

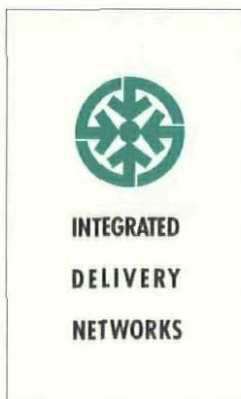
AN EFFECTIVE, EFFICIENT ELDER CARE PROGRAM

*Providence ElderPlace Focuses
On Maintaining the Continuum of Care*

Since 1987 Providence ElderPlace, Portland, OR, has offered elderly persons an alternative to nursing home care, allowing them to remain as healthy and independent as possible. The program is a type of integrated delivery network (IDN), offering comprehensive benefits and coordinating the delivery of healthcare services in a specific geographic market. (For more about IDNs, see Philip J. Karst, "IDN Development: Issues to Resolve," *Health Progress*, March 1993, pp. 24-25, 31.)

Providence ElderPlace is based on the Program for All-Inclusive Care for the Elderly (PACE), a model of a long-term care health maintenance organization (HMO) of the future. The goal of PACE, developed 20 years ago by On Lok Health Services of San Francisco, is to help frail elderly persons remain in their homes as long as possible. "On Lok" is Chinese for "abode of peace and happiness."

Current government policies and reimbursement mechanisms favor acute and skilled nursing



facility placement with little choice for those seeking less expensive, community-based services. PACE, On Lok's model of care, offers an innovative way to deliver effective, cost-efficient healthcare to the frail elderly. This cost-saving delivery system is financed through an integrated funding pool of Medicare, Medicaid, and private fees. As a capitated program, PACE is much like the proposed Oregon Basic Health Services Act, focusing on prevention and wellness and caring for persons

in the least restrictive place.

ElderPlace is sponsored by Providence Medical Center, Portland, OR, one of five not-for-profit hospitals operating through federal waivers guided by On Lok protocols, which create the flexibility critical for successfully merging acute and long-term care.

Providence ElderPlace was initiated after a study group of Providence Medical Center administrators and physicians visited On Lok. A feasibility study was completed with On Lok's assistance, and the study group supported mov-

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Summary Providence ElderPlace, Portland, OR, is an innovative long-term care health maintenance organization. The program is a type of integrated delivery network, offering comprehensive benefits and coordinating the delivery of healthcare services in a specific geographic market.

Providence ElderPlace is based on the Program for All-Inclusive Care for the Elderly (PACE), which was developed 20 years ago by On Lok Health Services of San Francisco. PACE helps frail elderly persons remain in their homes as long as possible.

PACE is financed through an integrated funding pool of Medicare, Medicaid, and private fees.

To be eligible for PACE, an individual must be in need of nursing home care but able to live in the community, with support. Providence ElderPlace provides all healthcare, community-based, and long-term care support services from an adult day healthcare setting. Participants usually attend the day center three times a week. When participants are not at the center, a team of workers visit their homes to observe participants and provide personal and chore support services.

ing ahead with the project.

The Providence Foundation matched seed funding from the Robert Wood Johnson Foundation and the Meyer Trust to develop the site buildings and provide start-up development costs. The foundation has continued to support the program for specific needs, including support for a chaplain.

RISK-BASED MODEL

Providence ElderPlace offers its participants a comprehensive package of services through a capitated system. Medicare pays Providence ElderPlace a set rate per member per month based on a variant of the Adjusted Average Per Capita Cost (AAPCC). The AAPCC methodology was developed for the federal 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) to reimburse risk-based HMOs. TEFRA HMOs have standardized per capita reimbursement based on demographic cost factors (age, sex, welfare status, and institutional status). The On Lok Program, on the other hand, "uses a single, higher Medicare cost adjuster that more accurately reflects the population's frailty and utilization experience" (see Marie-Louise Ansak, "The On Lok Model: Consolidating Care and Finance," *Generations*, Spring 1990, pp. 73-74).

The reimbursement rate includes a Medicaid component from each site's state, usually based on a comparison of the cost of its long-term care system. In Oregon the cost of the PACE model is compared with that of assisted living. A monthly rate for each member from Medicaid includes costs for nursing home care when someone leaves assisted living, a service not included in assisted-living reimbursement. On Lok has developed operational guidelines that are a part of ElderPlace's contracts with Medicare and Medicaid. ElderPlace is preparing for its first

mock survey using these guidelines. The staff hopes the Health Care Financing Administration will use these standards for ElderPlace's future regulations. Because it is in its final year of demonstration, ElderPlace continues to negotiate in good faith to increase its Medicaid rate. The program's costs per person per month are more than \$200 over its rate. ElderPlace staff anticipate a \$100 per-person-per-month rate increase.

HOW ELDERPLACE USES THE PACE MODEL

Participants The main goal of the PACE model is to help frail elderly persons remain independent in their homes as long as possible. To be eligible for PACE, an individual must be in need of nursing home care but able to live in the community, with support. The definition of eligibility for nursing home care varies by state. In Oregon, Medicaid defines eligibility. A person is eligible if he or she is over 55 years old and needs assistance with three or more activities of daily living. More than 68 percent of the 300 ElderPlace participants are cognitively impaired. Participants' average age is 79.

