CONVERGENCE

Rethinking Care for Older Adults

A Report on a Series of Convergence Conversations

December 10, 2020

It is often said that we have medicalized aging and lost sight of what people want as they age. To address this, we need a changed mindset, seeing older adults as people with different visions of their future, and not solely as patients needing care. Some older adults age with a disability over many years, while others run for president. Thus, we need to think about the whole continuum: some older adults may need a great deal of help, but others may just need a few supports.

Understanding the many emotional and social needs that are important to a person's life is essential to discerning what the best setting for them might be. And while untreated pain, depression, uncertain balance, and social isolation can combine to make it seem that many older adults are unable to remain in their own homes, new ways of designing housing and organizing support services open up a wide range of possible settings. Moreover, while the cost of services forces many people into Medicaid-supported nursing homes, others are there because of lack of knowledge of the alternatives. To address these and other issues, we need to move towards a system of care for older adults in which the financing is adequate and efficient but also as neutral as possible regarding people's preferences.

This report is a summary of a set of three conversations, supported by the John A. Hartford Foundation and conducted by the Convergence Center for Policy Resolution. The conversations covered two broad questions: a) Could it be possible for more older adults to remain much longer in their own homes and communities, and return to their homes more quickly after medical treatment, thus reducing the need for institutional care? and b) how might the business model of institutional care, and particularly nursing homes, be rethought in order to better provide for the needs and desires of older adults needing assistance?

To address these questions, this report on the conversation and generated ideas is arranged into three sections.

> Section 1 explores opportunities for older adults to remain in their own homes.
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> Section 2 explores alternative business models for the institutional sector.
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> Section 3 explores financing and workforce issues.

An appendix lists the participants in each conversation.

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Note: Within each section, a summary of the conversation is followed by bulleted items indicating recommendations made by participants. These are the views of one or more individuals and do not necessarily constitute a consensus view.

Section 1: Expanding the range of older adult-friendly housing and communities

Home and community are central to successful aging. This makes housing and lifestyle opportunities critical. Successful aging also requires a vision of people living longer, an awareness of research on the U-shaped happiness curve, and investments in a person's broader well-being to improve the health trajectory. That, in turn, suggests a need for more and better housing options, nestled between traditional single-family homes and institutional care and providing a wide range of coordinated services.

Design and Collaboration. Housing designers and developers are advancing the choices available. At the **housing design level**, one approach is housing units that accommodate a larger number of adults and have common areas and facilities. Another is to tweak existing multi-housing models by creating apartments that are designed for people of all ages and most physical conditions. These tweaks include interior changes to make the housing more accessible for people as their life evolves and incorporating special rooms to permit medical assessments and treatments, as well as other services, to be provided on-site.

It's important to note that the financial investment community appears bullish on home care and related housing models – but getting the numbers to work is a challenge, especially with the nationwide shortage of affordable housing.

In addition to a person's immediate living space, we need to pay attention to how to improve **community design**, using supportive services and social infrastructure to enable far more older adults to remain successfully and happily in their neighborhoods – even if they have challenging medical conditions – rather than assuming they must go into institutional care. It is important to think of this as the "social capital" and community needed to support an individual in a wide range of ways that are emotional as well as practical.

Social capital in the community can include such institutions as **senior villages.** These are membership fee-supported volunteer organizations that can support individuals in their own homes and be a link with professionals. Villages can assist in some post-acute care, ensuring that an individual is monitored, taking medications, and other features of daily life that otherwise might require an institutional setting. In other cases, for example, the **"Front Porch" model**, philanthropies and faith-based organizations have created and managed affordable housing communities that meet the needs of individuals with challenges related to aging, including the use of Wi-Fi and other technology.

Central to these efforts is creating a network to scale, rather than building by building. Senior villages have struggled to move to scale and to develop a model that works in low-income neighborhoods where fees would be onerous for many residents. But there is progress. Some communities are creating hub and spoke models (for example, in Ohio, Delaware, and Rhode

Island), in which villages are linked to medical services and social service centers. Meanwhile in Washington, D.C. and other cities, municipal governments are actively supporting the launching and growth of senior villages.

