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AGING AMERICANS 2016

Policy Challenges and Opportunities to Enable Successful Aging at Home

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UNIVERSITY of ROCHESTER

Professor Abraham Seidmann, PhD
Xerox Professor of Computers & Information Systems,
Electronic Commerce and Operations Management
Simon Business School, University of Rochester
Rochester, New York

Ray Dorsey, MD, MBA
David M. Levy Professor of Neurology
University of Rochester School of Medicine & Dentistry
Rochester, New York

FORWARD

July 25, 2016

We were delighted to host the d.health Executive Summit in New York City at the historic World Trade Center site for a second year in a row. Over 200 participants joined us in a collaborative effort to disrupt healthcare to allow Americans to Age at Home.

This year's Presidential primary campaign has largely ignored an issue paramount to a growing segment of our population. Nearly 90% of Americans prefer to age at home, yet barriers, such as antiquated reimbursement and licensing policies, prevent Americans from realizing this goal. To address this political "blind spot," the Summit assembled health, technology, finance, and policy leaders to discuss today's best ideas, form tomorrow's partnerships, and launch the care models of the future.

The d.health Summit agenda featured more than 10 CEOs and numerous thought leaders who are disrupting healthcare to modernize homecare, provide virtual visits into the home, transform the insurance industry, redesign and reframe successful aging, and revolutionize medical education. Noted journalists from *The New York Times, The Atlantic,* and *Fast Company* moderated the panel sessions. Nationally-known leaders in healthcare and the aging space joined new entrants to the market to provide unique perspectives and discover synergies.

This document provides policy recommendations based on what was an exciting day of discussion and collaborative thinking.

Avi & Ray

POLICY CHALLENGES AND OPPORTUNITIES TO ENABLE SUCCESSFUL AGING AT HOME

The rapid aging of the U.S. population — and of populations in both developed and developing countries around the world — is creating pressure for dramatic changes in healthcare systems and approaches originally established to handle far different demographic patterns in the last century. Skyrocketing costs associated with the health and wellness requirements of those living longer, growing demand for alternatives to hospitalization and reactive treatment of acute medical conditions, and the need to accommodate "aging in place" instead of institutionalization offer ample scope for transformative innovation. But this innovation faces significant hurdles: behavioral, attitudinal, financial, and regulatory. The second d.health Summit, held on May 4, 2016, at the New York Academy of Sciences, brought together 200 leaders from the health, technology, finance, and policy fields to develop disruptive solutions to enable aging at home. Speakers and attendees highlighted both the barriers to creative solutions and the policy changes that could help remove those barriers and ensure a higher quality of life for all Americans as they age.

We are confronting one of the great social challenges of the early 21st century — the aging of the American population. Currently over 50 million Americans are over 65, and by 2025 70 million will be….This social challenge will require health, technology, finance, and policy solutions.

— Ray Dorsey, M.D.
d.health Summit Chair and Professor, University of Rochester Medical Center

Aging Baby Boomers will redefine what it means to be old, and their expectations will drive change and evolution across the health spectrum.

— Drew Miller, Creative Director, Healthcare Practice, frog Design

AGING IN PLACE

An AARP survey has found that 90% of seniors want to "age in place" in their own home, but a majority fear that they will not be able to do so. 29% say their greatest fear is a loss of independence. How can we empower the elderly to remain in their homes on their own terms for as long as possible?

Super Aging makes the question an urgent one. As d.health Summit keynote speaker Stephen Johnston noted, the term relates to a country having 20% or more of its population older than 65. Today that's the case in 3 countries (Germany, Italy, and Japan), but by 2030 there will be 34 countries with that distinction. These demographic changes mean the costs of healthcare and wellness for the elderly will rise even as the number of younger people available to foot the bill declines.

What do the elderly need to remain independent and at home?

According to d.health Summit keynote speaker Drew Miller, seniors have four core needs: identity ("help me stay me"), routine ("help me stay in control"), sociability ("help me stay engaged"), and vitality ("help me stay physically and mentally fit"). Consumer technology, including technology not specifically aimed at the senior market, such as Amazon's Echo, has a role to play in meeting all these needs. The Internet of Things and connected homes can make tasks like shopping easier and more convenient, and services like Uber and Lyft offer transportation alternatives that can offset a decrease in mobility. Smartphones and teleconferencing can likewise help the elderly remain socially engaged even when unable to attend gatherings outside the home. Ideas include a telepresence to allow a window into the home of loved ones that looks and feels as close to reality as possible, enabling grandparents to have something akin to a shared living experience even when separated by thousands of miles.

