Chapter 12

Influencing Public Policy through Care Coordination Research

Marilyn Rantz, PhD, RN, FAAN; Lori Popejoy, PhD, RN; Katy Musterman, MBA, RN; and Steven J. Miller, MA

As people age, they want to live at home—not in nursing homes or assisted living facilities—retain as much independence and health as possible (Marek & Rantz, 2000; Rantz, Marek, Aud, Johnson, et al., 2005a; Rantz, Marek, & Zwygart-Stauffacher, 2000). In an effort to keep older adults at home for as long as possible, family members will often provide needed services, including care coordination. In 2009, the cost of caregiving by family members in the United States had an estimated value of $450 billion (AARP, 2013a). Giving care to older adult family members is challenging. Most family members are not trained to coordinate care, navigate the healthcare system, nor are they knowledgeable about how to best help older people maintain or regain health and independence. Furthermore, many family members do not live close to their older adult relative, making it challenging to monitor their condition and coordinate care from a distance (AARP, 2013b). When family members are not able to care for their loved ones, older adults often find themselves living in traditional long-term care facilities.

Traditional models of long-term care that include nursing homes and assisted living facilities are not uniformly accepted by older adults and their family members. The baby boom population is rapidly aging and is demanding new models of care that maximize independence and optimize physical functioning to enable better quality of life for community dwelling older adults. As with every other social institution in the U.S., the baby boomers have also shifted the vision of long-term care: they are demanding ways to age successfully without moving to a nursing home. The University of Missouri (MU) Sinclair School of Nursing (SSON) stepped up to the challenge of creating a different way of supporting older adults as they age, providing care on their own terms. Working with stakeholders, including consumers, politicians, community leaders, and long-term care

advocates, MUSSON opened a home healthcare agency and partnered with Americare Systems, Inc. to build a new senior living community focused on care coordination. This new model of care is called Aging in Place (AIP) and implementation of the model required strategic planning for shifting public policy, ongoing project effectiveness evaluations, stakeholder involvement, building a business for the AIP project, developing the care coordination program, passing legislation to enable building a demonstration site, building and operating the demonstration site, and overcoming challenges to diffusion of the care model. The goal of AIP is to allow older people to remain in the environment of their choice for as long as they wish without fear of forced relocation to a higher level of care (assisted living or nursing home) (Marek & Rantz, 2000; Marek, Rantz, & Porter, 2004).This chapter will discuss how public policy was successfully influenced by engaging others to create a much-needed new model of care coordination for older adults living in the United States.

KEY STEPPING STONES TO ULTIMATELY INFLUENCING PUBLIC POLICY

The Vision: Dramatically Change U.S. Long-Term Care Delivery

Although the AIP project began with a clearly stated vision from the outset, there were many stepping stones to success. The primary goal of the project, envisioned by MUSSON in 1996, was to change public policy in order to transform how long-term care is delivered in the United States. At that time, there were two major public policies that inhibited development of new solutions to better meeting the long-term care needs of older adults: 1) Regulations that force institutional care into categorical service "boxes" such as senior housing, residential care, group homes, assisted living, intermediate care, nursing facilities, skilled nursing, long-term acute care, acute rehabilitation, etc.; and 2) Regulations that limit payment for RN or APRN care coordination in home and community-based or facility-based long-term care.

An interdisciplinary group was selected and convened to guide the project. An initial ground-rule was to *not* let current public policies inhibit envisioning a new model of long-term care for older people. The group identified the typical path for older adults as transitioning from home to assisted living then to nursing homes as their health and functional abilities decline. It was recognized that once an older adult moves to a long-term care setting (assisted living or nursing home), state and federal regulations determine the amount and type of services that must be provided: if a person requires more care than allowed under the regulations, the person is forced to move to a higher level of care (Marek & Rantz, 2000; Rantz et al., 2000). For example, in assisted living, a person

must be able to navigate a path to safety without assistance or he or she is required to move to a higher level of care. Research shows that each move is detrimental to the person's well-being, often resulting in reduced functioning (Manion & Rantz, 1995). Older adults who move to assisted living facilities or nursing homes rarely return to living independently in the community. The only exception to this is when older adults are admitted for a short stay in a nursing home for rehabilitation, such as what would be needed after a fall with a hip fracture (Bentler et al., 2009). Once permanent admission to higher levels of care begins, the trajectory is a slippery slope resulting in the loss of independence and the need for more institutionalized care (see Figure 1).

The new model envisioned by MUSSON faculty allowed an older person to *age in place*, staying in the environment of their choice with key services *coming to them* as they age *via nurse care coordination*. The foundation was carefully built on the nurse care coordination research of the community nursing organizations that used the model of nurse care coordination, nursing home diversion demonstration projects of the 1970s and early 1980s, and the Robert Wood Johnson Teaching Nursing Home Initiative of the late 1980s.