Besides design modifications and volunteer support, homes can often be made more suitable for older adults by taking modest steps to make them safer for seniors. For example, the **CAPABLE program** is a rigorously evaluated approach that utilizes teams of an occupational therapist, a nurse, and a handyman. The therapist works with the person to identify challenges with basic activities, such as bathing, as well as potential dangers such as slippery floors or inadequate lighting, and develops a plan to help the person achieve functional goals that increase their abilities and safety. That plan might include work orders for the handyman to make simple fixes to bathrooms, kitchens, or other rooms. The nurse focuses helping the person identify and reach goals associated with such issues as pain, depression and medication management.

Some developers are making aging at home more viable by building **communities with easily available medical and other services** – and not solely for older adults. Some of these projects have a repurposed former hospital as their linchpin, with retail and social services introduced into the hospital building and former hospital services, for instance food preparation, serving needs in the wider community. Elsewhere, in places like New York City and Los Angeles, **public housing agencies and housing managers** are taking steps to improve social and service supports for older adults by organizing intergenerational housing to support seniors through steps including designing "grand family" units in low-income projects, and creating partnerships with AARP chapters and service providers. But as yet, most of these models have not been brought to scale.

Several attempts to move seniors out of nursing homes and assisted-living facilities and into public housing and other housing arrangement have encountered major regulatory and financial obstacles. These barriers highlight a general problem that needs to be addressed: the regulatory and payment system was designed for an earlier, generally out-of-date vision of care – with regulations devised for nursing homes often applied to very different types of institutions and settings. The result is often a lack of incentives for making it easier for people to enter, or move to, a non-institutional setting. It also helps explain why many promising ways to organize health and social services for older adults, like the **PACE program** and **Vermont's SASH** approach, have not spread widely despite their effectiveness.

Ideas for Action

- Federal, state, and local governments should review and revise the regulation of care facilities, to ensure that regulations designed for large nursing homes and an earlier vision of care are not hampering innovative new arrangements and facilities. In addition, governments should review and revise payment systems with a similar purpose of aligning rules to new forms of care and setting.

- Insurance and Medicare/Medicaid rules should be amended to encourage annual wellness assessments for older adults to be carried out in the person's home, and to make occupational and minor physical therapy more easily available at home or by telehealth.

These steps would allow healthcare personnel to become more aware of an older person's surroundings and lifestyle choices/desires and, as a result, be better able to develop care and support plans that are more customized to each person. Home visits can also help identify the strengths and weaknesses of the home setting and provide insights on what is important to the person, which is very hard to do in a doctor's office. In addition, bringing in CAPABLE-style teams help to address functional and safety challenges would improve the quality of life of older adults and reduce the likelihood of debilitating home accidents.

- Villages and similar community institutions should be considered by cities and counties as the focus for a comprehensive array of services for aging-in-place. Hospitals and health plans, with the support of local jurisdictions, might explore partnerships that would help village administrators or other managers to become better equipped to organize a range of care administration in a home setting, especially for patients discharged from hospitals. There are opportunities for trusted institutions and people in communities, including high-school community service programs, school nurses, food distribution services, cleaning services, and informal and gig transportation, to become part of this infrastructure to support older adults.

- The federal government, and state and local jurisdictions, should establish interagency bodies to coordinate the necessary programs, regulations, and financing streams to support home-based care and services. The federal Interagency Council on Homelessness, and state-level Children's Cabinets, are models to consider for coordinating housing-with-services models.

- Private health plans and hospitals could provide more support for integrated housing-based services. The IRS, for instance, could provide clearer guidance to nonprofit hospitals that this type of undertaking would qualify for their community benefit obligations. Meanwhile, other health plans could emulate UnitedHealth's collaboration with the federal Administration for Community Living and AARP to develop a shared payment model among health plans to support on-site services.

- Managed care organizations (MCOs) would be more inclined to collaborate with support service providers within housing complexes if the federal Department of Housing and Urban Development (HUD), and the Centers for Medicare and Medicaid Services (CMS), as well as local housing authorities, reviewed regulations and explored ways to share the potential savings between MCOs and support service organizations. HUD and the Department of Health and Human Services (HHS) could also work closely together, perhaps with a focus on Section 202 residents, to establish a budgeting arrangement that fully recognizes the costs, benefits, and savings across different programs. In addition, the federal government could explore ways to require or incentivize MCOs to explore shared services models.