As more than 60% of seniors live with one or more chronic diseases, providing effective healthcare is central to keeping them in their homes and independent as long as possible. Here, too, technology can reduce the burdens of transportation and in-person visits to physicians' offices for routine management of these conditions. By enhancing the quality of care, technology can help reduce acute incidents, emergency room visits, and hospitalization as well.

Many other opportunities exist to support seniors in the home, among them the following:

- **Integrated e-calendars that contain treatment regimens and appointments.**
- **Wearable technology and smart fibers that can provide around-the-clock monitoring of vital signs and behavior.**
- **Videoconferencing for regular medical appointments.**
- **Text messaging and apps linking to on-call medical support networks.**

Outside the home, senior centers can provide a richer experience and increased reach into underserved communities as well. Nonprofit health plan EmblemHealth has found a ready audience for its sites in poorer neighborhoods in New York, which provide information on health, food stamps, and other social programs, as well as offering free exercise and meditation classes. On the West Coast, the Gary and Mary West Senior Wellness Center, supported by grant from the Gary and Mary West Foundation, is just one of three senior centers in the country which provides meals to low-income seniors 365 days a year. The center offers comprehensive access and care coordination to more than 30 nonprofit clinical and non-clinical organizations under one roof. The insights from the center helped identify a critical unmet need for seniors — access to oral healthcare — which led to the establishment of an integrated dental clinic. In addition to providing clinical care, the dental center serves as a research platform to inform policies related to appropriate coverage, the impact of care delivery within a community-based organization and the effectiveness of a care coordination model.

It is also important to enlarge the scope of healthcare beyond its traditional limits to keep seniors active and engaged, in a time when families frequently do not live together, because social isolation affects health. AARP's Experience Corps tackles this isolation by engaging senior volunteers to tutor and mentor elementary-school children. Research has shown that the young people exhibit improved academic performance, and the older adults experience enhanced well-being as well.

Innovative approaches to mobility solutions, healthcare delivery, home services, and more, offer the promise of improved health and wellness for the elderly while reducing costs for the healthcare system as a whole, because aging in place is orders of magnitude cheaper, as panelist Stephanie Tilenius, founder and CEO of mobile continuous-care platform Vida, told attendees.

The system for seniors is in need of a makeover as we face the largest demographic shift in American history — the aging of America. This offers us a great opportunity to create a better and more responsive system of healthcare and supportive services.

— Shelley Lyford
President and CEO, Gary and Mary West Foundation and West Health

Our world is connected; our care needs to be too. Health is so much more than doctor visits. It's about a community of care surrounding individuals with personalized support they need.

— Damian Gilbert
Founder & CEO, TouchCare

HOW INNOVATION IS TRANSFORMING HEALTHCARE, PATIENTS' LIVES

Innovators in technology and healthcare are already bringing improvements to the lives of aging Americans, and their efforts address several key dimensions of such solutions:

Personalization • Flexibility • Holistic health • Thinking beyond the individual

Personalization

It is important to listen to the elderly to learn their wants and needs. Consumers of all types want faster and more convenient services, but individual cases call for individualized responses. Harnessing the power of technology and creative design can allow this customization — and thus greater happiness and better health outcomes as well — without the burden of prohibitive costs.

Aging2.0, a global innovation platform with a mission to improve the lives of older adults around the world, has appointed a Chief Elder Executive to make the younger generation aware of the day-to-day challenges seniors face. Inspired by Dr. June Fisher, Aging2.0's CEE, San Francisco State University students developed City Cart, a winner of this year's Stanford Center on Longevity Design Challenge, a combination of walker and cart intended to make shopping alone safer and easier for those with mobility issues.

EmblemHealth a nonprofit health plan, is rebuilding its customer support to make it faster, more transparent, more accurate, and more comforting, and is thinking about using the Internet and telehealth to bring together resources to support the individual in getting the right care at the right time in the right setting.

Flexibility

It is important to recognize that needs change over time. As individuals age, they tend to move from being fully independent and active, to a stage where activities (say, driving) become more challenging and they require more adaptive environments to ease daily tasks, to a point of dependence, where they need more and deeper care and more regular medical attention. Along this journey, they want to remain as much in control as possible, and it is to the benefit of society to help them do so. **frog Design**, a global design and strategy firm, has proposed OurPlace, a service-backed DIY framework for seniors to create their own small-scale communal living experience — outside an institutional setting — that can be updated and expanded to meet the changing needs of the members. In such an environment, technology would play a key role in enabling independence while facilitating interactions with the broader world, including use of delivery and transportation services as mobility becomes a greater issue.

