Village" to monitor apartments and homes during the day and provide remote support on demand by contacting mobile support provided by programs that support people with developmental disabilities living independently (or almost independently). HomeLink can also connect staff who live in nearby apartments to allow them to use encrypted technology to visually monitor homes directly and offer training via interactive microphones/speakers located throughout a supported apartment. And, when they are needed to help provide support in one home the HomeLink Team continues visual monitoring of other homes until the staff return to their post and ready to respond if another need arises.

CLO's Remote Behavior Analysis and Earbud Coaching Program (in development in 2009)

Behavior Analysis is both highly effective and necessary to address significant behavioral concerns such as self-injurious behavior or aggressive behavior, pica, inappropriate sexual behavior towards others as well as many other unsafe behaviors. Traditional behavior analysis can also be very expensive, requiring significant time to collect data, analyze behavior, develop an effective intervention plan, and to coach staff to implement plans consistently. This is even more challenging when someone lives in a rural community. In most cases, interventions are developed by Behavior Analysts based upon second hand observations related by family members or staff because the behavior isn't frequent enough or the home isn't close enough to directly observe. And even when direct observation is possible, the presence of a professional often changes the dynamics of both the behavior and how staff members respond to it. And once an intervention is designed and taught to staff persons, it is often difficult to know if it has been implemented consistently and effectively when the Behavior Analyst was not there. Imagine how much better it might be if the Behavior Analyst was "virtually" always available!

HomeLink Technologies offers a very effective vehicle for improving the effectiveness and cost effectiveness of Behavior Analysis. Behavior Analysts can now remotely watch multiple homes from one location and see how persons served exhibit behaviors first hand in their home. This can be done without intrusion and without needing to rely upon second hand observation skills of caregivers or families. Since HomeLink Technologies can passively record activities 24/7 (regardless of whether someone is watching or not), then behavior analysts can view archived home recordings at high speed (like a home DVR) to move forward through the day to capture example after example of a behavior they want to examine. These examples can be downloaded to a DVD and shared with clinical teams to ensure that the best plans are developed based upon direct observation. Once developed, the behavioral analyst can directly observe the home, staff and person served, and coach the staff or family to implement an intervention privately using an ear-bud phone. Since the behavioral analyst isn't present, the person being supported by a coached staff person attends to the staff and not the behavioral analyst (which will promote more effective teaching). Imagine being able to summon a behavioral analyst or a teaching coach at the push of a "Help Now" button in the home to help provide advice on how to handle a very difficult situation as it

is occurring? Or imagine "super-nanny" like help with a family having a child with Autism? Imagine knowing that programs are implemented whether the behavior analyst is present or not and that inappropriate behavioral control strategies are not used. With HomeLink all this is now possible.

CLO's Remote Quality Assurance Initiative (in development for 2010)

Good community programs serving people with developmental disabilities have an ongoing and active program of quality assurance. But such programs can be very intrusive. HomeLink Technologies can provide a tailored strategy to provide "eyes on" direct observations of home operations, teaching, interactions, and more. Perhaps a quality review initiative can be developed to provide announced visits where an evaluator will virtually "knock" and then observe and collect data using best the best practice "at-a-glance" observation assessments developed by CLO. Or perhaps daily or weekly DVR archived home recordings can be sampled to gather observational data on teaching and quality-at-a-glance? Imagine assessments being entered automatically in CLO's web-based ISOX (Information System of Excellence) database to create a performance dashboard for an agency to see their own home quality in real time? Consider having reports of care concerns in a home and the ability to examine up to 30 days of continuous archived video data to determine if persons served are safe and well supported.

Possible In-home or In-program Applications

HomeLink Technologies can be designed for local use too (with a mini monitoring station provided). This would allow a preschool to establish a local monitoring station within its preschool to allow a clinical supervisor to watch each classroom and provided ear bud coaching to teachers in training or for working with a challenging behavior. Imagine being able to simultaneously watch all 10 classrooms and help when and where needed. If more clinical help is needed, imagine being able to link up this system to connect University of Kansas clinicians to help provide expertise to that preschool in Great Bend, Kansas.

Fire Safety Training (current application)

Any program that has provided services in the community for any period of time understands the importance of fire safety. State and Federal funding and licensing for community services require that programs implement systems for promoting fire safety, including regular fire drills. National Fire Protection Association (NFPA) safety codes classify the combined capability of staff and persons served to move to a point of safety (evacuate) as either prompt, slow, or impractical, with each classification requiring more stringent building requirements (ranging from smoke alarms, to monitored fire alarms, to automated sprinkler systems and 2 hour rated walls and doors). To live independently in the community in typical housing, being able to evacuate timely is essential. HomeLink Technologies can help by conducting drills remotely, recording them on video, and then providing them to programs to aid in training techniques and as proof to fire marshals that the group can, in fact, promptly evacuate day and night. Smoke alarms, carbon monoxide alarms, and other local sensors can also be tied in to HomeLink as a redundant support for home fire systems. HomeLink team members can also provide verbal prompts and instructions to persons who many not know what to do when a fire alarm sounds. This offers a strategy to make sure that persons who are independent of staff can generalize training to respond correctly to an alarm when they are on their own.