- There are housing providers engaged in organizing very innovative models for place-based services but what is missing is a clear financing structure. HUD and HHS should launch more pilots to test models that might become a component of services for older adults.

- Coverage for non-institutional room and board costs needs to be included much more broadly in Medicare and/or Medicaid (See Section 3).

The Role of Technology. Telehealth is a valuable tool to enable older adults to remain in their homes, and it is important for payment systems to align with the need to make it broadly available. Technology is advancing rapidly and will be a game changer within the next 10 years. Wearable devices are enabling the **home-based monitoring** of conditions to expand, smart home technology is making homes safer and more livable for people with conditions, and breakthroughs in virtual reality technology are even helping to address social isolation and depression. In addition, **"hospital at home" technology** is developing to the degree that many post-acute services and care for chronic conditions can be safely provided in a home setting.

Ideas for Action

- It is critical for us to address the digital divide. For technology to be most beneficial and for the results to be equitable, broadband needs to be made universally available. Further, connectivity and cost need to be addressed in under-resourced communities. Congress should consider establishing an agency and program to achieve universal broadband availability, much as the Rural Electrification Administration was launched to ensure electricity services for all communities.

- Telehealth should be fully integrated into the caring system. The technology needs to be affordable, and we need to improve digital literacy training – for physicians and care providers, not just older adults. Both informal and paid caregivers need continuous training in how to use more advanced technology. Devices also need to be as simple as possible to operate. These steps would greatly expand opportunities for older adults to age safely in their own homes and communities.

- Section 1135 public health emergency regulations and payments for telehealth platforms to address COVID-19 should continue to be reviewed and, mostly, made permanent, including for the provision of services within an individual's home or "expansion sites" in the community, such as hotels, community centers, and adult day centers.

The bottom line on expanding the range of older adult-friendly housing and communities.

There is an enormous opportunity for home-based and age-friendly housing to become a much larger sector, functioning as a partner with and in parallel to the institutional sector. For this to happen, however, there needs to be a much more conscious and developed infrastructure to fit all the pieces together and to ensure that financing is aligned to an expanded home sector. That infrastructure would need several components, including:

Customization. Over-medicalization of aging has overshadowed the wide range of desires and needs of older adults, including lifestyle choices, socialization, etc. The emphasis needs to be more on customized, person-centered supports and services needed for aging rather than on medical care.

Technology. Developing technology can do much to improve monitoring, communication, safe homes, and more sophisticated medical services for older adults at home. But the technology needs to be simple to use, privacy and data sharing issues need to be addressed, and there must be adequate training for caregivers and older individuals. People in the support institutions in their communities need to be aware of developing technology and how it could be used.

The relationship with hospitals and institutions. The home/community sectors should not be isolated from the healthcare system. Home-based approaches need to be coordinated with medical providers through telehealth and a variety of partnerships.

A continuum of accommodations. A home-based sector needs to allow for a wide variety of types of housing and care models to reflect different lifestyles and forms of coordinated care.

Community based institutions. An important part of the infrastructure is community-based institutions that strengthen social capital, provide volunteer support, reduce social isolation, and help connect older adults with services and supports.

Collaboration between government programs and departments. Payment systems need to be made more flexible to align with the opportunities for older adults to remain in their homes and communities. In addition, special local government bodies to facilitate collaboration need to be piloted.

Funding commitments. It will also require a rebalancing of financing for the home-based sector to become a larger element in the spectrum of services and strategies for aging. Rebalanced payment systems and budgets should reflect the potential of home-based care need and corresponding savings in the institutional sector. Medicare and Medicaid need to be more flexible in their coverage of non-institutional care.

Section 2: Reimagining nursing homes and other care institutions

It is time to re-examine the business model of institutional care in America. A major problem with the institutional sector today is that nursing homes serve quite different populations within the same building. In particular, post-acute care patients requiring special services are alongside long-stay residents, the latter being there primarily because Medicaid pays room and board. But there is no clinical reason for the latter group to be in a nursing home with skilled nursing care. There are also people with physical disability needs, others with cognitive disability needs, and people who have behavioral disability needs.