Telemedicine offerings from firms such as **American Well**, **Doctor on Demand**, **TouchCare**, and **Pager** are giving patients more control over their lives. Rather than endure an endless round of trips to clinics, physicians' offices, and emergency rooms, patients can interact with medical professionals from the comfort of home. And while the

convenience of a rapid urgent-care response may drive initial interactions with some services, the companies find that at least some consumers look to establish longer-term relationships as repeat patients. Physicians, too, benefit by being able to see patients at their convenience without being locked into onsite office hours.

The Independence at Home Demonstration (innovation.cms.gov/initiatives/independence-at-home/), under the auspices of the Centers for Medicare & Medicaid Services, has been providing chronically ill Medicare beneficiaries with primary care services in the home setting. In the first performance year, 17 participating practices served over 8,400 Medicare beneficiaries. The results in the first year: fewer hospital readmissions within 30 days and less use of inpatient hospital and emergency department services for conditions such as diabetes, high blood pressure, asthma, pneumonia, or urinary tract infection, for a savings of over $25 million — an average of $3,070 per participating beneficiary.

Holistic health

Chronic patients — the elderly often suffer from multiple chronic conditions — benefit from knowledge and expertise directed toward the whole person, rather than an approach that tackles isolated diseases or conditions and acute incidents with limited context.

Telemedicine has an important place, because when done right, with the right physician and the right care, you get superior clinical outcomes. The reduction in travel time and associated costs benefit patients by reducing the disruption of their daily lives, helping them escape the feeling that they are held hostage by medical appointments. Around-the-clock, on-demand, smartphone-delivered telehealth services are already offered in some markets and to those who can pay. These services offer convenience and responsiveness to individual schedules and urgent needs as well.

Integrated care networks also have a role to play. Netherlands- based Parkinson Centre Nijmegen has established an integrated care network, from the home up through university health centers, built around dedicated professionals trained in Parkinson's disease, who engage patients as partners in healthcare and are achieving remarkable results, including a 6% reduction in expenditures for chronic annual care for Parkinson's disease alone. "Just imagine what would happen if you copied that model to … other chronic conditions," says medical director Bas Bloem. ParkinsonNet has already expanded into the United States in California in collaboration with Kaiser Permanente, and further expansion is possible.

Thinking beyond the individual

Because of their vital role in ensuring the health and well-being of aging members of society, it is important to engage and support seniors' family, friends, and caregivers. As appropriate, family and friends need to be kept informed on diagnoses and treatment regimens. Likewise, home health aides and visiting nurses need to be more integrated into the individual's chronic care, with improved information-sharing and tools to operate at a higher professional level. The physical and psychological toll that caring for a chronically ill spouse or parent takes must be recognized, too, and steps taken to lighten that burden.

Some 42 million family caregivers in the U.S. alone often must struggle — without training — to fulfill responsibilities that used to be the province of medical professions, such as managing multiple medications. In response, **AARP** has developed the Caregiver Advise, Record, Enable (CARE) Act, which has three key features:

- The name of the family caregiver is recorded when a loved one is admitted into a hospital or rehabilitation facility.
- The family caregiver is notified if the loved one is to be discharged to another facility or back home.
- The hospital or rehabilitation facility must provide an explanation and live instruction regarding the medical tasks — such activities as managing medications, giving injections, and wound care — that the family caregiver will perform at home.

To date, 20 states have passed the CARE Act, thereby requiring hospitals to include the family in the care team and keep them informed.

In the Netherlands, **ParkinsonNet** is offering consultations for spouses of patients with Parkinson's disease and seeing a massive response, as these family caregivers look to learn more and receive guidance. A collateral result is that patients have also expressed the desire to come alone, too, for such consultation.

Honor, a startup providing support for home health aides, has built the technological underpinnings of a service intended to optimally meet the needs of the elderly. Sophisticated programming matches the heterogeneous needs of the customers with the diverse capabilities of the company's cadre of care professionals, with the aim of putting the right person in the home, at the right time, for the right amount of time, with the tools to do the right job. Although the chief focus is on helping the elderly with the activities of daily living, rather than medical treatment, health systems have begun reaching out to the company for help tackling things like hospital readmission rates as well.

