

# archcare

**ArchCare Presentation**

**September 10, 2015**

**Program of All Inclusive Care for the Elderly**





## ArchCare's Mission

**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.**



# Objectives

**PACE Program Overview – Our existing program and model**

**History**

**Philosophy**

**Services**

**Identification of Eligible Participants**

**Embracing the PACE Planning Model**

**Lessons Learned**

**Next Steps**



# **Program of All-Inclusive Care for the Elderly (PACE)**



# History of PACE

- 1970s

On Lok opens one of the nation's first adult day centers in San Francisco.

The On Lok model of care expands to include complete medical care and social support of nursing home-eligible older individuals.

On Lok receives a four-year grant from the Department of Health and Human Services to develop a consolidated model of delivering care to persons with long-term care needs.

- 1986

Federal legislation extends the new financing system and allows 10 additional organizations to replicate the On Lok service delivery and funding model in other parts of the country.



# History of PACE

- 1990  
The first Programs of All-Inclusive Care for the Elderly (PACE) receive Medicare and Medicaid waivers to operate.
- 1994  
With the support of On Lok, the National PACE Association (NPA) is formed. 11 PACE organizations are operational in nine states.
- 1997  
The Balanced Budget Act of 1997 establishes the PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs.
- 2015  
114 PACE programs are operational in 32 states.



## **PACE Philosophy**

**Honors what frail seniors want:**

- **To stay in familiar surroundings**
- **To maintain autonomy**
- **To maintain a maximum level of function**
  - **Physical, Social & Cognitive**





# Who does PACE Care for?

- PACE serves individuals eligible for both Medicare and Medicaid benefits.
- Dual eligibles are **among the poorest, sickest** and highest users of health-care services in the nation.
- **> 50% of dual eligibles are in fair or poor health**, which is double the rate for other Medicare beneficiaries.
- 33% of dual eligibles have **significant limitations in activities of daily living**, compared to 11% of other Medicare beneficiaries.
- The **prevalence of chronic conditions is higher** among dual eligibles.
- These individuals encounter numerous **difficulties in coordinating benefits** between the Medicare and Medicaid programs, and these coordination issues are often a major barrier to getting needed health care services.





# How does PACE work?

- **PACE coordinates a person's Medicare and Medicaid benefits and services and ensures that they are integrated in an effective and timely manner.**
- **Scope of services is all-inclusive**
  - Primary care(including doctor and nursing services)
  - Hospital Health Care
  - Medical Specialty Services
  - Prescription Drugs / All Necessary Drugs
  - Nursing Home Care
  - Emergency Services
  - Home Care
  - Physical and Occupational Therapy
  - Adult Day Care / Recreational Therapy
  - Meals
  - Nutritional Counseling
  - Social Services / Social Work Counseling
  - Laboratory/X-ray Services
  - Advance care planning & end-of-life care
  - Acute care
  - Transportation
  - Respite Care





# How does PACE work?

**Interdisciplinary Care Team (IDT)** is central to the care model.

- **Team-managed** care vs individual case manager.
- IDTs have an **intimate understanding of a participant's needs and personal goals**. Services are not managed remotely. The focus is on the participant.
- **Staff primary care physicians** are part of the PACE IDT staff. (A program may request a waiver to incorporate community physicians into the model.)
- **Comprehensive & Continuous Case Management**
  - Assessment
  - Treatment Planning
  - Service Provision
  - Ongoing Monitoring
- Focus on **prevention and timely intervention**