To actually operationalize the model, it was necessary to gain a better understanding of what others thought was possible, to better understand the limitations of current public policy regulations, and to determine possible alternatives that included changing regulations. Toward that end, MUSSON faculty made site visits to innovative housing and community-based models of care in other states that were considered best practice long-term care sites, meeting with providers from a variety of disciplines and backgrounds. Additionally, long-term care advocates, geriatric researchers, community leaders, and consumers were instrumental in defining the AIP model. The resulting model included

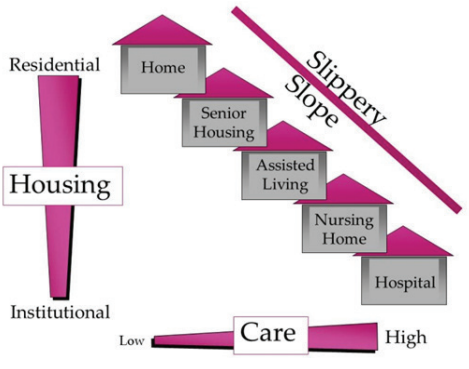


Figure 1 Traditional Trajectory of Transitions for Care and Services

best practice community-based health care with intensive registered nurse (RN) care coordination (Rantz et al., 2011). The vision also included the construction of elder housing for implementation of the AIP model within an ideally constructed environment (TigerPlace, named after the MU mascot) where people could age in place without being forced to move to higher levels of care as their needs increased.

Building a Business for the AIP Project: Sinclair Home Care

After three years of business and research planning, MUSSON received a $2 million grant from the Centers for Medicare and Medicaid Service (CMS) to establish a home care agency and evaluate the AIP model of care. As a result, in 1999, Sinclair Home Care, a Medicare and Medicaid certified home health agency was established as a department within MUSSON.

The key service provided in AIP is RN care coordination, a service not paid for at that time by Medicare or Medicaid. The CMS grant provided funding for this service for Medicare, Medicaid, and private pay clients of the home care agency so that the AIP model of RN care coordination could be evaluated for cost and clinical outcomes. The RN care coordinator manages the client's care needs across time, disciplines, and services (primary care, specialty care, social work, physical therapy, hospice, and others) regardless of payer, enabling the client to age in place. The mission statement of Sinclair Home Care reflects the dedication to the ideal of keeping older adults in the community home of their choice and states that the agency will promote the independence, dignity, and health of adults by providing the services and support needed for them to live in the home of choice. Sinclair Home Care is dedicated to the enhancement of the quality of life of clients served through the delivery of compassionate health care by skilled professionals continuously striving for excellence.

For 10 years, Sinclair Home Care provided Medicare and Medicaid home health services to six counties in the mid-Missouri region using nursing care coordination. Additionally, private pay services were available in one county. Services included skilled nursing care, medication management, wound care, nurse on-call services, personal care services, and physical, occupational, and speech therapies. RN care coordinators communicated with clients' physicians, therapists, and other caregivers to ensure that care was appropriate and necessary. As with many home healthcare agencies during this period, after the CMS-funded community-based AIP research was complete, it was challenging for Sinclair Home Care to remain profitable while continuing to provide what we knew was important to better care, the now "unfunded" care coordination work. Since it was no longer necessary, for evaluation purposes, to continue to operate a home health

and home- and community-based services business, on July 1, 2009, the Medicare and Medicaid components of Sinclair Home Care were sold to Oxford Healthcare by MU Health Care. MUSSON retained the private pay business which continues to provide AIP care coordination and home care services to TigerPlace residents; this facilitates ongoing evaluation of AIP at TigerPlace, as well as research activities and educational programs.

Strategic Planning for Shifting Public Policy: Electronic Health and Business Databases

With a clear vision to influence public policy, several implementation stepping stones were essential:

- Use an electronic health record for periodic data analysis of care delivery that included standardized data elements that enabled comparisons with traditional long-term care;
- Plan all data collection so it is doable, useful, and occurs within the normal workflow of the nursing staff and other employees;
- Use periodic comparison groups in the community and with state and national databases; and
- Publish ongoing results of evaluations that are of interest to policy makers because topics such as cost, quality, and staffing are addressed.

Project Effectiveness Evaluations: Building the Case to Influence Public Policy

It was necessary to obtain effectiveness data about AIP that would later be used to influence legislators. The outcomes of the CMS evaluation (1999–2003) demonstrated that clients who received care from Sinclair Home Care with RN care coordination had improved clinical outcomes compared with individuals of similar case-mix in nursing homes (Marek et al., 2005). Outcomes were also significantly better for clients with RN care coordination than without RN care coordination in a community-based waiver program called Missouri Care Options (MCO) (Marek, Popejoy, Petroski, & Rantz, 2006). Monthly costs to Medicare were significantly lower ($686) for MCO clients with RN care coordination compare to those without care coordination (Marek, Adams, Stetzer, Popejoy, & Rantz , 2010). Finally, total costs to Medicare and Medicaid were $1,592 lower per month in the AIP group than a nursing home comparison group over a 12-month period (Marek, Stetzer, Adams, Popejoy, & Rantz, 2012). These documented cost savings and better clinical outcomes proved useful as efforts to change public policy progressed.