Sensors and switches (in development for 2009)

Want to know if someone gets out of bed at night? How about a pressure sensor under the mattress pad that will alert HomeLink that a weight is not there? Or a door contact to tell you that a door has been opened or shut? How about a moisture alarm to signal for incontinence? Or an alarm that relays that someone has gotten too close to another person or too far from a location in a home? How about a button by each bed that must be pushed by up-at-night staff to ensure that they actually conduct an "eyes on" check every hour to avoid an alarm being sent to the HomeLink Technologies monitoring team? What about having the ability to remotely turn on a light for a person in need of support (perhaps at night) or turn on an appliance that is needed? With the right combination of technology all this can be done. More sensors and support technology are in development that can be compatible with HomeLink Technologies remote support—like remote sensors that are capable of monitoring seizure activities or labored breathing.

Back up Support

Technology is increasingly being relied upon to provide services that we simply can't live safetly without. That said, even the best systems can and do fail even for short periods of time. This makes it critical to understand system vunerabilities and weaknesses so that they can be minimized and so backup strategies can be tailored. HomeLink Technologies continously collects system metrics on its performance. Equipment and connections are constantly tested (pinged) to alert the HomeLink Team of a potential issue. Remote strategies can be used to logon and troubleshoot home-based systems and make corrections. Even the HomeLink Monitoring team is monitored and recorded by its own technology! Every alarm generated from a remote location requires a physical response to recognized and resolve the alarm. The latency for reponding is measured automatically by HomeLink monitoring software and becomes part of an informational database for later analysis. These data produce standard and custom reports that chronical home activity and the activity of the HomeLink monitoring staff. Want to see why it took 15 seconds to respond to an alarm? Its stored in archived video so that it can be examined to see what might be causing a delay.

Remote monitoring, though, is dependent upon broadband, microwave, or hard wired connections that might occassionally be interrupted for short period of times. So back up plans need to be individually tailored for each home or program that will allow redundancy if this is needed. In many cases, though, the loss of technology might just mean that the program is left with what it had in place before HomeLink support was in effect.

Balancing Issues of Privacy with the Need for Direct Care and Supervision

One of the most common questions voiced regarding HomeLink Technologies remote monitoring technology is that, to some, it seems intrusive and concerns are raised about privacy. Privacy is, of course, an important and very reasonable concern. Most of us do not have cameras in the common areas of our home recording passively or actively watching at night while we sleep. Having said that, most of us also don't have an endless stream of people checking in on us, staying in our home, or strangers coming in our home milling about while we are asleep either. And even if we did, most of us would be able to tell someone if that person stole from us, or fell asleep instead of helping us when needed, smoked in our home, made us feel uncomfortable, or committed an act of abuse or neglect against us. Unfortunately, this is not the case for a large majority of people with disabilities living in the community who currently need staff supervision. Most of these individuals do not have the ability to supervise and self-direct those persons who support them possibly alone at night, and many could not tell anyone (or would feel threatened to tell someone) if they were not cared for properly. As a result, many people with disabilities needing support are almost completely vulnerable to the undiscovered possibility of poor care.

Caregivers can and do breach the privacy of persons they support in ways that are not easily controlled or even known by anyone. We cannot be assured about what private areas unsupervised caregivers will intrude upon, client possessions they may use or take, private mail they may read, or private information or even identities they could use or sell (including confidential financial and personal information to protect the identities of persons served or family members and guardians). We only know what they self-report, which is of little assurance to most people.

On the other hand, remote monitoring technology can be tailored to view exactly what is desired and not view or detect what is to be private. Sensors are tailored to the exact needs and abilities of each person served. Motion detection, sound detection, pressure sensors, smoke or carbon monoxide detectors, door sensors and glass-breaking sensors all work together to provide monitoring when and where needed. As important, it can be designed to ensure that some areas are private. Cameras are pointed to common locations and cannot intrude upon unauthorized areas. The risk of theft or assault is highly unlikely because any on-site help would be remotely monitored.

Clearly, people with developmental disabilities who need direct care and supervision are placed in a position where they virtually have no privacy whatsoever. Their personal privacy becomes of secondary importance to their need for care. HomeLink Technologies enables the person in need of support to control the design of

support they need and to balance the amount of intrusion relative to the support they need. This sense of security allows for a better quality of life, including a safe and comfortable sleep environment.

House Social Services Budget Committee

Home Telehealth Presentation
March 16, 2009

Monte Coffman
Executive Director
Windsor Place
Coffeyville, KS

Windsor Place
Worthwhile Work

Windsor Place is a long-term care company located in Coffeyville.

The continuum of long-term care operations include:
*A home health agency serving over 1,300 clients
*2 assisted living facilities, and
*3 nursing facilities.

In addition to these core services, additional services provided to aged and disabled clients involve:

*transportation programs
*outpatient therapy
*2 monthly support groups
*adult day care
*respite care
*weekend Meals on Wheels
*The Age to Age Kindergarten classroom (only the second such project in the nation)
*In 1996, Windsor Place At-Home Care was formed and currently serves 1,300 clients in their homes.

Kansas Medicaid LTC Services

Nursing Facilities

Medical Clinical Care	RN's --- LPN's
ADL and Personal Care	CNA's --- RA's --- Other Staff
Social Needs	Activity Directors Social Workers

Kansas Medicaid LTC Services

Home and Community Based Services

Medical Clinical Care	VOID
ADL and Personal Care	Attendant Care Workers --- Homemaker Staff
Social Needs	Companion Services (added October 2008)

Kansas Medicaid LTC Services

	Nursing Facilities	Home and Community Based Services
Medical Clinical Care	RN's --- LPN's	VOID
ADL and Personal Care	CNA's --- RA's --- Other Staff	Attendant Care Workers --- Homemaker Staff
Social Needs	Activity directors/Social workers	Companion Services (added October 2008)

In 2006, Windsor Place met with and proposed to KDOA Secretary Greenlee and her staff the application of home telehealth and remote monitoring for the purpose of managing chronic diseases more effectively in the home.