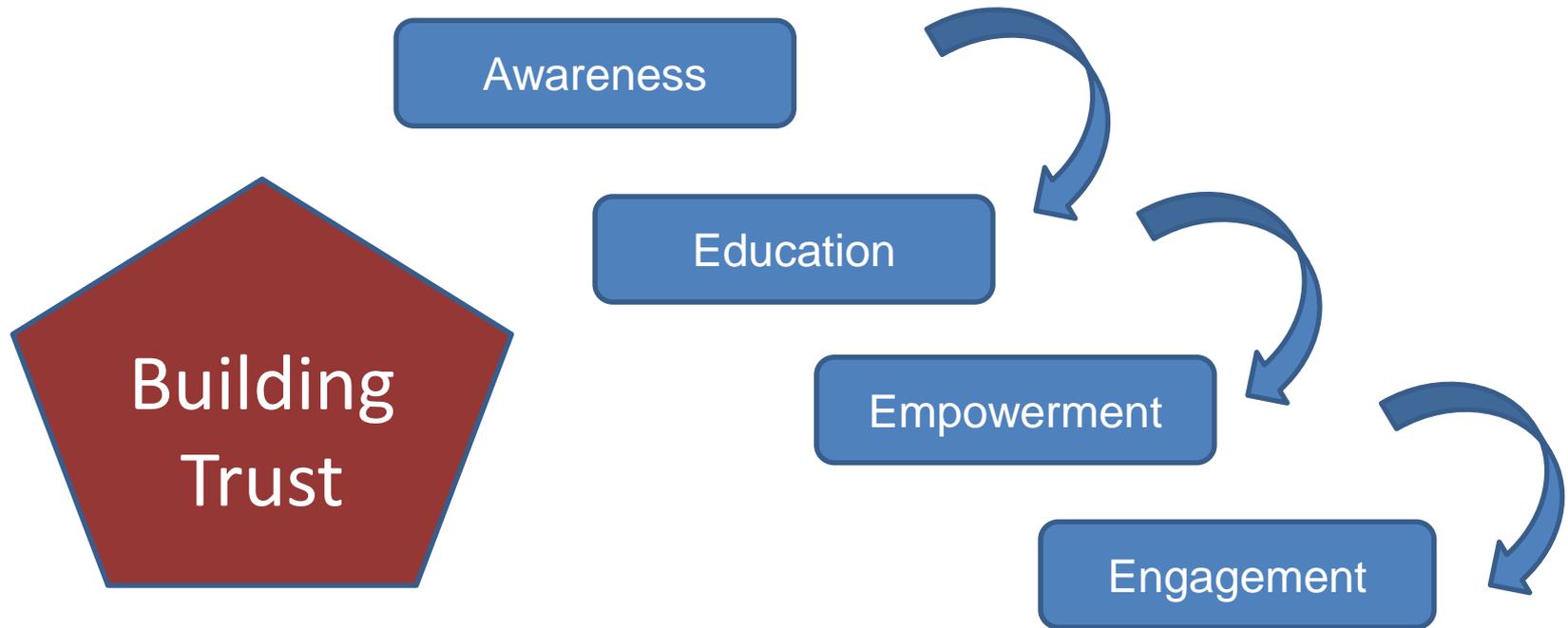


**ArchCare Senior Life received a grant from the Department of Health to integrate the DD/IDD population into the PACE Program.**



# Collaborative Partnerships

- Goal is to facilitate enrollment into the DD PACE program through investment in collaborative relationships.





# Awareness & Education

- Prepared marketing materials
- Created speakers bureau who are content experts of the program
- Joined DD councils in all three boroughs where we operate PACE programs - Bronx, Manhattan & Staten Island
- Opened PACE centers for educational programs
- Provide scheduled tours of the program sites
- Met with all LHCSA partners and are making available specialized training for their staff
- Provide multiple media for learning (e.g. e-learning, DVD & printed material)



# Staff Training & Education

- Multi – media approach
- Dedicated outside training partner experienced in DD
- Extending E- learning modules specific to DD for all PACE staff (e.g. Introduction for the Direct Support Worker, A Closer Look at Cerebral Palsy, Ambulation and Walking Aids for the DD population)
- Specialty DVD programs for specific clients needs (e.g. advocacy, care giver support, etc.)
- Staff participation in onsite educational programs with partners as we listen to their needs and the needs of the DD population



# Potential Collaborative Partnerships

- United Cerebral Palsy
- Willowbrook (classes)
- YAI (Young Adult Institute)
- Catholic Guardians
- Parish Networks
- Local DD Councils  
Bronx, Manhattan & Staten Island
- Hospital Emergency Room Staff
- AHRC
- Cerebral Palsy of New York State
- NYCHA
- Heritage House
- Parent to Parent
- MSC Organizations
- Beacon of Hope



# Identification of Eligible Participants

- Where are they located?
  - Skilled Nursing Facilities
  - Physician Referrals
  - Emergency Rooms
  - Living in Group/Adult Homes
  - At home without connection to community based services
  - Intermediate Care Facilities (ICF's)
  - Individual Residential Alternative (IRA's)
- Continuing to identify opportunity(ies)



# **PACE Planning Model Population Overview**

<b>Who is the population?</b>	<b>Developmentally Disabled, 55 and older, Dual Eligible (Medicare &amp; Medicaid)</b>
<b>What do we know about the population?</b>	<b>Goals include: Quality of Life, Autonomy, Choice &amp; Socialization</b>
<b>Who are the primary stakeholders to collaborate with?</b>	<b>Families/Caregivers, Providers of Care, NYSDOH, OPWDD, CMS &amp; DSRIP PPSs</b>



