support in the daily delivery of care. The second paper will describe the emotional labor undertaken by home-care staff, with attention to how their deployment of "tact" to maintain clients' dignity highlights the inherent conflicts of the paid caregiving relationship. The final paper will draw from the caregiver diaries to discuss the everyday challenges of providing consistently "good" care within broader structural conditions. Implications for workforce development, quality improvement, and commissioning of home-care services will be discussed.

EMPOWERMENT IN HOME CARE FOR PERSONS WITH DEMENTIA: IMPLICATIONS FOR PERSON-CENTERED CARE

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A key element of person-centered care, which is a priority across long-term care systems, is the "empowerment" of direct-care workers – understood as the legitimated autonomy to adapt care around individuals' needs and preferences, instead of completing tasks by rote and routine. The nature of empowerment in the particular context of home-care is not well-understood, however. This paper draws from ethnographic data collected as part of a mixed-methods study of "good" home care to describe how caregiver autonomy is enacted and experienced in daily care. We examine the close link between autonomy and isolation for these workers, which can curtail the knowledge exchange that supports person-centered care in other settings. We also examine the relational and structural limits of autonomy, highlighting organizational surveillance techniques as a particular example. The paper concludes with a discussion of the implications of these findings for efforts to empower direct-care staff to provide person-centered in-home care.

CLOSE ENCOUNTERS OF THE CARING KIND: EXAMINING EVERYDAY EXPERIENCES OF HOME CARE USING STAFF DIARIES

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Written diaries are increasingly used to gather data in academic, educational and vocational settings. Diaries get us "up close" to people's lived experiences, yielding rich data free from retrospective bias. As part of a mixed-methods study, 11 home caregivers for clients with dementia kept reflective diaries for eight weeks. This paper reports findings from the diaries relating to: *caregivers' key skills,* including their efforts to preserve client's dignity and agency and to mediate among clients, relatives, and the home-care organization; the *daily demands of the job*, including physical and emotional stressors; the *challenges of the job,* from interpersonal to logistical tasks; and the *daily experiences of job-related satisfaction*, including the practices of self as a skilled and caring worker and the sense of being appreciated. These findings are discussed in relation to the caregivers' representations of home-care clients in the diaries, which range from *idealization* to *candor*.

TACT AND DUPLICITY IN INTERPERSONAL RELATIONS BETWEEN PAID HOME CAREGIVERS AND THEIR CLIENTS

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This paper explores tensions arising from caregivers' practices of skilled interpersonal work, specifically the exercise of tact to protect the dignity of clients. The threat to self-esteem from low-paid, low-status employment is buffered by satisfaction from close relationships with clients. Emotional labor required of caregivers in the course of routine work may be rewarded by emotional capital and enhanced self-worth. Caregivers exercise great skill in supporting personhood and agency, particularly to deflect and cover up mishaps of mental and physical incompetence. However, the requirement – or "feeling rule" – of tact to maintain the personal dignity of clients breaches norms of fair and transparent dealing between people in close interpersonal relationships. Tact may be a manifestation of professional skill but can also undermine the authenticity in relationships between client and caregiver that its exercise aims to instantiate, and underlines the ambiguous nature of a personal relationship underpinned by pay.

SESSION 415 (SYMPOSIUM)

INTEGRATED CARE FOR PEOPLE WITH COMPLEX CARE NEEDS: PAST, PRESENT, AND FUTURE

Chair: J.M. Wiener, *RTI International, Washington, District of Columbia*
Co-Chair: W.L. Anderson, *RTI International, Research Triangle Park, North Carolina*
Discussant: J. Chen Hansen, *American Geriatrics Society, New York, New York*

Integrated care systems have a primary goal of providing coordinated care using formal linkages of different types of providers to provide high quality care to populations with complex care needs. The symposium will open with a background analysis of the need for integrated care systems for people with complex care needs, including an overview of the benefits and challenges. The symposium will then present three research projects funded by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation that examine the past results, present challenges and future opportunities for integrated care. The first paper analyzes the effect that Minnesota's well-established integrated systems of care have had on

health care and long-term services and supports (LTSS) use among dually eligible individuals over age 65. The second paper examines several current integrated systems of care to determine how care coordination is operationalized and the challenges that remain when exchanging information across acute care and LTSS providers. The third paper will examine the opportunities and challenges for expanding the Program of All-Inclusive Care for the Elderly (PACE), a fully-integrated care system, to serve younger people with disabilities and the implications of these findings for the older populations currently served by PACE. The discussant will respond to the studies' findings and discuss the evolution of integrated care and the potential for these delivery systems to provide high quality care for populations with complex and unique needs.