In Feb 2007, a KDOA grant funded our pilot project. On August 1, 2007, the pilot program was operational. Extremely promising results were realized during the pilot's first year.

An extension of this grant was awarded last summer. Results continue to be quite exciting in this paradigm shift.

3 Benefits of Telehealth

-Access to care

-Quality improvement

-Efficiency and lower cost of care

Four Key Elements to Telehealth

-Accurate physiological information

-Shared data with patient

-Data-driven coaching/patient education

-Optimized provider involvement

Award-winning Measurement Technologies
Accurate, Reliable, Unobtrusive and Easy to Use

Blood Pressure & Pulse

Takes readings when patient slides cuff up the arm, then presses "Start" button.

Standard Scale

Low step, a wide, steady platform, a large digital display and voice announcement.

TeleStation

Asks simple health questions. Responses are communicated to the clinical software.

ECG/Rhythm strip

Simple wristbands with snap-on connectors.

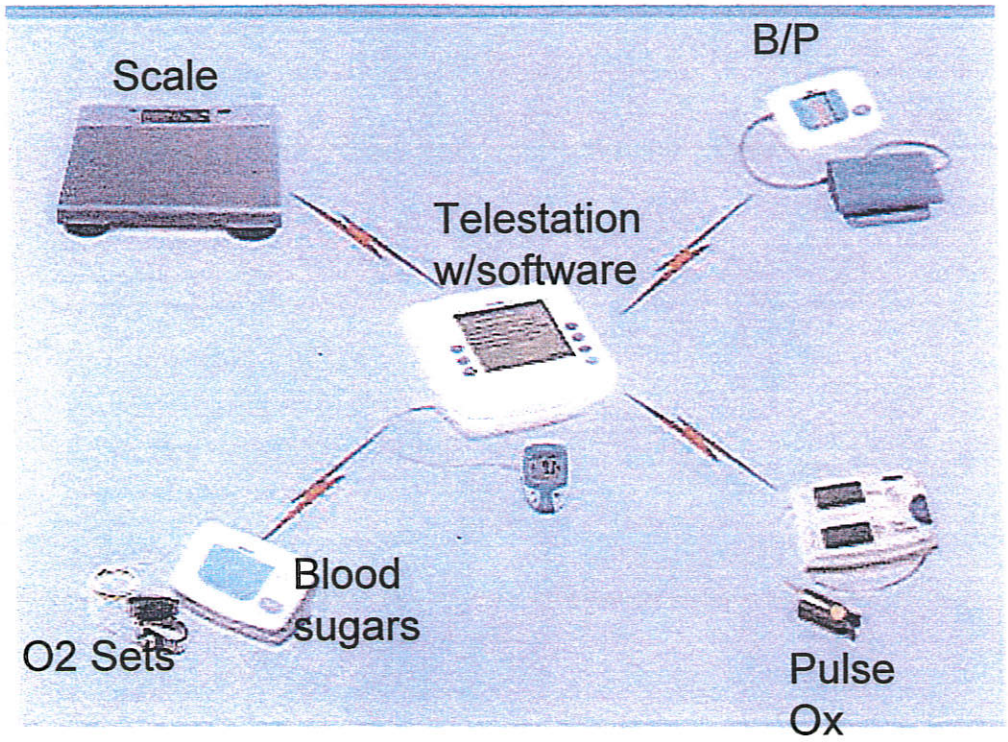
Pulse Oximeter

Spot checks oxygen saturation and pulse within seconds.

