ArchCare PACE Program
Building and Growing

September 15th, 2016
The mission of ArchCare, the Continuing Care Community of the Archdiocese of New York, is to foster and provide faith based holistic care to frail and vulnerable people unable to fully care for themselves. Through shared commitments, ArchCare seeks to improve the quality of the lives of those individuals and their families.
ArchCare’s Ministry 2015

ArchCare serves **6,464 individuals daily in 13 counties:**
- Bronx, Brooklyn, Manhattan, Queens, Staten Island, Dutchess, Orange, Westchester, Putnam, Rockland, **Sullivan**, Onondaga and **Ulster**.

- **338 retired religious** from 9 orders
- **5,176 individuals** who are poor.

- Institutional Care 26%
- Home & Community Based Care 74%

**Continuum of Services**

- Wellness Programs
- Parish Integration
- Time Bank
- Home Care
- Tele Health
- Social Day Care
- Out-Patient Clinic
- Sub-Acute Care
- Assisted Living
- Nursing Home Care
- Specialty Hospital
- Palliative Care
- Hospice

- PACE
- I-SNP
- IE-SNP
- MLTC

**Care Coordination Options**
Dual-Eligible and Developmentally Disabled Populations in New York

Dual-Eligible Population

- Dual eligible population estimated at 839,300 in NY*
- Population accounts for 14% of the Medicaid population, but 43% of Medicaid Spending in NY*
- Majority of MLTC beneficiaries (93%) are dual-eligible, accounting for more than $10 billion in expenditures
- In NY State Long-term care represents 74% of Medicaid spending for the dual eligible population compared to 62% for the US*

Developmentally Disabled Population

- In 2013 there were more than 770,000 disabled individuals receiving NYS Medicaid, or 15% of all enrollees
- Spending on this population accounted for $17.5 billion, or 38% of all NYS Medicaid spending
  - $22,494 per enrollee compared to the average of $8,798 per enrollee for the NYS Medicaid program
New York State Policy Environment

• With inception of NYS Medicaid Redesign Team in 2011, “care management for all” is a key tenet.
• Large segments of the Medicaid population already transitioned into managed care.
• Mandatory managed care enrollment of individuals under the aegis of the NYS Office for People With Developmental Disabilities (OPWDD) – not yet scheduled.
• OPWDD’s Transformation Panel recognizes the importance of transitioning to managed care and Value Based Payment models.
• Voluntary enrollment options:
  • Fully Integrated Duals Advantage for individuals with Intellectual Developmental Disabilities (FIDA-IDD) demonstration program – to begin April 2016.
  • Developmental Disabilities Individual Support & Care Coordination Organization (DISCO) pilots – still to be fully defined.
  • ArchCare Senior Life PACE IDD.

Opportunities
• PACE IDD addresses “dual aging” - PACE can serve adults with IDD as well as their aging parents/caregivers to optimize the health status of the family as a whole.
• PACE Innovation Act: potential for PACE IDD to serve people with IDD < 55 years of age and not requiring SNF level of care
  • Provide intervention at an earlier stage to more effectively optimize a person’s health status.
ArchCare Senior Life (PACE) Philosophy

Honoring Senior’s Desires:

Stay in Familiar Surroundings

Maintain Autonomy

Maximize Physical, Social and Cognitive Function
ArchCare Senior Life (PACE) Program Overview

- **Census**: 520
  - Growth of more than 75 members since January 2015
- **3 PACE sites**: Manhattan, Bronx, and Staten Island
- **2 Alternate Care Sites**: Bronx and Staten Island (pending application)
- **Community Based Physician Waiver Program**
  - 50 slots initially approved
- ArchCare awarded **BIP grant to care for the developmentally disabled**
- Participation in **NPA Process Improvement Program (Lean Six Sigma)**
- Implementation of other **Innovative Pilot Programs planned for 2016**
Highbridge Alternate Care Site
- Located in the Highbridge Housing Development in the Bronx
- Large sunny indoor space with a big terrace for planting and BBQ’s
- Supports occupancy of 30

Staten Island / St. Marks Alternate Care Site (pending application)
- Located on Staten Island – next door to a large Parish replacing previous Senior Center that lost funding
- Senior Housing with 250 units planned across street
- Supports occupancy of 40
ArchCare Senior Life (PACE) Program - Alignment with the Triple Aim