Flexible prefabricated housing, progressive needs-based renovation, on-demand services, sensor-driven responsive environments, community responsibility, location and identity driven technology. Together these solutions will promote independence and ongoing social engagement, while meeting seniors' just-in-time needs to support them as they get older.

— Drew Miller
Creative Director, frog Design

BARRIERS TO INNOVATION HAMPER CREATIVITY, INFLATE COSTS

Despite the promise shown by the innovative approaches described above, effective expansion and deployment of creative efforts to improve healthcare for our aging population face a variety of obstacles:

Burdensome regulations • Outdated payment mechanisms • Structural limitations • Interoperability issues

Burdensome regulations

Governmental regulation of healthcare is important in ensuring the safety and well-being of the public. Nevertheless, entrenched interests, inflexibility, and outmoded models of the industry retard innovation and thus extend the suffering of many with chronic conditions.

Regulations have grown in number and reach over the past three decades. Panelist Thomas McInerney, president and CEO of insurance holding company Genworth, observed that the result is overcomplication that leads people to abandon efforts to obtain, for example, long-term care insurance, because there are too many difficulties involved just in buying it: pages and pages of material, multiple signatures, etc. This inefficiency is a drag on the ability to offer useful, innovative new funding options that could lower costs and see widespread adoption in the marketplace.

Ossification of the research and evaluation cycle is an even greater drag on creativity. Clinical trials can take years and cannot keep pace with either the rate of experimentation or the lifespans of start-up companies in the field. A focus on isolated evaluation of medical interventions reduces the usefulness of results and keeps treatment options out of the arsenal of the healthcare provider, because unapproved devices and treatments and generally won't be reimbursed.

In contrast to Medicaid, which already in most states is allowed to sponsor telehealth for people who need it, Medicare historically has not covered telemedicine except in exceptional circumstances. Lack of support from this dominant player — perhaps now changing, with the possibility of coverage beginning next year — has retarded adoption of this technology.

At the state level, complexities with licensing of physicians and varying regulatory frameworks for, e.g., home health aides, make it difficult and costly for provider companies to try expanding beyond a single state, either with a local presence or via telemedicine, and for patients to obtain consistent care from their preferred physicians and other medical professionals in their travels.

Outdated payment mechanisms

If regulatory inertia slows the spread of innovation, outdated payment structures can bring it to a halt. Fee-for-service compensation structures reflect an emphasis on the treatment of acute cases and have little room for approaches that look at the patient's health holistically. Until payers realign their thinking to value prevention and long-term outcomes over short-term interventions, transformative innovation remains unlikely.

Panelist Thomas DeRosa noted that at present there is no government reimbursement for maintaining wellness; the burden rests entirely on the individual. Medicare does not pay for appropriate housing, nor are there tax incentives for families paying for facilities that keep impaired family members out of the hospital.

Beyond U.S. borders the same problem exists, according to panelist Bas Bloem. A reimbursement system aimed at institutions is the hurdle that is preventing the replication for other diseases of ParkinsonNet's success with Parkinson's disease, even in the Netherlands. Innovations such as consultations for spouses receive no reimbursement — after all, the spouse is not sick. Likewise, the operations of Parkinson TV, which delivers information to patients at home on topics they request, are not reimbursed, but instead must be covered out of Parkinson Centre Nijmegen's budget.

Keynote speaker Drew Miller characterized the fee-for-service healthcare delivery system as "broken". The industry is highly invested in the status quo, and the emphasis on discrete payments leads to an interest in doing more rather than doing better, treating the sickest rather than promoting health, and resistance to workflow and technological changes that could increase efficiency.

Panelist Walter Jin, co-founder of Three Fields Capital and Pacific Healthcare Management, observed that there is a lot of capital waiting to be put into healthcare, particularly on the technological side, but the payment structure isn't there to support the purchase of innovative technologies. Home care and nursing homes just don't have the money. Speakers acknowledged a similar hurdle for the adoption of telemedicine by seniors; the costs of a smartphone and monthly data plan to enable video consultations with physicians, for example, may be prohibitive for those on fixed incomes.

Academic medicine, too, has disincentives to explore transformative changes to the healthcare system. It is a major beneficiary of the fee-for-service model, as those fees are used to underwrite losses from research and education inherent in system. Thus there are institutional pressures to support the status quo rather than face the need to develop new funding models to maintain the schools' missions.