Many of the long-stay residents could receive help at home or in some other congregate care setting where the focus is on personal assistance – they often have functional and cognitive limitations but do not need skilled nursing. COVID-19 has highlighted the rationale for many individuals with post-acute care needs to receive care in other settings, including at home (a pattern that was developing before COVID-19). Even without these developments, nursing homes will face significantly higher costs in the future due to increased labor and capital costs because of likely post- COVID-19 developments and heightened infection control procedures. Thus, the nursing home sector is especially poised for significant change.

In addition to reconsidering the categories of residence in institutional settings, it is also important to think carefully about the scale of institutions. Facilities do not always need to be large institutions. There is an array of small-home housing/care settings for many people with a degree of independence, such as **"green houses."** These smaller facilities have registered high levels of satisfaction and have exhibited significantly lower COVID-19 death rates. However, in many states, regulations designed for large facilities and earlier models are impediments to the approval and establishment of these innovative and smaller facilities.

Alternative business models for nursing homes and other institutions

Within 10 to 15 years, large numbers of baby boomers will enter nursing homes. Most have saved less than their parents did, and therefore the financing of nursing homes will require large infusions of money from Medicaid and possibly Medicare. This projected increase in demand for care, combined with the questionable structure of the institutional sector, requires us to think about different models that will a) provide the right care for older adults in the right setting, and b) is financially viable.

One possible change in the model might be for nursing homes to "downsize" by transferring some of their current categories of residents to other institutions and home-based care. Hospitals today are now really health systems that are providing an increasing range of skilled care and receive well over half their revenue for outpatient services. **Hospitals** might expand their growing pattern of creating extended care wings to provide skilled services for many people who would currently be in nursing homes. **Payment systems** need to align with such alternatives, and hospitals would have to rethink parts of their business model – but providing these post-acute services to older adults is potentially a better fit than expanding ambulatory care.

In the downsizing view of nursing homes, advances in technology and rethinking housing-based services mean a significant number of long-term nursing home residents would be served in their homes or through alternative types of institutions, like green houses and other types of facilities, in a continuum of care options between a person's own home and a nursing home.

Meanwhile, nursing home operators could also re-examine the range of services they provide outside their facilities – much like many hospitals are rethinking their portfolio of in-hospital and outpatient services. In the US, many nursing home operators are already diversifying their model: operators are acquiring home-care agencies, hospices, and assisted living facilities. There is also a lot of consolidation taking place. So, the future may well see large companies providing a continuum of types of care for those who can afford it or have financial assistance or insurance coverage. In effect, this is becoming a form of Continuing Care Retirement Communities "without walls."

In addition, Medicaid directors are looking at lower utilization of nursing homes.

It is thus perhaps time to look at different roles for a variety of care institutions and medical facilities, and to think about transferring budgets that focused on nursing homes towards financing other types of residences with increasing support for home and community-based

services. This strategy would require major investments in alternative housing, supports and staff for community-based services.

With most people needing personal-care primary care – including those with chronic conditions, cognitive impairments, and some physical disabilities – the need now appears to be for much greater investment in the infrastructure of residential options, not just home-based care. Anticipating this trend. in the early 1980s **Oregon** used Medicaid waivers to launch a strategy to move a substantial number of people who did not need skilled nursing out of nursing homes into a variety of **assisted living** and home-based care. Oregon's strategy of permitting a greater level of aging in place involved a reassessment of the degree of disability that could be accommodated outside nursing homes, the waiving of stringent regulations for occupancy of alternative types of residence, and a focus on building a greater capacity of providers to deliver services.