- Hospitalization rate of 534/1000 compared to 962/1000 for comparable FFS Medicare beneficiaries
- Readmission rate of 13.9%
- Home care hours – 170 pmpm
- Risk score of 2.59 compared to forecast of 2.58

- 3 Star Ranking – NYSDOH Consumer Survey
- Ranked 2nd in NYS for CMS Quality Ranking
- Disenrollment rate less than 2% for the year (2015)
- Grievance rate less than 3% for the year (2015)

- Influenza vaccination rate: 81%
- Pneumovax vaccination rate: 90%
- Adherence for diabetes medication: 94%
- Members with a fall: 4% compared to target of less than 14%
- 1.7 falls per 100 member months compared to 13.5
## Current Programs

- ✓ Music and Memory Therapy (granted funded)
- ✓ Dementia Art Program
- ✓ Family Support Groups
- ✓ Horticulture Program (in the Bronx and Harlem)
- ✓ Palliative Care
- ✓ Falls Prevention
- ✓ IPRO Transitional Care Program
• Invisible disability that has no dedicated providers

• Congregate around specific providers that they are comfortable with

• PACE offers them ‘one stop shopping’

• Founder of Sign Language Center (he is deaf) and his advocacy person toured the center

• The ‘Sign Language Center’ regarding teaching staff to sign

• They also will offer in person assistance with the hard of hearing or deaf during enrollment, UAS assessment and family meetings for a relatively low fee.
ArchCare Participation in NPA Process Improvement Program

✓ We are 1 of 5 PACE Programs participating nationally
✓ Provides opportunity to improve internal processes through system redesign and empowering middle management
✓ NPA is supporting system redesign through the program with goal of scaling for its members

✓ First Project focus **Member Retention**
  ✓ include end to end enrollment process review,
  ✓ assessment of procedural items that slow process of integration for members once enrolled,
  ✓ identify when and why members in a 12 month period disenrolled,
  ✓ evaluate staff interaction in developing life plan,
  ✓ evaluate success of “Welcome Teams”

✓ Second Project selected **“First Day Experience”** will build on findings in ‘member retention’ project
New York State Developmentally Disabled BIP Grant Program

Goal:
Enroll 150 nursing home eligible seniors with intellectual and developmental disabilities (IDD) to remain in their homes and communities through participation in PACE. The project is consistent with New York State’s goal of Care Management for All and the Office for Persons with Developmental Disabilities (OPWDD) People First Waiver.

Objectives:
PACE is a community-based program providing personalized home and community based services.

- Provide comprehensive, integrated, health care and supportive services to adults with IDD through an enhanced PACE model focused on the specific needs of the population.
- Analyze financial feasibility of sustaining and growing services for IDD participants through PACE and measure participant satisfaction, health outcomes, etc.

Outcomes:
- 95% of PACE participants with IDD will complete a Health Care Proxy and Medical Orders for Life Sustaining Treatment (MOLST). (100% achievement)
- Management of hospitalizations, readmissions and emergency visits. (1 ED visit, 2 hospitalizations, no readmissions)
- Actuarial analysis of medical expense with development of appropriate capitation rates (actuarial firm retained to complete utilization and cost analysis)
New York State Developmentally Disabled Grant Program

Market Growth and Development

• Transition of developmentally disabled (DD) clients from Terence Cardinal Cooke (TCC) Article 16 clinic.
  • Potential transfer of 50-75 new participants

• **Joined DD councils** in the Bronx, Manhattan and Staten Island

• Partnering with community agencies, such as YAI Network, United Cerebral Palsy, AHRC, Self Help and Cerebral Palsy of NY

Care Coordination

• Developed and are implementing policy and processes specific to the personalized care of DD individuals

• Focus on improving population health through personalized care
  • Addressing mental/behavioral health, poly-pharmacy and preventive care
  • Reducing ED and hospital utilization and readmissions

• Working with LHCSA partners regarding population needs and providing specialized training to their staff