Glucose meter connection

Bayer Ascensia Contour 7151B

Wireless or Manually-Entered Measurements

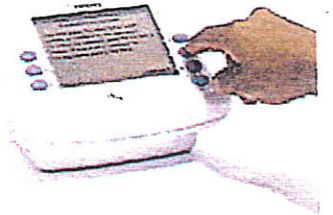


Plus any of these Manual Measurements

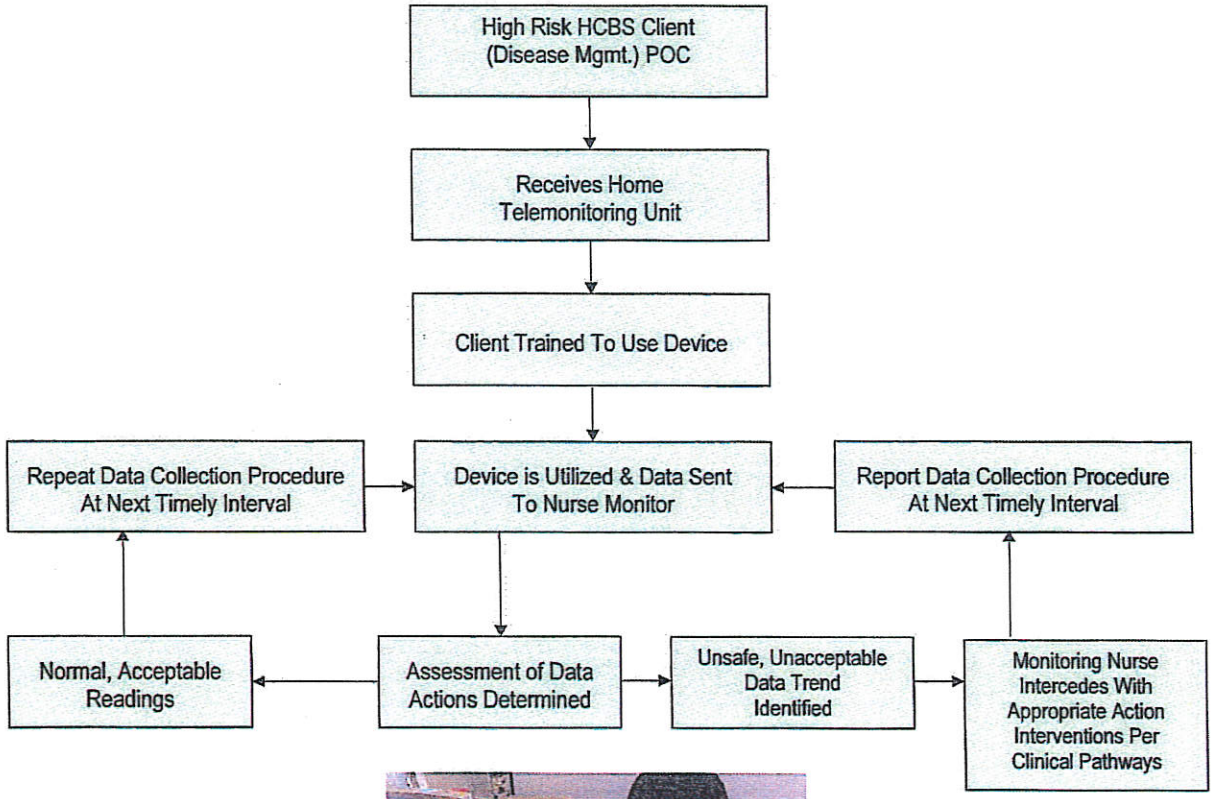
- Glucose (blood sugar)
- Peak Flow
- Spirometry (FEV 1)
- Clotting Time
- Temperature
- Hemoglobin A1c
- Respiration Rate
- Zo

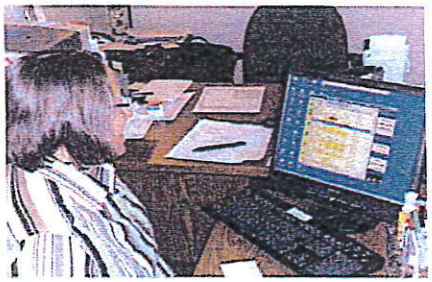
Wireless Measurements

- Weight
- Blood Pressure, Pulse
- SpO2, Pulse
- Rhythm Strip



KDOA-HCBS PILOT PROJECT
Monitoring Process High Risk HCBS Client





Windsor Place
Worthwhile Work

Client's begin Telehealth session

Session Data Transmission

Sent to Nurse's Computer

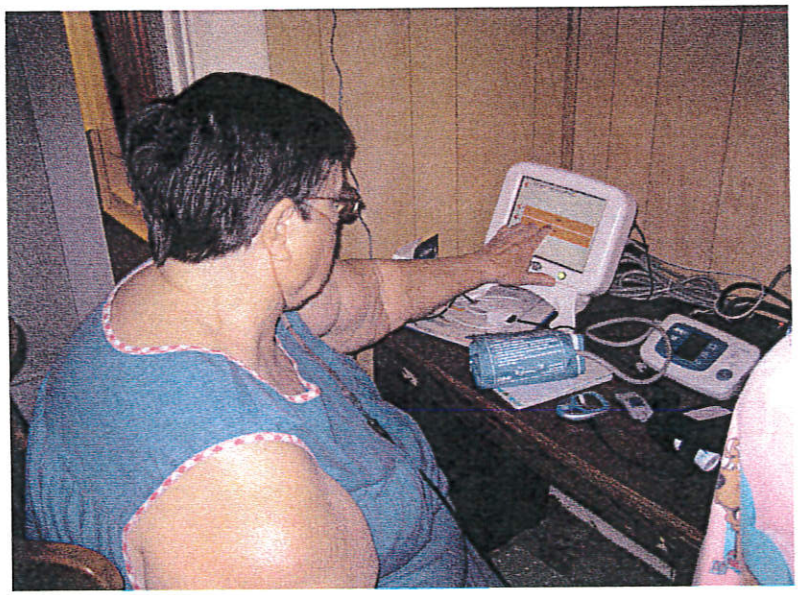
Data Reports Analyzed/Assessed

Communications Back to Client

Education Tips

Intervention Actions

Retake Measurements



Windsor Place

Worthwhile Work

MARY's DAY

Mary uses Telehealth equipment to measure her Weight, Blood Pressure, Pulse Oxygen and Blood Glucose readings. A typical day for Mary is as follows:

07:30am Mary wakes, walks into her dining room and sitting relaxed, places the **Blood Pressure** cuff on her arm and presses the START button on the B/P meter. Her B/P is automatically transferred to the TeleStation (main monitor).

07:32 Mary places the **Pulse Oxygen** clip on her finger, presses start and the meter measures the oxygen in her blood. This is transferred to the TS.