# PACE Planning Model

## Influencers and Interventions

Influencers of the Aims to be addressed	Proposed Interventions/ Initiatives
<ul style="list-style-type: none"><li>▪ Enhanced coordination in services and management of benefits.</li><li>▪ Multiple agencies involved</li><li>▪ Improving the current delivery system to support and aging DD population</li><li>▪ Avoid stigma of DD population</li></ul>	<p><b><u>Housing</u></b> – supported by OPWDD</p> <p><b><u>Services</u></b> – supported by PACE model and IDT care team which includes:</p> <ul style="list-style-type: none"><li>▪ Coordination of support services</li><li>▪ Coordination of healthcare</li><li>▪ Continuation of support services in the home</li><li>▪ Transportation and meals</li></ul>



# PACE Planning Model

## Aligned Payment Model

The goal is to deliver person centered care and support services through improved coordination amongst all stakeholders with efficiency and effectiveness within a total cost of care capitation.

## Other Requirements

### Requirements for implementation:

- Available and appropriate housing
- Timely and effective communication between key stakeholders and agencies (OPWDD & NYSDOH) in support of the shared vision and goals
- Removal of Medicaid codes
- Identification of eligible individuals
- Streamline Medicaid waivers



# Lessons Learned

- New program requiring significant investment in awareness and education to get to engagement of all parties – collaborative partners, participants and their families
- Build Trust
  - Understanding social determinants
  - Addressing healthcare needs
  - Understanding, addressing and aligning health benefits to individual needs
  - Engaging families and caregivers as they are the decision makers
- Programmatic Structural Matters
  - OPWDD waivers duplicate potential services offered by PACE
  - Medicaid code removal process can take up to 3 months
  - PACE Enrollment occurs the 1<sup>st</sup> of each month only
  - New Learning Curve for OPWDD agencies and collaborative partners
  - Lack of Housing Opportunities for the DD population.



# ArchCare Commitment to the DD Population

- ❑ Our mission is faith based caring for the vulnerable and needy
- ❑ PACE has waivers for access to community physicians and nurse practitioners
- ❑ DD population is currently cared for at Terence Cardinal Cooke
- ❑ Experience in managed care and capitation programs
- ❑ According to the National PACE Association less than 7% of the PACE Members reside in Nursing Homes



**PACE honors a person's preference to be served in her/his home & community to be with family and friends, and supports a person's autonomy, choices & personal goals.**





# DD PACE Approach

Who is the population?	Developmentally Disabled, 55 and older, Dual Eligible (Medicare & Medicaid)
What do we know about the population?	Goals include: Quality of Life, Autonomy, Choice, Socialization
Who are the primary stakeholders to collaborate with?	Families/Caregivers, NYSDOH, OPWDD, CMS, DSRIP PPSs

Measurable Aims	Drivers of the Aims to be addressed	Proposed Interventions/ Initiatives	Aligned Payment Model	Other Requirements
<p><b>Health of Population:</b></p> <ul style="list-style-type: none"> <li>• <u>Advance Directives (MOLST)</u></li> <li>• Cultural Barriers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Enhanced coordination in services and management of benefits</li> <li>▪ Multiple agencies involved</li> <li>▪ Improving the current delivery system to support and aging DD population</li> <li>▪ Avoid stigma of DD population</li> </ul>	<p><b>Housing</b> – supported by OPWDD</p> <p><b>Services</b> – supported by PACE model and IDT care team which includes:</p> <ul style="list-style-type: none"> <li>▪ Coordination of support services</li> <li>▪ Coordination of healthcare</li> <li>▪ Continuation of support services in the home</li> <li>▪ Transportation and meals</li> </ul>	<p>The goal is to deliver person centered care and support services through improved coordination amongst all stakeholders with efficiency and effectiveness within a total cost of care capitation. We have engaged an outside actuary to support the financial data analysis as the DD PACE membership grows tracking and trending data.</p>	<p><b>Requirements for implementation:</b></p> <ul style="list-style-type: none"> <li>▪ Available and appropriate housing</li> <li>▪ Timely and effective communication between key stakeholders and agencies (OPWDD &amp; NYSDOH) in support of the shared vision and goals.</li> <li>▪ Removal of Medicaid codes</li> <li>▪ Identification of eligible individuals</li> <li>▪ Streamline Medicaid waivers</li> </ul>
<p><b>Healthcare of Individual:</b></p> <ul style="list-style-type: none"> <li>• Mental / Behavioral Health</li> <li>• Poly pharmacy</li> <li>• Preventive Care</li> </ul>				
<p><b>Cost of Care:</b></p> <ul style="list-style-type: none"> <li>▪ <u>Reduce Hospitalizations &amp; rehospitalizations</u></li> <li>▪ Reduce ED visits</li> <li>▪ <u>Establish &amp; manage service delivery within capitation</u></li> </ul>				



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