Challenging Existing Paradigms: Legislation to Enable Building TigerPlace

Clearly, the outcomes of AIP in the community were positive; now the challenge was to leverage the research outcomes to enable changes in Missouri long-term care regulations so TigerPlace could be built and operated in a new paradigm. The AIP vision always included having an ideal housing environment where older adults could live and receive excellent care and services. It was extremely challenging to build a new kind of facility that offered increased resident autonomy, service, and care coordination within the highly regulated long-term care industry. It became apparent that if the vision of a building was to become a reality, new regulations had to be written. Based on the positive initial results of the CMS AIP evaluation, legislation was proposed and passed in 1999 and 2001 which established four demonstration sites for AIP in Missouri. MUSSON and Americare Systems, Inc. applied for and became one of the demonstration sites and TigerPlace is the only remaining AIP demonstration site.

Involving Stakeholders: The Public-Private Partnership

Passage of the legislation and actual implementation of the public policy change required engaging all stakeholders. Before the legislation was proposed, an attempt was made to involve any person with an interest in the proposed legislation. This included those interested in preserving the status quo.

Marilyn Rantz, PhD, RN, FAAN, a faculty member at MUSSON, took the lead in the AIP project and began meeting with key stakeholders. Tim Harlan, a state representative, took an interest in the project and Dr. Rantz met with Mr. Harlan and officials of the Missouri Department of Health and Senior Services to draft potential legislation for a demonstration project. After months of meetings and ongoing communication through email and phone calls, drafts were ready for discussion. Dr. Rantz discussed the potential legislation with other crucial stakeholders, including the representatives from the nursing home associations (Missouri Health Care Association and Missouri Association of Homes and Services for the Aged), the ombudsmen, the Area Agency on Aging, and other state legislators.

Mr. Harlan began meeting with his legislative colleagues to build support for the law. In addition, advocates who were also stakeholders began calling legislators endorsing the law. It was essential that consensus about the proposed change be established before bringing the legislation to the floor for a vote. While some associations were hesitant to endorse the new law, they did agree to not oppose the legislation, which was critical in its passage. Through the combined efforts of all of the interested parties, the legislation

that enabled the AIP program finally passed in 1999 and 2001. After passage of the law, MUSSON continued to work with state officials and in partnership with Americare Systems, Inc. to build TigerPlace as an AIP demonstration site.

The public–private partnership between MU and Americare is unique. In order for the partnership to work, the two entities needed a shared vision and an understanding of the care model and the role each would fulfill. Through considerable discussion, legal agreements were established to delineate the roles and responsibilities of each party. This ongoing relationship building continues to the present with representatives from MUSSON and Americare meeting monthly to discuss operational issues.

Building the Demonstration Site: TigerPlace as AIP Long-Term Care Facility

In 2004, construction was completed for TigerPlace. Designed as an ideal environment for AIP, it is operated by Americare with home care services provided by Sinclair Home Care. To enable people to remain in the same apartment as they age and as care needs change, it was decided to license TigerPlace as an Intermediate Care Facility (ICF), thus enabling residents to use their long-term care insurance when they qualify. The building was built to nursing home standards (with some waivers that enable the environment to not appear "institutional") with private studio, one-, and two-bedroom apartments and is operated as an independent living community. Americare provides housekeeping, maintenance, two meals per day, and transportation services. Sinclair Home Care provides RN care coordination including: an RN on call 24 hours a day; comprehensive healthcare assessment on admission, every six months, and as needed when physical or mental health significantly changes; medication management; wellness checks; personal care services; and health promotion activities including exercise classes at TigerPlace. Unlike typical ICF care, there are legal exceptions in place for the license that allows residents to receive care and services at TigerPlace as their needs change, without requiring them to move to a higher level of care. Residents of TigerPlace can stay there through the end-of-life, so they can truly age in place (see Figure 2).

Domestic pets have been an integral part of TigerPlace since the beginning. The planning team recognized the important benefits of pets for older adults and TigerPlace residents are encouraged to have them (Johnson, Rantz, McKenney, & Cline, 2008). There is a veterinary clinic on site, which is staffed by the MU College of Veterinary Medicine.