Assisted living is an increasingly important part of the institutional equation. Analyses suggest that when accounting for the cost of room/board/living in one's own home, assisted living is a viable option and a better setting for many people. Yet it is a somewhat chaotic sector in terms of regulation, oversight, and quality, but it has developed into a variety of arrangements, including special wings of buildings designed primarily for independent living. Meanwhile, a San Francisco pilot program, utilizing vouchers for subsidized home care services for middle-income individuals, is a modern form of a single-room occupancy hotel that provides an affordable form of assisted living with communal food services and other services together with a nearby home health agency. A full spectrum of assisted living approach thus can include enabling people to live in an "institution" that is essentially a multi-family rental home setting with support services. But without an injection of federal funds, there is generally a disincentive for states and cities to adopt similar approaches for non-Medicaid eligible individuals. That is because jurisdictions seeking to move in this direction often face a classic "wrong pockets" problem: where the return to an investment accrues to an agency oor organization other than the one making the investment. So outcomes analyses may indicate there will be improvements in quality of life, a reduction in stress for individuals and family, reductions in ER visits, etc., that would lead to savings in Medicare and Medicaid, but the costs borne by other programs and hard-pressed agencies at the local level.

Changes in the role of nursing homes, moreover, would require significant adjustments in reimbursements and substantial increases in funding to raise the quality of services for seniors whose best option is a nursing home. Thus, thinking about reconfiguring what nursing homes do requires us to think very differently about the financing of an institution that can barely keep its head above water. Encouraging nursing homes to diversify might be one way to help strengthen the business model of existing facilities. Diversification might also involve some buildings being repurposed as affordable housing with support services.

Upgrading traditional nursing homes to serve long-term residents adequately would require a substantial capital investment and an emphasis on **Institutional Special Needs Plans**. The Netherlands is one of the countries that have made that investment in conjunction with reforming the care system.

These considerations imply that we need to be clearer about the exact role of institutions that exist between large nursing homes and home-based care, and about which categories of individuals can be most effectively served by different institutions. We also need to consider new kinds of institutions, what services each would provide and to whom, and how each would be financed. There will need to be discussions not just with facility operators and budget managers, but also with architects, design professionals and clinical experts.

Ideas for Action

- States should review the Oregon experience and develop plans to seek Medicaid waivers, overhaul the regulation of care institutions, and conduct cost-benefit analyses across programs to expand the variety of non-nursing home options for their residents. That will require a significantly increased level of inter-agency cooperation and planning. The aim should be to create a continuum of care models with the care of many nursing home residents transferred to a variety of assisted living facilities and other settings. Utilizing HUD Section 202 housing could be part of this transfer strategy. The structure should protect residents without stifling innovative models.

- Nursing home operators should explore business models that combine nursing homes with providing a range of services for smaller institutions and home care. In addition, operators should explore ways to repurpose sections or entire traditional nursing homes as a mix of affordable housing, units with support services for residents, etc.

- States and the federal government should explore the potential for hospitals to expand their extended-care wings, including identifying necessary changes in payment systems. In addition, jurisdictions should examine the possibilities for failing hospitals to be repurposed into health and support centers, or hubs, that provide a range of medical, food and social services to small care institutions and home-care organizations.

Section 3: Exploring the financing and workforce elements

Redesigning the care system for older adults can only occur in conjunction with a realignment of the financing system and a strong financial commitment by the public sector to support alternative models and greater home-based care. The current financing structure skews care towards nursing home settings and makes innovation difficult. In addition, efforts to provide a customized set of services in the most appropriate setting is limited by inadequate compensation and training for direct care workers, who have very few career paths to advance their roles within the system.

A major challenge to new models of care, and integrating housing, health, and other services, is also that, essentially, Medicare pays for healthcare and Medicaid pays for long-term care services. That means different levels of government, and different programs, pay for different

elements of the needed range of services. And while Medicaid has more experience in covering a range of services, it might well be that Medicare should be the source of all funding for these activities; among other things, that would avoid the contortions that **I-SNPs and the PACE** program must go through to coordinate services (though the end result must not be the over-medicalization of care needs).

The caregiving workforce also needs to be revamped, so that more people can see it as a viable and rewarding profession. Currently, it is generally poorly paid, trained, and utilized.

Addressing the financing and workforce challenges requires action on several fronts.

Medicaid/Medicare. The current Medicaid policy of paying for room and board only in nursing homes makes it difficult for many individuals to remain in their homes and to obtain services in settings other than a nursing home. Because of this and other rules regarding what Medicaid will pay for, thousands of older adults are unable to live in their own homes and must move into nursing homes. But should Medicaid and/or Medicare pay for room and board outside nursing home settings?