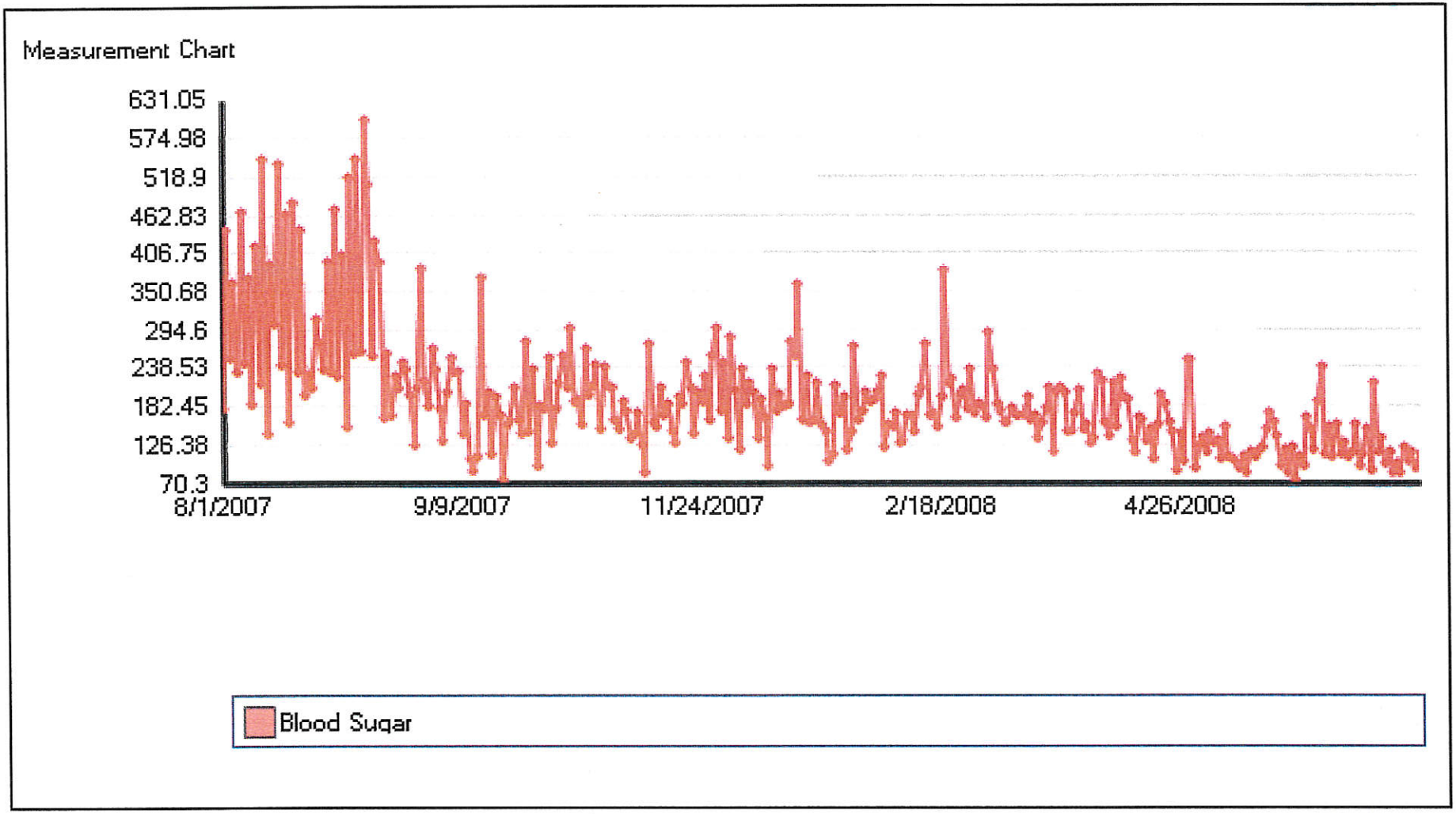
07:34 Mary checks her **Blood Sugar.** Once the measurement is taken, she will plug a cable from the TeleStation into the glucose meter. This transmits that reading to the TS.

07:37 Next, Mary gets up to do her **Weight.** In about 10 seconds, this measurement will automatically go to the TS.

07:40 Taking all these measurements in the comfort of her home, Mary has used about **10 minutes** of her day.