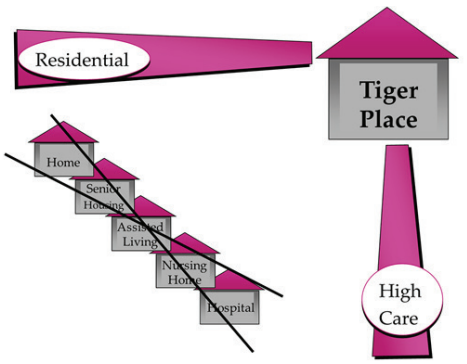


Figure 2 New Vision *Without* Transitions for Care and Services

Veterinary and nursing students assist residents in caring for their pets by walking dogs, administrating medications, and feeding animals whose owners are in the hospital or receiving rehabilitation in other facilities. A veterinarian does monthly rounds to check on resident pets and offer advice to residents with issues or concerns. The residents rest easy knowing that their pets will always be taken care of if they become incapacitated or after they die because there is an adoption policy in place at TigerPlace.

Care Coordination: Central to Sinclair Home Care Services at TigerPlace

The care service line provided at TigerPlace is a home healthcare RN care coordination model combined with routine client assessments that effectively catch problems early so that interventions to restore optimal health can be provided. A wellness center is open five days per week and is available to all residents of TigerPlace. Services provided at the wellness center include vital sign checks, assistance with minor health problems, and registered nurse consultation for residents and families. The majority of care takes place in the resident's apartment. Residents pay privately for home care services such as medication management, assistance with activities of daily living, personal care services such as bathing and dressing, and wound care. Residents are assessed upon admission, every six months, and as needed based on physical and mental health needs. If residents meet Missouri's ICF criteria, they are evaluated more frequently and receive an increased amount of RN care coordination to maximize their independence and health.

Sinclair Home Care arranges for services to restore and maintain optimal health. When residents are ill or have periods of lower functioning, they receive increased services, which are removed when residents are able to return to their higher level of

functioning. This reduces overall care costs and encourages clients to maintain or improve their health and functional ability. RN care coordination is provided to all residents as a part of the overall wellness package. The RN care coordinator works with residents' care providers and family members to address potential and actual health concerns. The goal is to communicate potential problems so that interventions can be put into place before they lead to acute illnesses and hospitalizations.

The direct care pricing models changed when AIP moved from the community to a congregate housing setting. Instead of hour-long home health aide or nurse visits, visits were priced in smaller increments so an aide (or nurse) could complete tasks over several "visits" in the apartment throughout the day or week. This worked for a few years, then the pricing model was changed to a package structure to better support frequent short visits, improve use of staff time, and accommodate for individualized care in the AIP model. As a result of transitioning to a package structure, client satisfaction improved because the costs to the client were more predictable. The AIP services at TigerPlace through Sinclair Home Care are a stable and viable business operated by MUSSON.

Social work services have been an integral part of AIP since the inception of Sinclair Home Care. A licensed clinical social worker (LCSW) is available to help with counseling, community resource linkages, and other forms of psychosocial support. The LCSW assists with mental health and psychosocial assessments, advance directive planning, client social histories, and provides support with hospice care. The LCSW and RN care coordinator maintain a close working relationship when care planning with residents and their families. The integration of nursing and social work has maximized communication and an ability to view the residents in a holistic way that promotes early interventions.

More Project Effectiveness Evaluations: AIP at TigerPlace

A subsequent evaluation of the first four years of the AIP program at TigerPlace and another senior housing community receiving AIP services from Sinclair Home Care revealed significant cost savings and health improvements over traditional long-term care (Rantz et al., 2011). The combined care and housing cost for any resident who received care services beyond AIP basic services (routine assessment, access to the wellness center, exercise classes, and other health promotion activities) and who qualified for nursing home care has never approached, nor exceeded, the cost of nursing home care at either location. Subsequent evaluations have found that both mental and physical health outcome measures provide evidence that AIP is an effective model for health restoration and independence for older adults through the end-of-life.