Though a shift to value-based payments would ameliorate some of these problems, issues may persist. For example, "value-based payments" mean different things to different people, observes EmblemHealth President and CEO Karen Ignagni. Thus there is a need to focus on incentives, both upside and downside, while negotiating standards of quality, cost, and patient satisfaction, so that providers, and particularly those seeking a competitive edge, are encouraged to take risks to achieve those goals. Too much in the system, even where it is changing, is confined to the upside: rewards for achievements, but no punishments for falling short. This lack of downside risk prevents enduring change.

And although the Medicare Access & CHIP Reauthorization Act of 2015 signals a shift toward value-based payments by Medicare -- with its creation of a Quality Payment Program that includes the aim of making a new framework for rewarding healthcare providers for giving better care, not more just more care -- panelist Bruce Leff, M.D., of Johns Hopkins University School of Medicine, observes that Medicare has found it challenging to turn proven models of care into payment systems. Despite the clear cost savings and positive outcomes obtained during the first year of the Independence at Home Demonstration by CMS, for example, we have yet to see that success turning into actual Medicare payments for quality.

The focus on technology, data, and value (better health outcomes at lower costs) has opened up the possibility of a transformation in health and healthcare, aligning services and providers around the needs of individuals.

— Clay Johnston, M.D., Ph.D.
Inaugural Dean, Dell Medical School,
University of Texas at Austin

Structural limitations

Structural limitations of various kinds inhibit creativity and the expansion of new technological approaches to health as well.

Providers have been resistant to technological change — or at least to going beyond mere digitization to transformation of their practice of medicine. Designs that are not easily embedded in the clinical workflow, or that provide too much data too confusingly, may be partly to blame. At the same time, much data critical to managing chronic care and the aging — details on movement and exercise, for example — remain unstructured and outside the clinical software environment.

Payers have been slow to provide patients with actionable information about providers; insurance company pages often offer just a ZIP code search with pages of results but no real information on the doctors or practices listed.

Measurements of holistic success are elusive, increasing the reluctance of payers to fund more innovative options. Because each individual has his or her own unique set of conditions, both medical and social, the impact of each assortment of medical interventions and personalized services must be assessed. "Which of these interventions is most effective at keeping them healthy, and above all, which combination of interventions is more effective than other combinations?" asked d.health Summit keynote speaker Stephen Johnston in a recent blog post. Complexities of tracking all this information mean that data often are not gathered, further postponing interpretation and creation of normative guidelines.

Infrastructure also limits the spread of telemedicine. Transportation options generally are more limited in rural areas, giving patients with chronic conditions an incentive to be early adopters of telehealth. But rural areas often still lack high-speed Internet access, foreclosing the possibility of online video consultations and making even e-mail reminders of appointments more challenging.

Fragmentation. Lack of information clarity. Vested interests. These are the biggest obstacles to improving healthcare for Aging Americans.

— Stephen Johnston
Co-Founder, Aging2.0

Interoperability issues

Interoperability issues plague the modern healthcare system, although there is some movement toward establishing common standards on the part of Department of Health and Human Services. Legacy systems may present substantial hurdles for interoperability when users try to connect them with the more modern information systems. Other communications difficulties stem from having to meet the necessary regulatory restrictions intended to protect patients privacy.

Hospitals have spent tens of millions of dollars to put electronic medical records systems into place, but when a patient calls or goes to urgent care, they may not have access to a current list of the person's medications, allergies, etc., because they do not, or cannot, receive and incorporate automatic feeds of information from, e.g., the patient's primary care physician, or the physician's office is incapable of transmitting such data.

Large existing fixed investments in legacy systems require innovators to spend time and money on custom interfaces that are to some extent dead ends, because the results are one-off tools that cannot be scaled to broader markets.

Home healthcare agencies face similar problems interacting with physicians and providers. Such agencies are often smaller and lack the funds to develop custom solutions to interoperability issues with the differing electronic health record systems in place at practices in their region. There is thus a need for reimbursement and regulations to incentivize the sharing of information.

An attendee noted the challenges in delivering tech-enabled services to patients and caregivers as well, stating that although his company has a number of great ideas for helping patients with chronic conditions, they would have twice as many "if the government could help knock down some of the important barriers," as providers and vendors are "more interested in closed systems and market share," and there are too few "paved roads" for consumer-mediated requests for data that would enable innovative services.

Aging Americans are looking for support systems and solutions that will help them gracefully and successfully age at home. When looking at technology such as Telemedicine, they seek better Comfort, Control, Convenience, and Cost.