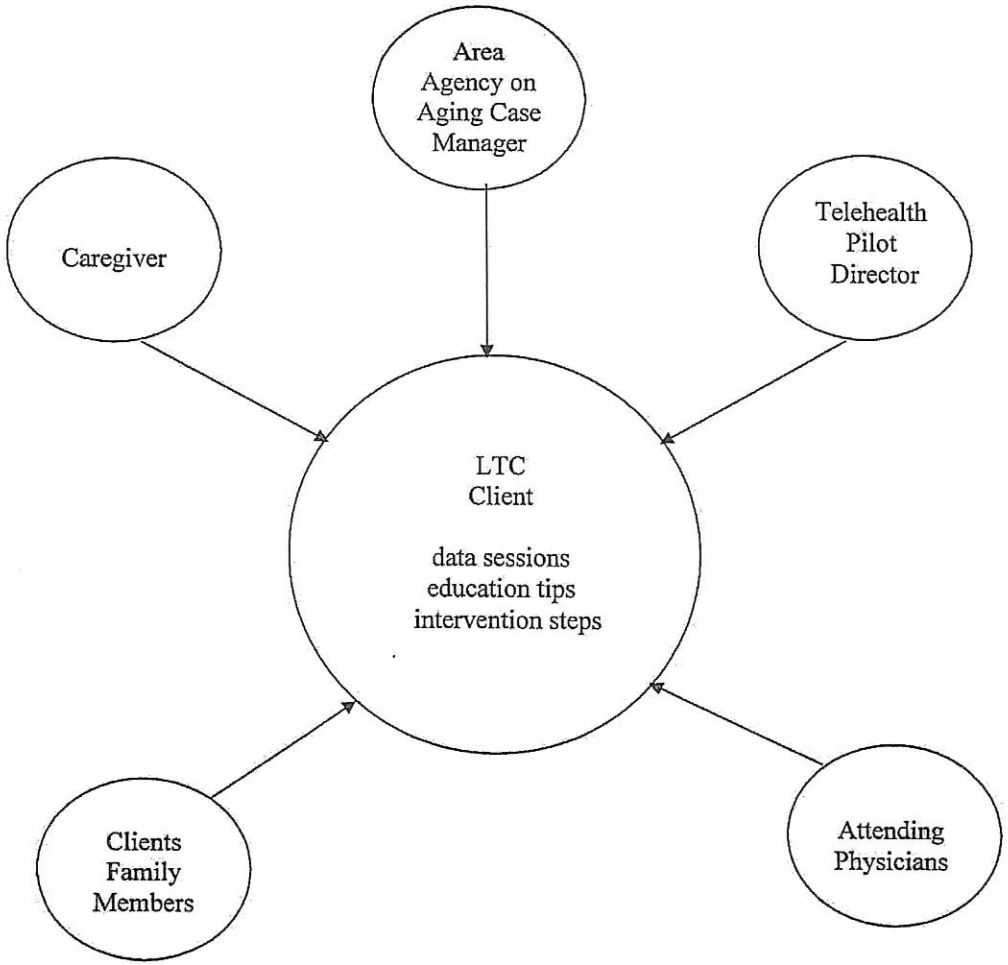
The **TeleStation will transmit** the readings it has received from each device via a **TOLL FREE** number and send them to a **secure, password protected website** so that the **TeleHealth nurse can see them.** This transfer happens about 15 – 20 min after the first measurement was taken, giving Mary ample time to do all measurements.

On occasion, Mary will have assessment questions, information or education, or a simple Birthday greeting. She will answer these in a matter of minutes and the TeleStation, as with the measurements, will transmit the answers to the secure website.