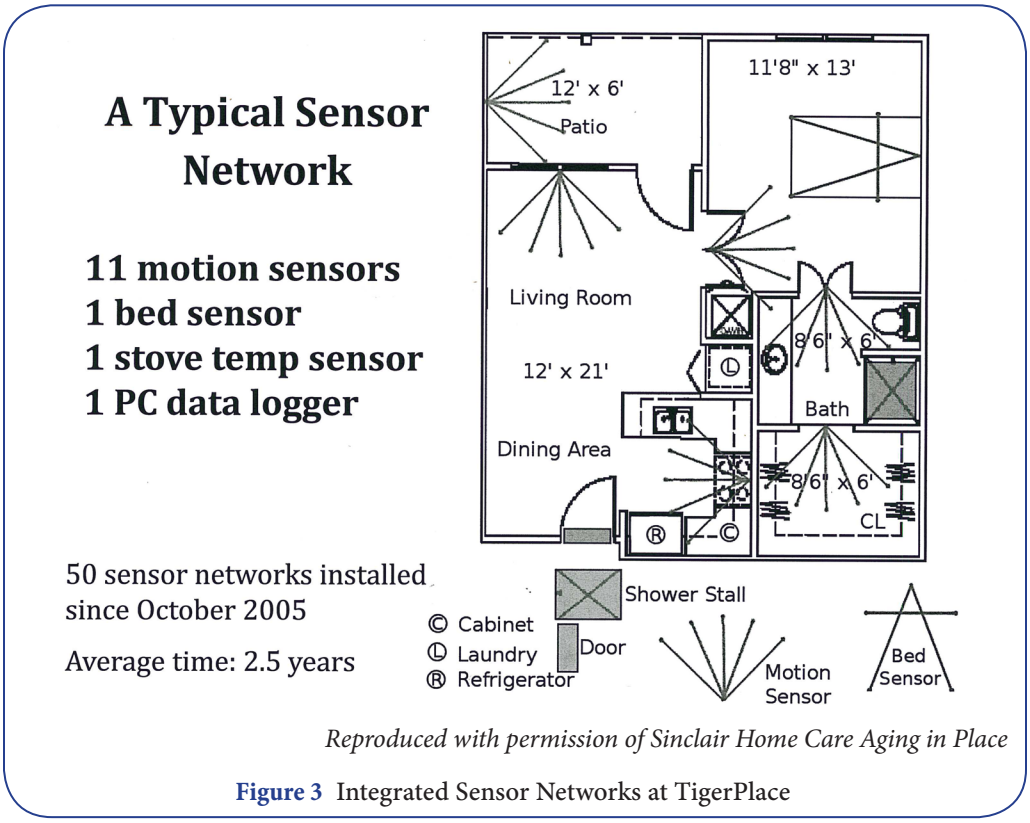
Technological Innovations: Technology to Enhance AIP

As the construction of TigerPlace was being planned, a challenge was posed to the engineering faculty at MU by Dr. Rantz for them to work with nursing and other faculty to develop new solutions to the persistent problems facing older adults. Specifically, they were challenged to develop technology that would help older adults stay as healthy and functionally independent as possible.

Working with older adults, the research team developed unobtrusive sensor technology that would monitor individuals as they performed every day actions (Rantz et al., 2005b). The participants do not wear any devices or perform any specific actions. The resulting integrated sensor network includes motion sensors, video sensors including the Microsoft Kinect, and a bed sensor that captures pulse, respiration, and restlessness as the resident sleeps. A web-based interface was developed to display the data from the sensors in a way that is easy to use, easy to understand and interpret, and clinically relevant (Alexander et al., 2011). Integrated sensor networks have been installed in over 50 apartments at TigerPlace. See Figure 3 for a diagram of this network.

The goal of the sensor network was to support care coordination at TigerPlace. The interdisciplinary Eldertech research team has accomplished this goal and more (Rantz et al., 2010; Rantz et al., 2012). The technology developed and implemented by the Eldertech team detects changes in function and health status of older adults and alerts staff to those changes so proactive interventions can manage healthcare problems in early stages, when interventions are most effective.

Using the sensor data, clinicians detect early changes in health conditions including urinary tract infections, increased congestive heart failure, changes in mental status, and many others before traditional healthcare assessment (Rantz et al., 2012). Based on the clinicians' observations and a retrospective analysis, alerts generated from the sensor data were developed with input from the nursing and engineering faculty. A one-year, two-group pilot study (people living with sensors and those living without) was completed using the sensor network to detect changes in health status indicating an impending acute illness or exacerbation of a chronic illness. In that pilot study, the care coordinator and other clinicians received these alerts; when warranted, the nurse or LCSW would assess the resident and intervene as necessary. Intervention participants living with the sensor networks showed significant improvements as compared to the control group in the Short Physical Performance Battery gait speed score at quarter 3 ($p=0.03$), average left hand grip at quarter 2 ($p=0.02$), average right hand grip at quarter 4 ($p=0.05$), and the GAITRite (a sensor mat that analyzes participants' gait while simply walking on it) functional ambulation profile at quarter 2 ($p=0.05$) (Rantz et al., 2012).



Reproduced with permission of Sinclair Home Care Aging in Place

Figure 3 Integrated Sensor Networks at TigerPlace

Based on the results of the pilot study, the integrated sensor network has been incorporated into the usual care at TigerPlace. The sensor technology is used as a decision support system for care coordination; it augments traditional healthcare assessment by facilitating earlier detection of illness and exacerbation of a chronic illness. It is now being tested in a large scale clinical trial funded by the National Institute of Nursing Research and the technology is now being commercialized so others can benefit from the technological innovations.

Challenges to Diffusing the Care Model: Becoming a National Long-Term Care Model

Based on the success of TigerPlace, Americare Systems, Inc. is planning another AIP facility in the Missouri region and working with MUSSON as planning progresses. This is the first step to widespread adoption of AIP throughout the country. Many other organizations and companies have been onsite to discuss the model at TigerPlace for replication in their locations. They have learned about TigerPlace through national publicity of the research about AIP, as well as the extensive technological innovations research.