Some argue that Medicaid payment requirements should be reviewed to permit coverage for room and board in a variety of settings since a core purpose of the federal-state program is to cover long-term care costs as well as health needs.

Others maintain that Medicare might be a better funder, while some contend that Medicare does not know how to deliver long-term supports, services and housing and states do. The experience with COVID-19 suggests, however, that presumption may not be correct. Moreover, an advantage of Medicare is that it is available to older adults of all income levels, and therefore could be a good vehicle for providing a wide range of supports for more than only low-income adults. Another argument often voiced is that utilizing Medicare would make it easier to replicate the generally successful approaches of other countries. Moreover, Medicare Advantage has been gradually widening the types of support services plans can cover.

Ideas for Action

- States and the federal government should build on existing limited Section 1115 waivers by launching a comprehensive series of state initiatives to pilot Medicaid funding for room and board in a wide range of housing options that enhance the broad purposes of Medicaid.

- Alternatively, or in conjunction with 1115 waivers, Congress should federalize at least a portion of the long-term supports and services that are currently covered by Medicaid. That approach would suggest shifting coverage and the oversight of these institutional services to CMS, as well as expanding Medicare to provide full coverage for community-based care. Federalization would also give states a greater incentive to move individuals into community care.

- All levels of government should make greater use of "Pay for Success" private financing models to amortize the cost of large capital investments with a stream of potential future savings. This private financing tool may makes it easier for states and localities to cover significant investment costs in new models of care.

- The federal government should expand the opportunities for community-based services through "Money Follows the Person" demonstrations.

- Congress should create a new part of Medicare, financed through payroll tax and general revenue, to cover long-term care costs, including room and board coverage.

- CMS and Congress should further expand the ability of Medicare Advantage plans to include nonclinical services that enhance successful aging, including room and board.

- A long-term care option should be added to Medicare Advantage plans.

Role of private health insurers. The focus of private insurance has traditionally been the relationship between the patient and the physician. But this focus may be changing as we recognize that where somebody lives has a significant impact on health outcomes. Indeed, while payment silos continue, they are also beginning to break down, with plans providing a range of services and more flexibility to tailor services to individual needs. Traditional insurers are also offering products in new settings, such as assisted living, and some are even investing in housing; many of these insurers recognize that financing housing-based wraparound services can make a big difference to outcomes and costs. Many insurers, too, are outsourcing case management, realizing that their infrastructure and traditional approach to care management does not meet the full needs of institutionalized beneficiaries and individuals receiving medical services at home. While this outsourcing to third parties can create a burden on providers and create some confusion, the practice of being more flexible by going beyond strictly in-network services is gaining momentum.

Ideas for Action

- Large insurers should work closely with housing providers to develop ways to deliver wraparound products. In addition, health insurers – particularly MCOs – should explore "co-opetition" techniques to encourage competing companies to invest jointly in housing and nonmedical support services. A feature of this could be a pilot program whereby Medicare or Medicaid-eligible older individuals moving into certain housing complexes could be required to sign up with one of the plans responsible for covering residents and funding supportive services. (It might be that smaller insurers would have more flexibility to undertake these collaborations.)

- PACE should be explored as a vehicle for competency support. Work undertaken by the national PACE Association seeks to build on the existing infrastructure of housing/community service networks and generate the economies of scale needed to

deliver services that combine housing and the supportive services that PACE offers. It might be possible to have a PACE program build its own housing and employ housing workers and service providers – though this approach might raise fair housing concerns and would need to be accompanied by a more appropriate structure of regulation for PACE.

Long-term care insurance. The nursing home model might be thought of as a marriage of inconvenience: facilities need skilled nursing care money to survive; meanwhile, Medicaid underpays, and housing and other services come from different pots of money via different programs. One of the fundamental economic problems is that we expect middle-class people to risk a low-probability event – the need for long- term care – which could involve an extremely high financial burden. But we only provide significant assistance if the person becomes sufficiently low-income to qualify for Medicaid. The traditional approach to addressing these risks is through insurance. However, the availability of long-term care insurance has been declining, with insurers dropping out of the industry. That exodus has happened in part because policyholders are holding their policies longer than expected and because of a combination of medical advances and diseases like Alzheimer's combine to make insurance payouts larger and harder for companies to predict.