Providence ElderPlace staff act as care managers. For income and enrollment eligibility, potential participants—both private pay and public funded—are evaluated through a state-developed functional assessment administered by a public case manager, an employee of the local Area Agency on Aging.

Only 7 percent of ElderPlace participants are private pay. These persons have family members involved in their cases. ElderPlace staff find that the cost of care for these private-pay participants is higher because, for example, family members prefer foster care to home care and nursing home care to foster care.

Services Resources integrated in the PACE model include all physician services, preventive care, prescriptions, inpatient and outpatient services, therapies, home care, social services, transportation, nutrition, respite, hospice, and long-term care services. Providence also has two day healthcare centers. These offer more medical staff, services, and rehabilitation than a day-care center, which is more of a social model. In most states, Medicaid only reimburses day healthcare.

Providence ElderPlace is allowed to provide, create, or purchase any needed service not guided by traditional Medicare or Medicaid regulations. ElderPlace is responsible for efficiently controlling costs and effectively managing the limited resources available.

Providence ElderPlace purchases many support services from Providence Medical Center, includ-

ELDERPLACE'S CONTINUUM OF CARE

A nursing home referred 76-year-old "Mary" to ElderPlace after she had a stroke. When she first enrolled, Mary received medical care from the program's geriatrician and rehabilitation (four times a week) from the staff physical and occupational therapists.

ElderPlace helped Mary transfer from the nursing home to an adult foster care home. Because she had become depressed during her recovery, Mary joined an ElderPlace therapy group, which she continues to attend. Now mobile in a wheelchair, Mary helps other ElderPlace participants as a volunteer peer counselor. She also heads the ElderPlace welcoming committee for new participants.



ing payroll and accounting, purchasing, management information systems, community relations, security, and mail services. ElderPlace also purchases many care services from the Sisters of Providence Corporations, including hospital, pharmacy, and laboratory services. The costs of these services must be competitive to make the risk-based model work.

From two adult day healthcare settings, Providence ElderPlace provides all healthcare, community-based, and long-term care support services. Providence ElderPlace manages these centers, which are the core of its program. By having participants attend a day center at least three times a week, more than 50 center-based staff have the opportunity to observe participant's health status. Even the drivers who transport participants between the day centers and their homes have been trained to look for difficulties. If the driver spots a problem en route to the center, he or she informs the aide welcoming the participant, and the participant is immediately taken into the clinic to see a nurse or doctor.

When participants are not at the center, a team of workers visit their homes to observe them and provide personal and chore support services. The constant observation and preventive services for the participants, as well as the training and support for the family care giver, reduce hospital and nursing home utilization.

The medical center continues to support ElderPlace by joining with the program to develop critically needed housing services. Because ElderPlace was unable to negotiate cost-effective rates for foster care, ElderPlace and Providence Medical Center will develop 40 Department of Housing and Urban Development supportive housing units, 30 single-room units, and foster care homes staffed by ElderPlace home care staff. This will reduce housing and care costs and increase home and day healthcare services.

MULTIDISCIPLINARY TEAM

The multidisciplinary Providence ElderPlace team does not manage dollar by dollar but rather through care management. Each morning the team of physicians, nurses, social workers, therapists, healthcare aides, activity coordinators, and home care and driver representatives meet to identify critical issues that need to be dealt with that day, or to solve problems physicians or administrators on-call identified the night before. Each participant's care plan is formally reevaluated quarterly for appropriateness, although changes in care often occur between quarters.

Program administrators monitor utilization.

When costs in one program area exceed budget, program administrators analyze the cause and, if necessary, establish task forces to rectify the problem. These task forces include direct service staff, advisory council members, and administrators. ElderPlace has conducted studies on transportation, pharmacy, and supplies and made recommendations for improving cost efficiencies. Care decisions are not based on individual care costs.

COST: STILL A BARRIER

At this time, a person purchasing PACE services privately is responsible for paying the long-term care portion. In Oregon, Providence ElderPlace's Medicare rate is \$1,349, which is less than half the cost of purchasing nursing home care privately (\$3,000), but still a large expense for most individuals or families.

Until they need long-term care services, most people are unaware that Medicare does not cover long-term and chronic care. Providence ElderPlace and its sister organizations—Providence Senior Care (the medical center's senior membership club and care management programs), the Good Health Plans (the system's TEFRA HMO), and regional home care programs—are cooperatively investigating offering a long-term care insurance plan that will support community-based long-term care benefits for persons who must purchase these critical services privately.

WHY PACE WORKS

PACE works because it is a participant-centered care management service. It is not a system that has been developed to support existing healthcare systems. The model offers autonomy and authority to the provider, who also acts as the insurer. The provider creates or purchases whatever services are needed to ensure a full continuum of services. Once a participant has enrolled, access to services is easy; payment for services is uncomplicated and straightforward.

Families find great support from PACE. It meets their goal of keeping their families together as long as possible. In-home nurses, nutritionists, and therapists provide support and guidance regarding the care of elderly family members. Respite care helps family care givers stay strong as long as possible.

PACE is a single-access service providing comprehensive care to enrolled members for the rest of their lives. It enables individuals and their families to receive the best geriatric care available. PACE is a critical model of the future that supports the changing healthcare system of today. □