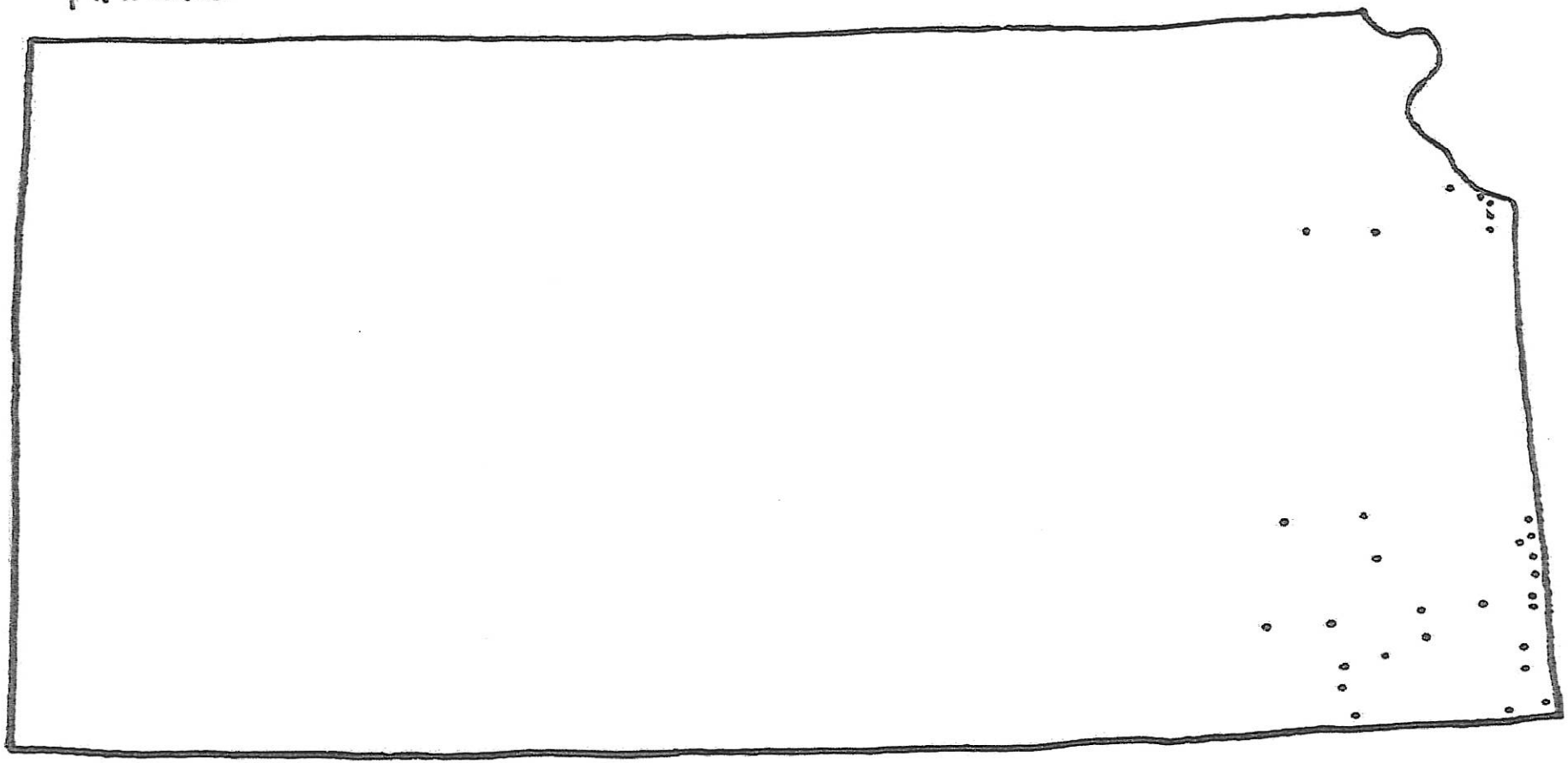
Windsor Place
Worthwhile Work

Care Coordination and Integration Expansion



Windsor Place
Worthwhile Work

Kansas



Coffeyville – 8
Dearing – 2
Independence – 4
Cherryvale – 1
Neodesha – 3
Yates Center – 1
Iola – 1
Fall River – 1

Chanute – 7
Erie – 2
Parsons – 1
Galena – 4
Baxter Springs – 3
West Mineral – 2
Scammon – 1
Pittsburg – 4

Frontenac – 2
Arma – 2
Mulberry – 2
Englevale – 1
Arcadia – 1
Ft. Scott – 4
Girard – 1
Edgerton – 1

Olathe – 2
Roeland Park – 1
DeSoto – 1
McLouth – 1
Lawrence – 1
Topeka – 2

Windsor Place
Worthwhile Work

Variable	Baseline Mean	Intervention Mean
Hospital Visits	1.10	.63
Hospital Days	12.60	7.70
Hospital Costs	$45,554.02	$15,700.14
UAI Scores	46.56	46.56
ER Visits	.43	.23
ER Costs	$1,234.48	$424.92

Table 2: Comparison of baseline and intervention means of pilot variables.

Long Term Care

	NF	HCBS
	approx 10,500 people are here approx cost $2950 per month →	approx 5800 frail elders are here approx cost $950 per month
	seniors/funding source want to move this trend from NF to HCBS	
medical/clinical needs	RN/LPN's provide care here.	**There is a void of care here.** Telehealth would fill this need and allow seniors to stay in their homes longer.
Personal/ADL needs	CNA/RA's provide care here.	Attendant care and homemakers provide care here.
Social Needs	Activity directors/Social workers	Companion services added Oct 2008

Cost savings opportunities -The monthly cost difference between HCBS and NF is approx $2,000
-If 500 Kansas elders could be deferred from NF placement,
the annual savings would be $12,000,000.
(500 x $2,000 x 12 months)

Windsor Place
Worthwhile Work

Long Term Care

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Cost savings opportunities 1372 PD consumers incurred $24M in Medicaid hospital costs in FY 2008.
Projected FY2009 Medicaid hospital cost for PD consumers is $28M.
If 500 consumers could be averted, savings could be $8.7M annually or more.

Windsor Place
Worthwhile Work

2-20

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Windsor Place
Worthwhile Work

BREWSTER PLACE

Kansas House of Representatives
Committee on Aging and Long Term Care
March 17, 2009

Testimony of Tom Akins, VP of Development and Planning
Brewster Place Retirement Community
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toma@brewsterplace.org

Mr. Chairman, members of the committee, thank you for the opportunity to present testimony this afternoon. My name is Tom Akins and I serve as Vice President for Planning and Development at Brewster Place Retirement Community here in Topeka. Since we first opened our doors in 1964, Brewster Place has been just that...a "place"...26 acres located just west of 29th and Topeka serving approximately 375 residents. Two years ago, Brewster decided that concentrating on just those residents at just that location wasn't enough to fulfill our non-profit mission.

After researching different models and laying the groundwork for our efforts, in November 2009 we rolled out a new concept called Brewster at Home. Brewster at Home is all about ***providing the services people need, when they need them, in the place they call home***. Brewster at Home is a membership-based organization that provides three simple but powerful benefits: first, it provides a "passport" to Brewster Place activities, trips, and programs to provide much-needed socialization opportunities; second, it features a "network of providers" – local, trusted partners – who offer (at a discounted price for Brewster at Home members) a myriad of services, including handyman services, home health, companions, nutrition, housekeeping, meals, move management, massage

therapy, computer training, and much more; finally, it offers telemonitoring that includes:

- Sensors that can detect and notify a caregiver if a person is potentially unsafe (e.g. have fallen, did not get out of his chair or turn off the stove).
- Health technologies that monitor blood pressure, weight, glucose and other conditions in real time while the person is at home. This enables notification of caregivers immediately of significant changes and reduces the need for doctor's visits.
- Medication dispensers that provide the appropriate medicines at the appropriate time and remind a person to take them – with immediate notification to caregivers if a dosage is missed.

These telemonitoring products are in keeping with goals enunciated by the Kansas Department on Aging in Secretary Kathy Greenlee's testimony before the House Vision 2020 Committee last month on February 9. In her testimony, Secretary Greenlee listed five goals that guide the department's efforts on Long Term Care and Telemedicine. Secretary Greenlee said that the Department's efforts must:

- Support health
- Support independence
- Manage chronic disease
- Minimize visits
- Be accessible across care settings

So with a system in place like Brewster at Home, technology that works, and outcomes that are in line with the Department on Aging's goals, what's missing from this picture? **Data.**

Current marketing efforts around telemonitoring focus almost exclusively on the private pay market...if you can afford the technology, you get the technology. For reimbursement to become a reality – whether through Medicaid or through other third party payors – we need statistically valid data to help us establish outcomes and to demonstrate to taxpayers and insurance companies that a front-end

investment in technologies that keep elders safe, independent, and in their own homes will actually save money. Much like getting the oil changed in your car every 3,000 miles, an investment in technology-based services helps avoid more costly problems down the road. Insurance companies provide reimbursement for annual physicals for just the same reason.