— Abraham Seidmann, Ph.D.
d.health Summit Chair and Professor,
Simon Business School, University of Rochester

Almost 25% of Medicare beneficiaries with Parkinson's disease, a common neurological disorder, reside in long-term care facilities. While the VA, private insurers, and Medicaid are increasingly covering and embracing telehealth, Medicare's policies actively prevent its adoption. In 2015, Medicare spent less than 0.01% of its budget on telehealth.

— Ray Dorsey, M.D.,
d.health Summit Chair and Professor,
University of Rochester Medical Center

POLICY RECOMMENDATIONS

The current care delivery models, infrastructure, and reimbursement systems will need to evolve if we want patients to benefit from access to affordable and high-quality healthcare.
— Tom DeRosa, CEO and Director, Welltower

One of the craziest elements of U.S. healthcare is that millions of Medicaid recipients, who are often the costliest, neediest, most vulnerable members of the population, are in programs which are essentially indifferent to whether those recipients go to the hospital, as they have no financial exposure or negative consequences to inpatient costs and services. There have been some attempts to reconcile accountability under single umbrellas, but they are scattered and slow in adoption. If CMS were to create a clear mandate that established accountability for all costs with single organizations, the impact on health costs and outcomes would be dramatic, saving tens of billions of dollars while improving care quality for millions.
— Robert M. Herzog, CEO and Founder, eCaring

As long as the healthcare system is focused on paying providers for care, rather than health, it will continue to be a struggle working with patients and individuals on critical strategies that actually improve their health, rather than simply treat them when they are sick.
— Clay Johnston, M.D., Inaugural Dean, Dell Medical School, University of Texas at Austin

Innovative technology and healthcare services offer the promise of better lives for aging Americans, at a lower cost to society and the taxpayer. What can the new presidential administration do to foster transformative innovation that achieves the end goal: independent adults living where they want to live, how they want to live, for as long as possible? We offer the following policy recommendations:

Renovate the regulatory system.

The gradual accumulation of disparate regulations adds complexity and cost while deterring agile development to meet changing needs. The new administration should undertake a top-to-bottom evaluation of the existing regulatory framework, on an abbreviated timetable, with an eye toward jettisoning outdated requirements; simplifying procedures for patients, providers, payers, and vendors; reducing cycle times for research and approval of products and treatments in individualized care plans; and restoring flexibility. An important option to explore is national licensing of physicians, or a federal framework for mutual recognition of licenses by state regulators. Barriers include state medical licensing boards and issues involving scope of practice.

Universal medical licensure (versus state by state)... facilitates efficient care delivery for aging-in-place patients (and their caregivers), and helps maximize the impact of highly specialized physicians.
— Owen Tripp, Co-Founder and CEO, Grand Rounds

Reform healthcare payments.

The new administration should accelerate the shift to value-based payments that reward providers for patient health and wellness, rather than being tied to specific procedures or devices. Critical to the success of this shift is the development of new metrics of value that are appropriate to the changing demographics of the American population, and the administration should commit to funding the (expensive) development of scientific, objective, fair measures for general use so that underserved and vulnerable groups get the healthcare they need and deserve. Important, too, is addressing misaligned incentives and enabling or increasing reimbursement for telemedicine and home healthcare. While private insurance plans such as Medicare Advantage offers some telehealth services, the Medicare fee-for-service model does not.

Telemedicine reimbursement (by Medicare). I cannot think of anything more important. (It is the) most important catalyst by far to bring about home care for individuals with chronic conditions. I cannot think of a close second…. (Medicare's reimbursement of telemedicine) has extraordinary potential for transforming home healthcare and chronic illness management.
— Senator Tom Daschle, Founder and CEO, The Daschle Group, 2016 d.health Advisory Board

Foster interoperability.

Every person should be able to access his or her own medical data and access telehealth everywhere. HHS under the new administration should work to ensure that standards of interoperability are defined in a timely fashion, and that their implementation is incentivized by appropriate rewards and penalties, so that information can flow freely wherever the patient desires it to go.

Require interoperability and data exchange for all health EMRs to facilitate population health management.
— Brooke Hollis, Associate Director, Sloan Program in Health Administration, Cornell University

Tackle the social determinants of health.

Social and behavioral factors play key roles in determining long-term health and wellbeing. The new administration should look to support improvements in such factors, whether by guidance calling on health plans to get Medicaid patients on food assistance or accelerated implementation of rural high-speed Internet access to facilitate connected living and telehealth.

