On Lok: A Successful Approach to Aging at Home

COMMENTARY

Grace K. Li, MHA
On Lok Lifeways

Cheryl Phillips, MD, AGSF
On Lok Lifeways

Kimberly Weber
On Lok Lifeways

ABSTRACT

The Program of All-inclusive Care for the Elderly (PACE) is a proven model for successfully delivering medical and long-term care services to seniors whose desire is to age at home. PACE is a vertically integrated system of care that is centred around the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. Through this paper, we share On Lok's story and how the PACE model has become a national model, replicated in communities throughout the United States.

History

On Lok Lifeways has a dynamic history of serving frail older adults in the San Francisco community for nearly 38 years. Through On Lok's program, frail elderly are cared for in a progressive model of medical, social and psychosocial care, today known as the Program of All-inclusive Care for the Elderly (PACE). On Lok's main objectives are to allow frail elderly to age in place and to ensure safety, health and well-being by providing a coordinated network of support.

On Lok was started in 1971, by a community dentist, Dr. William Gee, and a social

worker, Marie-Louise Ansak, who saw that traditional models of healthcare in San Francisco for frail elderly were not satisfying the needs and preferences of the community. On Lok's founding was based on research and community input that indicated that seniors wanted to live at home while aging and needed support to complement their existing lifestyles and caregiver support systems, rather than being institutionalized. Further research by Ansak demonstrated that there was a substantial group of aging individuals who needed more healthcare and supportive services than they were receiving, but those individuals did not require the extensive services provided in nursing homes. In response, Ansak outlined a comprehensive system of care which included all necessary medical and social services, based on the British day hospital model that allowed people to live at home. With these basic principles, Ansak and Gee created On Lok (Cantonese for "peaceful, happy abode") and, later, the prototype for PACE (Lehning 2008).

Ansak and Gee identified the needs of the elderly community and worked tirelessly to obtain donations and different streams of funding until they gained initial Medicare and Medicaid waivers for capitated reimbursement in 1983. Following this initial victory, On Lok was successful in attracting other major foundations and organizations to support the replication of On Lok's model nationwide. The program became known as PACE, a model of care built on the ingenuity of the vision and commitment of the co-founders and community of San Francisco. PACE subsequently gained permanent waiver status from United States Congress in 1997.

The intricacies of how On Lok works help to illustrate why the PACE model has had tremendous consumer use, financial stability and national interest. Since the late 1980s, PACE has been replicated nationwide, and today there are 71 PACE provider organizations in 31 states serving more than 18,000 seniors. On Lok's reach throughout the Northern California Greater Bay Area includes centres in San Francisco, Fremont and San Jose serving over 1,000 elderly participants.

Overall, the PACE model approach takes care of many of the older and most frail seniors in our communities, and PACE organizations are able to provide the highest quality of care while also achieving financial success. This paper describes how this is possible while also providing tangible results.

Who Can Join PACE?

PACE has four basic eligibility requirements for enrolment: an individual must (1) be 55 years or older, (2) live within the PACE local service area, (3) be certified nursing home eligible (4) and be able to live safely in the community at the time of enrolment. Given these eligibility requirements, the average profile of an On Lok enrollee is female and age 84, has 13 medical conditions, is dependent in 2.7 activities of daily living (bathing, dressing, feeding, etc.), has some degree of cognitive impairment (59%) and is usually within the last three to four years of life.

Although qualifying for PACE may be seemingly straightforward, it is important to understand the distinction between the characteristics of a senior in PACE, referred to as participants at On Lok, and a senior living in a nursing home. The distinction hinges on the individual's ability to live safely in the community. On Lok is able to assist those individuals who, at the time of enrolment, can live safely within the community. These individuals are able to do so with support of family or informal caregivers or other friends and neighbours, but do not need require the more intensive level of available around-the-clock skilled nursing services provided by nursing homes. Through the wraparound coordinated services of On

Lok's PACE program, participants are able to live longer, healthier and more independent lives while still remaining in the community.

What Is PACE?

Once an individual is certified as nursing home eligible, PACE coordinates and provides all needed preventive, primary, acute and long-term care services so that individuals can continue to live in the community. The model is designed to use interdisciplinary teams (IDTs) to assess need and provide and manage care for each senior. This approach focuses on the needs of the participant while providing comprehensive care and incorporating a cost-effective approach to healthcare expenditures.

Funding

In the late 1970s and early 1980s, On Lok received a waiver from the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services, to offer a comprehensive program of care for the elderly through Medicare and Medicaid waivers for capitated reimbursement. The Medicare payment is based on each individual's Medicare risk factor, whereas the Medicaid (and/or private pay) rate is based on the state's contracted rate, which is currently no less than 90% of the fee-for-service equivalent cost of a comparable long-term care population. The PACE organization receives monthly capitation payments based on each enrollee's eligibility for public programs. The pooled payments allow On Lok to provide services based on the participant's plan of care regardless of eligibility and funding source. In this financing model, the PACE organization assumes full financial risk for all necessary care through end of life.