WHERE'S THE REST OF ME? THE CASE FOR INTEGRATED CARE

J.M. Wiener, *RTI International, Washington, District of Columbia*

Older people with disabilities currently receive care in a fragmented and uncoordinated financing and service delivery system, both within and between the health and long-term care systems. Financing for acute care is largely the responsibility of Medicare and the federal government, while long-term services and supports (LTSS) is dominated by Medicaid and state governments. As a result, no organization is responsible for managing all aspects of care for a person. Indeed, under the current system, the financial incentives are to shift costs between Medicare and Medicaid, especially for users of LTSS, where Medicaid's financial role is large for LTSS and small for medical care and Medicare's financial role is small for LTSS and large for medical care. The fragmented financing and delivery system has negative consequences for older people, including high levels of hospitalization and potentially avoidable hospitalizations.

INTEGRATING CARE FOR DUAL MEDICARE-MEDICAID ELIGIBLE SENIORS: A NEW LOOK AT THE MINNESOTA MODEL

W.L. Anderson[1], S. Long[2], Z. Feng[1], *1. RTI International, Research Triangle Park, North Carolina, 2. Urban Institute, Washington, District of Columbia*

With few incentives for program coordination, the 10 million Americans who are dually eligible for Medicare and Medicaid often receive fragmented and inefficient care. Using 2010–2012 Medicare and Medicaid fee-for-service claims, managed care encounters, and enrollment data, we assessed the impact of enrollment in the Minnesota Senior Health Option (MSHO) —a state-wide fully-integrated Medicare-Medicaid model and the first of its kind—on health care and long-term services and supports use among elderly dual eligibles, relative to similar enrollees in Minnesota Senior Care Plus (MSC+), a Medicaid-only managed care plan with Medicare fee for service. MSHO enrollees had 60 percent higher likelihood of community-based services use and 49 percent lower likelihood of hospital-based care than similar MSC+ enrollees. Adopting fully-integrated care models similar to MSHO in Minnesota may have merit for other States as they consider strategies to improve care delivery for dual eligibles under Medicare and Medicaid.

INFORMATION EXCHANGE IN INTEGRATED CARE MODELS

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Integrated care models offer the organizational structure to support the coordination needed to provide high quality care to populations with long-term service and support (LTSS) needs. This study describes how care coordination is operationalized by examining the information exchange processes in several integrated care models. We conducted an environmental scan, convened a technical advisory group, interviewed subject matter experts, and conducted case studies of three integrated care systems. We determined that care coordination and information exchange remain high touch processes, and organizational trust and personal relationships between providers remain foundational to successful care coordination; existing electronic health records are inadequate for integrated care models because they do not capture all information needed to support those with LTSS needs; electronic exchange of information with LTSS providers generally does not occur; and interpretation differences of regulations that protect patient health information create barriers to exchanging information and providing coordinated care.

CHALLENGES AND OPPORTUNITIES TO EXPAND THE PACE INTEGRATED CARE MODEL TO NEW POPULATIONS

S. Karon, M. Knowles, E. Vreeland, R. Love, G. Chiri, *RTI International, Research Triangle Park, North Carolina*

The PACE program has a long history of successfully serving people age 55 and older who need nursing home level of care in the community. The program provides integrated medical and social services, coordinated through highly-structured interdisciplinary teams and primarily provided through adult day health centers. The PACE Innovation Act of 2015 allows expansion of this model to other populations. We present findings from a recent study of how the PACE model might serve younger people with physical, intellectual, developmental, or mental health disabilities. Challenges identified include the structure and function of the interdisciplinary teams, acceptability of day center-based services, organizational capacity to support populations with unique needs, and adequacy of payment risk adjustment methodologies. We will discuss implications of these findings for the older populations currently served by PACE, and identify ways in which the PACE model might evolve to meet changing views of service provision and coordination.

SESSION 420 (SYMPOSIUM)

INTERNATIONAL PERSPECTIVES ON DIVERSE ROLES FOR OLDER PEOPLE IN HIGHER EDUCATION

Chair: T. Scharf, *Newcastle University, United Kingdom*

In focusing on students between the ages of 18–24, traditional models of higher education (HE) typically overlook