• Extended **e-learning modules specific to the DD population** to all PACE staff
• Operations and Services
  • Competencies and skills of staff and caregivers
    • Extensive e-learning modules specific to the DD population to all PACE staff available in hard copy and DVD’s available for new staff and caregivers
    • A special DD team formed all having have extensive experience with the population, this ‘team’ travels to all three sites and acts as a “specialized” IDT team.
  • Service Coordination
    • Transportation for tours and family introductions are provided to reduce the anxiety of coming to a new setting
    • Procedures for dining, rehab and medical assessments in place for participants requiring behavior management.
  • Access
    • Investigating alternate care site (ACS) for NYC in anticipation of continued growth with this population.
    • Under consideration – home based telehealth program
New York State Developmentally Disabled Grant Program

Opportunities and Challenges

• Universal support from key stakeholders (e.g. New York State, Providers, Community Based Agencies, Housing)

• Time to build trusted relationships with key decision makers

• Removal of codes on Medicaid

• Need to preserve housing while ‘releasing’ services to be delivered by PACE

Performance to Date

• Enrolled 27 members (~60 more to be enrolled in February/March)

• One ED visit and no hospitalizations with 26 members since grant began

• Actuarial firm retained for utilization and cost analysis
Stories from Developmentally Disabled Participants

• Joey and Alfie
  • Willowbrook State Institution was the home of Alfie and Joey, before their sister took them in
  • Keeping people like Alfie and Joey out of institutions as they and their loved ones age is a challenge
  • ArchCare Senior Life (PACE) at Carmel Richmond delivers all the care these now developmentally disabled seniors need to stay healthy and live safely in the community

• Carmen and Mary Nin
  • The Nin sisters were living at home with their mother in an apartment in the Bronx when their mom became sick and was placed in the hospital with subsequent nursing home placement
  • Because of their disabilities they were unable to stay at home alone and had not left the house in 20 years
  • Since joining PACE they have attended our Day Health Center in the Bronx five days a week and really enjoy it
  • With PACE they are able to live full productive lives safely in the community
Stories from Developmentally Disabled Participants

• Margarite and Bernice
  • Margarite’s mom heard of our program and contacted us to see if we could help her with her daughter, Bernice
  • She has not seen a MD or left her home for 10 years.
  • She has come to the Center to see the PACE PCP.
  • The IDT team is currently working with her to be able to leave her home and enjoy the outside again.
  • She has even allowed the physical therapist to treat her to improve her walking and balance
  • With all this support Margarite’s mom has also joined PACE and is smiling and happy to have helped both her daughter as well as herself
ArchCare Commitment to the PACE Program

Program Expansion / Membership Growth

- IDD/DD population and other Special Needs populations (e.g. Deaf, Parkinson's, neurodegenerative)
- Physician Community Waiver Program
- Development and partnerships in facilities for programs and services
- PACE Innovation Act; (i.e. reduce age for enrollment eligibility, increase community understanding of the benefit of case management for a longer life in the community and/or at home)

Personalized Care Coordination

- Investment in enhanced care coordination and the IDT through:
  - Health Information Exchange
  - Risk stratification and outcomes measurement informing life plans
  - Improvements and innovations in service and care delivery including use of enabling technology

Quality and Operations Improvement

- Continued active participation with the NPA, CMS and DOH in collaborative projects, benchmarking and shared learning
• Expansion of PACE model for:
  • Individuals under the age of 55
  • Older adults who are at-risk of requiring nursing home care
  • Chronically ill
  • Disabled Population

• Provides CMMI authority to provide waivers in support of improving the PACE program furthering the Triple Aim agenda of better health, better health care, lower cost

PACE Innovation Act supports Adaptation of the PACE model for new populations and promotes PACE growth, efficiency and innovation
• Further New York State agenda of Care Management for All with focus on the DUAL and IDD/DD populations:
  • Health Benefit Solution:
    • Build on New York State Balancing Incentive Program for the IDD/DD population
    • Recognize PACE as an integrated Medicare and Medicaid health benefit solution along with other managed care solutions (e.g. MLTC, FIDA, MAP)
  • Program Delivery:
    • Personalized care coordination within the home and community
    • Interdisciplinary team approach
    • Continued enhancement of care coordination programs and services through people and processes supported by enabling data, health information exchange and supportive technologies

• Develop alternative options for access to programs and services
  • Physician Community Waiver Program
  • Integration of Article 28 and Article 16 clinic programs
  • Free standing Article 28 sites coordinating with other service providers

• Expansion of Program Eligibility
  • Reduce age limit to 45 for the IDD/DD population
Our PACE Members