The operations team at TigerPlace has willingly offered their expertise and assistance to others to replicate or innovate the RN care coordination model. When people visit, they clearly state that TigerPlace is a national model for a new long-term care environment.

There were many challenges for AIP to overcome to receive this recognition. Foundational are the care coordination cost, quality, and staffing evaluations about AIP in the community and at TigerPlace. Those evaluations have drawn attention to the effectiveness and cost savings of RN care coordination as an effective care delivery model regardless of setting. In addition to the challenges of operations and evaluations, the main challenge was business viability for the community-based services.

In the original 1999–2003 evaluation funded by CMS, the RN care coordination model was developed and used in public housing, private homes, and congregate housing. The grant supported the RN care coordination costs and the typical care was funded by the Medicaid Home and Community Based Services. After the grant concluded, to help the agency be viable as a business, more profitable services such as private pay and private insurances balanced the challenges of limited Medicaid funding. Even with that business approach, it was extremely challenging for the home care agency to break even on costs using public reimbursement mechanisms such as Medicaid and still provide the much needed care coordination.

Today, it is likely that recent Medicare funding approval for care coordination will improve the business viability of the RN care coordination using the AIP model in public housing. Specifically, there are now mechanisms to bill for "complex chronic care coordination services." These "services are patient-centered management and support services provided by physicians, other qualified healthcare professionals, and clinical staff to an individual who resides at home or in a domiciliary, rest home, or assisted living facility… the reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living" (AMA, 2013, p.35). This would considerably reduce the challenges faced ten years ago to constantly seek grant funding or donations to support the critically important RN care coordination function for the elderly and disabled. With new deployment today in public housing situations, it is likely some modifications to the model will have to be made to best fit current reimbursement policies.

The Cutting-Edge Challenge: Staying Alive Until Change Becomes Widespread

As a cutting-edge program, there are no others out in front to watch, learn from, and anticipate challenges to be expected in the future. The operations team has to work closely

and constantly keep the goal of helping older adults maintain independence through the end-of-life in focus in all clinical situations. It can be easy to revert to traditional solutions for older adults who are experiencing health changes or events that may pose safety hazards. These traditional solutions are often encouraged by primary care providers and usually involve moving to a higher level of care such as assisted living or nursing homes. There is a belief that traditional long-term care will somehow solve safety problems like falling.

Constant education about the AIP model of care that encourages independence and health promotion is needed to remind other healthcare providers, families, residents, surveyors, and sometimes our own team members that residents living at TigerPlace can be independent while also receiving safety and care measures thought only to be available in traditional care facilities. Staff members working in the AIP model make extraordinary efforts to promote resident independence, decision-making, and maintenance of maximum physical and cognitive function through the end-of-life.

However, because the care model is cutting edge, consumers, healthcare providers, and regulators not familiar with AIP try to "make it fit" into some traditional "box" or typical category of traditional assisted living, nursing home, or housing concept. Surveyors not experienced in evaluating TigerPlace and the approach to care often struggle to understand it. When surveyors conduct the annual inspection, they are often confused because traditional care systems are replaced by care coordination, health promotion activities, and independent decision-making by residents. It is a lively, dynamic model of care delivery that looks very different from the usual facilities that surveyors visit. Until the AIP care model with RN care coordination is more widespread, explanation and education will be a constant part of daily operations.

What to Do When You Are the Only One

It is essential that organizations providing new and unique models of care continue to work with stakeholders (lawmakers, physicians, visiting scholars, nurses, families, and the clients served). *Keep involving stakeholders* to reinforce and renew the vision and involve the next generation of leaders (undergraduate and graduate nursing students, engineers, social workers, informaticians, new healthcare providers, and others) so they can continue, distribute, and improve upon the model.

Focus on innovation. The constant focus on innovation promotes an openness to new ideas so the care services can improve and be more efficient and effective. The focus on innovation in AIP have resulted in building an electronic health record that supports care coordination by improving documentation of care delivery, communication, and

functional status. Simultaneously, this electronic healthcare record serves as a continuous source of data to support research and evaluation. A major innovation has been the development of sensor technology to enhance the wellbeing and functional status of older adults.

Continuously promote the project through personal communication, publications, and presentations. Take the time to develop fresh summary documents (flyers, pamphlets, short news articles) about the services, outcomes, and innovations developed by the new model of care. While it takes time to tour people through the organization, that time is critical to promote and spread the word from person to person. Talk to colleagues, policymakers, and others, leaving summary briefs for them to remember the project at a later time. Publish the results in journal articles and press releases. Present results at local, national, and international conferences. Talk to community stakeholders and groups. Open the doors to the organization so that visitors can see the model and envision a new way of thinking about care delivery.