Racial and ethnic disparities in healthcare have been a major public health goal for two decades. Mandatory collection of accurate patient level data on race, ethnicity, and language would allow all healthcare quality indicators to be tracked for equity of care delivered.
— Dr. Lynne Richardson, Professor of Emergency Medicine, Icahn School of Medicine at Mount Sinai

Encourage planning and engagement.

The average American is unprepared for old age, and family and friends often have not been involved in planning for the stages of the senior's life. The new administration should look to incentivize early planning for later life in the form of savings akin to 401k plans. Moreover, the administration should implement regulatory reforms that make it easier to involve informal caregivers in the healthcare process, giving them rights in accord with the patient's wishes.

* * *

The sweeping demographic changes that the United States faces in the first half of the twenty-first century pose significant public policy challenges. Strong leadership is required to enact the reforms and embrace the innovations that will enable our seniors to age in place in health.

WHAT ONE POLICY CHANGE WOULD YOU RECOMMEND TO THE NEXT PRESIDENT THAT WILL ENABLE AMERICANS TO AGE AT HOME?

SELECT POLICY RECOMMENDATIONS – D.HEALTH SUMMIT 2016

"Telemedicine reimbursement (by Medicare). I cannot think of anything more important. (It is the) most important catalyst by far to bring about home care for individuals with chronic conditions. I cannot think of a close second ... (Medicare's reimbursement of telemedicine) has extraordinary potential for transforming home health care and chronic illness management."
— Senator Tom Daschle, Founder and CEO, The Daschle Group, 2016 d.health Advisory Board

"Have CMS provide universal reimbursement for telemedicine."
— Howard Reis, President, The Castleton Group (collaborative focused on connected healthcare)

"The most viable recommendation is to allow all participants in Medicare's various payment innovations to cover telehealth as they find prudent - such as Medicare Advantage, accountable care organizations, bundled payments and the Independence at Home Demonstration."
— Gary Capistrant, Chief Policy Officer, The American Telemedicine Association

"Clarify (unrestrain) role of telehealth in home health and hospice agencies."
— Dr. Steven Landers, CEO, VNA Health Group

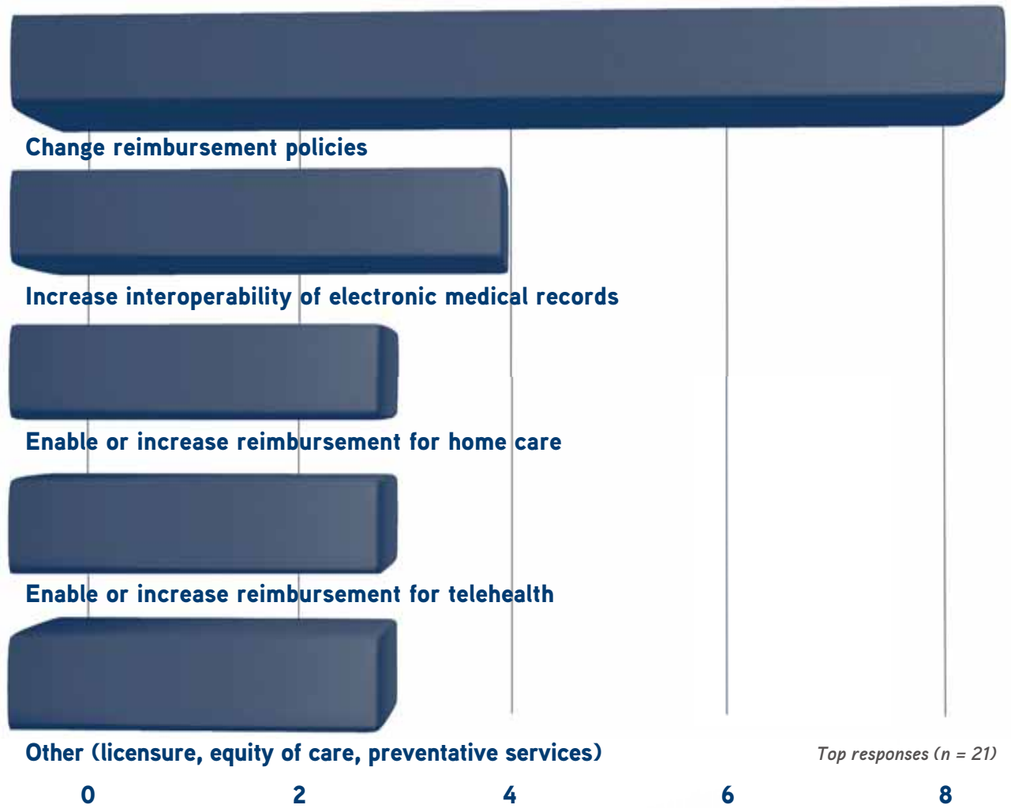
"Require interoperability and data exchange for all health EMRs to facilitate population health management."
— Brooke Hollis, Associate Director, Sloan Program in Health Administration, Cornell University