We are beginning to build an anecdotal body of evidence that supports our belief that telemonitoring services keep people healthier, more independent, and utilizing the emergency room on a much less frequent basis – all while saving the state money.

We think there are partners willing to collaborate on demonstration projects that will provide much-needed data. We believe that a powerful partnership between providers, research-based universities, local health systems, health insurers, advocacy groups, and grantmakers – working in concert with the state – can give you the information you need to make determinations about the long-term public policy implications of telemonitoring.

A great example of this partnership model is embodied in CAST – the Center for Aging Services Technologies. CAST has become an international coalition of more than 400 technology companies, aging services organizations (including Brewster Place), research universities, and government representatives. Their mission is straight-forward: to lead the charge to expedite the development, evaluation, and adoption of emerging technologies that can improve the aging experience.

At its core, we think the state should insist on the following four items of any demonstration project it supports:

1. Which telemonitoring systems will aid in managing chronic disease?
2. Which telemonitoring systems will help our elders remain in the setting almost all prefer—their home?
3. What staffing patterns will be necessary to support telemonitoring systems?
4. Can the use of telemonitoring systems save money?

Other states are successfully utilizing Medicaid waivers approved by the Centers for Medicare and Medicaid Services. Most promising, perhaps, is a waiver being utilized by the State of Pennsylvania's Office of Long-term Living to provide reimbursement for home telemonitoring for adults ages 60 and older under approval from the Centers for Medicare and Medicaid Services (CMS). This initiative includes a demonstration telemonitoring reimbursement policy to cover a range of services provided by home health, durable medical equipment providers, pharmacies and hospitals through contracts with local county Area Agencies on Aging. State officials in Pennsylvania expect the program to help with a workforce shortage by increasing the number of persons that can be served by homecare staff, while enabling state Medicaid savings by allowing more consumers to remain safely in their homes and delay moves to more expensive skilled nursing care. They believe – as do we – that it's just not feasible for the vast majority of elders who need assistance, but want to stay in their own homes, to pay for an in-home aide 24 hours a day; instead, technology can help us monitor elders' wellbeing 24 hours a day, seven days a week.

It comes down to this: telemonitoring can provide significant benefits to our elders, including the opportunity to stay healthier and more independent – and it can, we think, save the state significant amounts of money. What ***we*** need is the ability to undertake demonstration projects that will provide us with an opportunity to provide you with the information and data ***you*** need to make sound public policy. As you look to the future of telemonitoring, I would respectfully urge you to seek ways to support demonstration projects, including both policy changes and financial support.

Thank you.

Telemedicine and Long Term Care

House Aging & Long Term Care
March17, 2009
Bill McDaniel
Commissioner, Program & Policy

A Divided World

- For seniors, health care is delivered through the acute care system and long term care system.
- These are very different worlds:
  - Hospitals and doctors' offices
  - Nursing homes and home and community based (HCBS) services.

Long Term Care & Telemedicine

- At Dept. on Aging, we focus primarily on long term services and supports.
- Goals:
  - Support health
  - Support independence
  - Manage chronic diseases
  - Minimize risks
  - Access across care settings

Recent Trends

- An increasing number of providers are marketing telehealth and telemedicine products as way of maintaining independence.
- Products range from motion sensors to incontinence devices and medication dispensers.
- Nearly all levels of activity can be monitored.

Marketing Angle

- Concerned family member and seniors themselves are being presented with telehealth options as a way of staying at home longer.
- The marketing is successful because of a real desire to remain independent and prevent nursing home care.
- However, this is a market driven, not data driven approach.

Telemedicine LTC Payor Options

- Medicare
  - Hospitals, doctors, skilled rehab
- Medicaid
  - Remote monitoring
  - Chronic care management
  - Assistive technology
- Long Term Care insurance
  - HCBS Services definitions

Telemedicine Payers

- Private pay
  - Not a third party reimbursement issue
  - Direct product marketing to consumers
  - Promises of greater independence

The Missing Link: Data

- What devices help seniors remain at home?
- What devices help manage chronic disease?
- Which devices perform better than others?
- What level of staff are needed to support the technology?
- What money can be saved?
- Who are the most suitable product users?

Experiments and Outcomes

- From the private market experiments, we need data and outcomes.
- Public sector support may be an option but must be data driven.
- Medicaid is a possible funding source for telemedicine devices, but must be outcome-based.

Things to Consider

- Add long term care services to the conversation and your mental check list.
- Insurance companies are not the main payors in the world of long term care and telemedicine.
  - Medicare, a little
  - Medicaid, a lot
  - Private funds, a lot

Things to consider

- How to get this paid for.
  - Seniors are already buying, without support from data and outcomes
  - Medicaid is an option but is short on data.
  - Medicare interventions must include acute and long term care.
- Demonstration pilots are crucial.
  - Data from any source is helpful.

Location, Location

- The senior needing to see the doctor may be living in a long term care setting.
- Skilled rehab may be provided at the nursing home.
- Chronic care management is a huge unmet HCBS need.
- The most complete records about the "patient" may be at the nursing home.
- Electronic health records impact all provider types.