Know When to Change

Nothing remains static. Health care is dynamic and the forces that shape healthcare delivery are under constant pressure to change. It is critical to keep abreast of changes on the state and national horizon and be positioned to respond to changes. When pressures appear to be potential problems for operating the innovative care delivery model, stop and decide: (a) Must something be done? (b) If so, what? and (c) How aggressive should the response be? The model will need to evolve and ultimately the day may come when a decision for radical change must be made. If that happens, work with an operations team to guide the project as a business and as an evolving innovation. Teams make better decisions than single decision makers, especially in cutting edge innovations.

SUCCESSFULLY INFLUENCING PUBLIC POLICY

The TigerPlace AIP experience has illustrated four key steps toward successfully influencing public policy.

Take Expert Advice Seriously.

About three years ago, AIP team members were urged to prepare short videos of the RN care coordination and costs results of the AIP innovations and cost-effectiveness evaluations. These were not easy to plan and do, but three different versions were produced and captured the ideas well enough for ANA and the American Academy of Nursing (AAN) to use as they pursued influencing CMS to change policies about Medicare funding for

care coordination. It is rewarding to know that the efforts of the AIP evaluation and communicating the results effectively in the three-minute videos had at least some part in getting Medicare regulations changed for RN care coordination for those with complex chronic care needs. Care coordination was specifically addressed in one section of the Medicare regulations (AMA, 2013, p. 35) and there is opportunity for a second change in the transitional care management services:

> These services are for an established patient whose medical and/or psychosocial problems require moderate to high complexity medical decision-making during transitions of care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital, or skilled nursing facility/nursing facility, to a patient's community setting (home domiciliary, rest home, or assisted living). (AMA, 2013, p. 36)

With these funding mechanisms, there is potential for the RN care coordination innovation to help millions of other older adults.

Publicize the Results

MU has consistently distributed both written and video press releases which have been syndicated by news outlets, television and radio, and professional publications throughout the country. Scholarly articles about the evidence of cost, quality, and outcomes of RN care coordination and technology innovations at TigerPlace were written to publicize the results in peer-reviewed journals. In addition, an AAN Edge Runner application was prepared. Using the ongoing evaluation results, the AIP Project and TigerPlace received an Edge Runner designation in 2008. The application materials have been updated to keep them current for use for public policy briefs.

Continuously Engage Stakeholders

Stakeholders must be consistently updated about the progress of the innovative care delivery models so they can maintain enthusiasm for the innovations. Routinely engage them in conversation and share important information about the program. For TigerPlace, an AIP Advisory Board was established at the beginning of the project in 1996 and the group of about 20 diverse community stakeholders continues to meet quarterly. The Board is made up of community aging advocates, Missouri Department of Health and Senior Services representatives, faculty and staff of the University, and others. Board members help build and maintain positive relationships with the community at large to help provide continuous community recognition and support for the TigerPlace innovations. Communication and relationships are critical to project success.

It is essential that lawmakers who are key stakeholders stay engaged. The AIP Board is chaired by the legislator (now retired) who sponsored the aging in place legislation in 1999. As a former legislator, he helps explain the project and build continued support for it with current legislators. He helps keep local, state, and national representatives informed about the original intent of the legislation backing the project and the positive contributions the project has made to health care. Results about cost savings and improved outcomes for older people are of interest to legislators. The operations team at TigerPlace also engages current legislators in conversations and they often tour the site; they get to know staff and residents personally and appreciate the positive results of the innovation. The team and board members take every opportunity to explain the work and showcase the service.

From the outset, national nursing organizations (American Academy of Nursing, American Nurses Association) and CMS were involved. Ideas were shared early and often. Results about outcomes of care and costs were shared as they were measured, articles written, and press releases circulated.

Most importantly, the voices of clients need to be heard. Satisfaction surveys are helpful, but frequent private interviews with residents and families can provide much needed insight to their needs and desires. The AIP and TigerPlace central goal is to keep older adults happy and healthy, promoting the highest quality of life as idealized by the individual; this is impossible to do without their input.

Always Engage in Public Policy Change

Although there are now Medicare mechanisms to fund care coordination, there are still remaining issues that need to be addressed through public policy change. The primary issue at this stage is to enable and facilitate the construction of long-term care facilities that continuously promote health, regaining independence when functional decline occurs, and enable older people to remain in the one place to receive care services as their needs change. There are state-specific hurdles for spreading the success of AIP at TigerPlace by replicating the building and care delivery model across the country. In Missouri, with regulatory waivers and state statute changes, the construction and evaluation of AIP at TigerPlace was enabled over 10 years ago. Now, it is time for other states to replicate it so that consumers have access to this cost- and clinically-effective new model of long-term care. Some states are well-positioned with long term regulations and state regulators who are interested in pursuing a different approach. Other states will require changes in building and operational regulations to enable construction of this

independent living environment that enables getting the right services at the right time through the end-of-life, without fear of unwanted relocation.