"Make health plans and managed care organizations (and payers) responsible, accountable, and exposed to costs for both Medicaid and Medicare."
— Robert Herzog, CEO and Founder, eCaring

"Universal medical licensure (versus state by state)... facilitates efficient care delivery for aging-in-place patients (and their caregivers), and helps maximize the impact of highly specialized physicians."
— Owen Tripp, Co-founder and CEO, Grand Rounds

"Racial and ethnic disparities in healthcare have been a major public health goal for two decades. Mandatory collection of accurate patient level data on race, ethnicity, and language would allow all health care quality indicators to be tracked for equity of care delivered."
— Dr. Lynne Richardson, Professor of Emergency Medicine, Icahn School of Medicine at Mount Sinai

Recommended Policy Changes



Top responses (n = 21)

APPENDIX A

2016 d.health Executive Summit Advisory Board

- **SENATOR TOM DASCHLE** Founder & CEO, The Daschle Group
- **NANCY M GREEN** Healthcare Global Lead, Verizon Enterprise Solutions
- **DAVID KLEIN, MBA** Special Advisor to the CEO, University of Rochester Medical Center
- **BRUCE LEFF, MD** Professor of Medicine, Johns Hopkins University School of Medicine
- **PHILIP LEVINSON, MBA, MPA** Venture Advisor, Learn Capital
- **CAROL RAPHAEL** Board Chair, AARP
- **JOSEPH M. SMITH, MD, PhD** CEO, Reflexion Health
- **SETH STERNBERG** Co-Founder & CEO, Honor
- **AVIVA SUFIAN, MPP, MPH** Consultant

APPENDIX B

2016 d.health Executive Summit Speakers

- **ELISE SWEENEY ANTHONY, JD** Acting Director, Office of Policy at ONC, HHS
- **BASTIAAN "BAS" BLOEM MD, PhD** Medical Director, Parkinson Center Nijmegen (PARC), The Netherlands
- **CYNTHIA BOYD, MD, MPH** Associate Professor of Medicine, Johns Hopkins University School of Medicine
- **THOMAS J. DEROSA** CEO & Director, Welltower, Inc.
- **CHRISTINA FARR** Journalist, *Fast Company*
- **DAMIAN GILBERT** Founder & CEO, TouchCare
- **JENNIFER HAJJ, MBA** Senior Consultant, Sachs Policy Group
- **KAREN IGNAGNI** President & CEO, EmblemHealth
- **WALTER JIN** Founding Partner, Three Fields Capital
- **S. CLAIBORNE "CLAY" JOHNSTON MD, PhD** Inaugural Dean, Dell Medical School & VP of Medical Affairs, The University of Texas at Austin
- **STEPHEN JOHNSTON, MBA** Co-founder, Aging2.0
- **STEVEN LANDERS, MD, MPH** President & CEO, Visiting Nurse Association Health Group
- **NOAH LANG** Co-founder & CEO, Stride Health*
- **SHELLEY LYFORD** President & CEO, Gary & Mary West Foundation; West Health Institute
- **THOMAS MCINERNEY** President and CEO, Genworth Financial
- **DREW MILLER** Creative Director, frog Design
- **JONATHAN RAUCH** Author & Journalist, *The Atlantic*
- **OSCAR SALAZAR** Chief Product Officer and Co-founder, Pager
- **ROY SCHOENBERG, MD, MPH** Co-founder & CEO, American Well
- **PAULA SPAN** Author & Journalist, *The New York Times*
- **SETH STERNBERG** Co-founder & CEO, Honor
- **STEPHANIE TILENIUS, MBA** Founder & CEO, Vida
- **IAN TONG, MD** Chief Medical Officer, Doctor On Demand
- **OWEN TRIPP, MBA** Co-Founder & CEO, Grand Rounds
- **DEBRA WHITMAN, PhD** Chief Public Policy Officer, AARP*

*Unable to participate

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