Ideas for Action

- Rather than relying on private insurance for middle-class households, Congress should create a long-term care program within Medicare (see above).

- Alternatively, or in addition, Congress should enact a public catastrophic program designed to cover the unpredictable and outlier costs that are making a viable private long-term care industry impossible.

Workforce issues. Effective restructuring of the care system for older adults will be very difficult until the concerns of the workforce are addressed. Care workers are low paid, often need to work in multiple locations to earn enough for their family's needs, and training is very basic and varies widely across states.

Caregiving needs to become a true career. One necessary component is to create a real career path. Nursing may be a model to examine, with its high-skilled specialty areas and the opportunity for more experienced nurses to be involved in case management and coordination. In addition, telehealth creates new opportunities for care workers to be part of an integrated team, in some cases with driver, personal care workers and other visitors acting as the "eyes" and front-line connectors for medical providers. Improving technology will help achieve this team approach more broadly, enabling a team with a range of skills to be assembled and coordinated. Such care teams, including worker-owned cooperatives, could allow us to reimagine what the function of each worker is, and create higher total value that would be able to support higher wages for care workers.

Ideas for Action

- Private agencies and government programs should significantly increase payment levels for care workers. Higher wages for care workers would lead to more experienced and skilled workers, reduce turnover, and improve the quality of care.

- The Department of Labor and the states should overhaul training and regulation of care workers. Currently, there are many job classifications, each with a combination of different regulations emanating from both the federal government and the states.

- States should review licensing to make it easier for care workers to work at the "top of their license" and to be key part of a team of medical, social service and care workers able to deal with the full needs of older adults. Medicare and Medicaid should adjust their payment systems to reflect new roles and team responsibilities for care workers. Experience suggests that a team approach to care, with care workers working closely with other professionals and care workers sharing roles and functions, leads to greater satisfaction among workers (and their clients). The team approach also increases the total "value added" and so increases the business case for increased pay.

- "Cash and Counseling" programs are available in many states and should be used more widely to permit Medicaid beneficiaries to choose their own home care agency. These programs can include the employment of family members. Evaluations indicate significant impacts on unmet needs, satisfaction, and quality of life.

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Appendix: Participants

October 15, 2020: Care at Home, Housing and Communities Group

Name	Organization
Larry Atkins	Long-Term Qual. Alliance
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Marc Cohen	U Mass
Ryan Frederick	Smart Living 360
Howard Gleckman	Urban Institute
Stephen Golant	University of Florida
Kathy Greenlee	Greenlee Global
Ruth Katz	LeadingAge
Scott Keller	Dynamis Advisors
Gail Kohn	DC Age Friendly City Coordinator
David Lindeman	Director of Health CITRIS UC Berkeley
Stephen Lucas	Council of Large Public Housing Authorities
Andy McMahon	UnitedHealth
Brian Rahmer	Enterprise Community
Rani Snyder	Hartford Foundation
Barbara Hughes Sullivan	Village to Village Network
Sarah Szanton	Johns Hopkins University
Adrienne Todman	National Association of Housing Redevelopment Officials
Anne Tumlinson	ATI Advisory

October 22, 2020: Business Model Group

Name	Organization
Gretchen Alkema	SCAN Foundation
Erica Brown	Milbank
Lynn Feinberg	AARP
Len Fishman	UMass Boston

Howard Gleckman	Urban Institute
David Grabowski	Harvard Business School
Jennie Chin Hansen	SCAN board
Chris Koller	Milbank
Robert Kramer	National Investment Center
Joanne Lynn	Altarum
Andy McMahon	UnitedHealth
Vincent Mor	Brown University
Len Nichols	Urban Institute
Kavita Patel	Mary's Center
Robyn Stone	LeadingAge
Jill Sumner	American Health Care Association

October 28, 2020: Workforce and Payment Group

Name	**Organization**
Gretchen Alkema	SCAN Board
Susan Coronel	AHIP
Robert Espinoza	PHI
Richard Frank	Harvard University
Howard Gleckman	Urban Institute
Josie Kalipeni	Caring Across Generations
Cindy Mann	Manatt Health
Michelle Martin	AHIP
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