CONCLUSION

The key to moving demonstration projects into public policy is the rule of the 3Ps: Persistence, Persistence, and Persistence. The process is long and arduous. It takes hours of meetings, presentations, and conversations. But in the end, the work is necessary and worthwhile especially when it improves the lives of older adults and their families.

REFERENCES

AARP. (2013a). Valuing the invaluable: 2011 Update. The growing contributions and costs of family caregiving. Retrieved from http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

AARP. (2013b). Providing care: Obstacles to long-distance caregiving. Retrieved from http://www.aarp.org/relationships/caregiving-resource-center/info-09-2010/pc_obstacles_to_long_distance_caregiving.html

Alexander, G. L., Wakefield, B. J., Rantz, M., Skubic, M., Aud, M., Erdelez, S., & Al Ghenaimi, S. (2011). Passive sensor technology interface to assess elder activity in independent living. *Nursing Research,60*(5), 318–325. PMCID: PMC3272505.

American Medical Association (AMA). (2013). CPT Codes for evaluation and management. See http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page

Bentler, S. E., Liu, L., Obrizan, M., Cook, E. A., Wright, K. B., Geweke, E. A…Wolinsky, F. D. (2009). The aftermath of hip fracture: Discharge placement, functional status change, and mortality. *American Journal of Epidemiology, 170*, 1290–1299. doi: 10.1093/aje/kwp266

Johnson, R. A., Rantz, M. J., McKenney, C. A., & Cline, K. M. C. (2008). TigerPlace: Training veterinarians about animal companionship for the elderly. *Journal of Veterinary Medical Education, 35*(4), 511–513. PMID: 19228901.

Manion, P. S., & Rantz, M. J. (1995). Relocation stress syndrome: A comprehensive plan for long-term care admissions. *Geriatric Nursing, 16*(3), 108–112.

Marek, K. D., Adams, S. J., Stetzer, F., Popejoy, L., Petroski, G. F., & Rantz, M. (2010). The relationship of community-based nurse care coordination to costs in the Medicare and Medicaid programs. *Research in Nursing & Health, 33*, 235–242. PMCID: PMC3046776.

Marek, K., Popejoy, L., Petroski, G., Mehr, D., Rantz, M. J., & Lin, W. (2005). Clinical outcomes of aging in place. *Nursing Research, 54*(3), 202–211.

Marek, K. D., Popejoy, L., Petroski, G., & Rantz, M. J. (2006). Nurse care coordination in community-based long-term care. *Journal of Nursing Scholarship, 38*(1), 80–86.

Marek, K., & Rantz, M. J. (2000). Aging in place: A new model for long-term care. *Nursing Administration Quarterly, 24*(3), 1–11.

Marek, K. D., Rantz, M. J., & Porter, R. T. (2004). Senior care: Making a difference in long-term care of older adults. *Journal of Nursing Education, 43*(2): 81–83.

Marek, K. D., Stetzer, F., Adams, S. J., Popejoy, L., & Rantz, M. (2012). Aging in place versus nursing home care: Comparison of costs to Medicare and Medicaid. *Research in Gerontological Nursing, 5*(2), 123–129. PMID: 21846081.

Rantz, M. J., Marek, K. D., Aud, M. A., Johnson, R. A., Otto, D., & Porter, R. (2005a). TigerPlace: A new future for older adults. *Journal of Nursing Care Quality, 20*(1), 1–4.

Rantz, M. J., Marek, K. D., Aud, M. A., Tyrer, H. W., Skubic, M., Demiris, G., & Hussam, A. A. (2005b). A technology and nursing collaboration to help older adults age in place. *Nursing Outlook, 53*(1), 40–45.

Rantz, M. J., Marek, K. D., & Zwygart-Stauffacher, M. (2000). The future of long-term care for the chronically ill. *Nursing Administration Quarterly, 25*(1), 51–58.

Rantz, M. J., Phillips, L., Aud, M., Marek, K. D., Hicks, L. L., Zaniletti, I., & Miller, S. J. (2011). Evaluation of aging in place model with home care services and registered nurse care coordination in senior housing. *Nursing Outlook, 59*(1), 37–46. PMID: 21256361.

Rantz, M. J., Skubic, M., Alexander, G., Aud, M., Wakefield, B., Koopman, R., & Miller, S. (2010). Improving nurse care coordination with technology. *Computers, Informatics, Nursing, 28*(6), 325–332. PMID: 20978402.

Rantz, M. J., Skubic, M., Koopman, R. J., Alexander, G., Phillips, L., Musterman, K. I., Back, J. R, … Miller, S. J. (2012). Automated technology to speed recognition of signs of illness in older adults. *Journal of Gerontological Nursing, 38*(4), 18–23. PMCID: PMC3366277.