PACE Comprehensive Services by the IDT

One feature that the PACE model is best known for is the approach to integrated care through the IDT. The IDT is responsible for coordination and the direct care provided to the participants, regardless of the setting, which can include nursing homes. PACE has a core staff of IDT members, which include primary care physicians, nurse practitioners, nurses, master's level social workers, registered dietitians, occupational therapists, physical therapists, recreation therapists, personal care workers (for centre and home care) and transportation staff.

Once individuals are enrolled into On Lok, they are offered the full range of long-term and medical care services by the IDT. Although participants' care plans may differ based on their particular needs, a typical day may go as follows: A participant is scheduled to attend the PACE centre to receive specific and routine services. An On Lok driver picks up the participant from home and brings the participant to the local On Lok PACE centre. On any given day, the participant may be scheduled to see the primary care physician, or medical specialist, depending on current needs. Likewise, the participant may be attending the centre to receive physical or occupational therapy after recovering from a significant acute episode (e.g., stroke, broken hip) or for a maintenance program that focuses on strength training and range of motion. Additionally, the participant may be scheduled to attend the centre for assistance with personal care needs such as bathing, or for socialization and recreation to prevent (or minimize) isolation. The participant also enjoys a hot meal before returning home. Upon returning home, the participant may be greeted by a home care worker who provides additional support and care in the home until a family member returns or the participant's care and safety needs have been met. In fact, On Lok is the vessel for keeping participants healthy and stable while allowing them to

age safely and with dignity in the familiar surroundings of their own homes.

All of the care coordination is carefully designed through the participant-centred care plan, which is what links the PACE participants to the services needed to support their medical, functional, psychosocial and spiritual needs. These plans are thoughtfully developed by the IDT through comprehensive assessments and full interdisciplinary discussions, including conversations with the participants about what is most appropriate for their needs. The true element of success is not only the care plan itself but the detailed coordination by the IDT members in carrying out the plan and the level of integration by those disciplines. The core IDT meets each morning to discuss On Lok participants and related observed changes in condition, updates on medical status, transitions of care and general evaluations of the participants' health. This frequent contact allows for a preventative and proactive approach to care allowing the IDTs to catch potential health concerns early on and to avoid more costly and unnecessary courses of treatment. Rather than diagnosing and "managing" discrete diagnoses, the whole person becomes the focus of the treatment plan. Again, by design, the PACE model integrates the care provided by the IDT through observation, planning, coordination and, ultimately, treatment of the participants.

Another important distinguishing feature of the PACE model is the direct involvement of physicians as a core part of the IDT. They provide the necessary overarching medical management that helps to guide the rest of the team in their overall treatment planning of the participants. For participants in an acute care setting, the primary care physicians are in daily contact with the hospital physicians and serve as the conduit to the IDT. Because of this close communication, the team's case management of the participants' care helps to facilitate major transitions at the end of life, such as hospital discharges, new placements to assisted-living facilities or changes in family dynamics. The clinic is based primarily on an "open access" structure to scheduling, which means that participants are seen when they need to be seen. Because of the close supervision that is provided in home care and the adult day health centre, early changes in condition are quickly recognized and can be readily assessed by the physician or nurse practitioner before the medical problem progresses to something more serious. Early recognition of common problems such as infections and dehydration typically lead to clinic interventions such as intravenous fluids or antibiotic treatment, thus avoiding unnecessary and risky hospitalizations. Additionally, referrals to medical specialists are coordinated through the primary care physician. Thus, all medications and treatment orders are approved by the primary care physician, thereby avoiding the "polyphysician syndrome" that is common with seniors in the community who see multiple physicians but without an active primary care physician coordinating all aspects of care.

The successful management of participants' overall care is through the PACE team, whose approach is to manage treatment options rather than manage by strict rules or frequent denials. It is with participants' individual goals in mind and close and regular communication with them and their family that the IDT is able to effectively meet their care needs. It is also this approach that has resulted in quite remarkable utilization results for On Lok. On Lok has shown lower hospitalization rates and lower cost per participant than Medicare parts A and B (see Appendices 1 and 2). Despite serving individuals with multiple complex medical conditions and who meet nursing home eligibility, the average bed-days per 1,000 are

at or below the regional Medicare Advantage health plan rates that serve both healthy and at-risk seniors. The difference in hospital days, admissions and lengths of stay is even more dramatic when compared with traditional Medicare fee-for-service (FFS). The costs of medical care at the end of life are often cited as one of the most expensive aspects of Medicare expenditures. The Dartmouth Medicare FFS data (www.dartmouthdata.org) provides regional data for total Medicare expenditures in the last six months of life. The average Medicare part A and B costs for Medicare beneficiaries in the San Francisco area in this data base for 2000–2003 were $3,900 per month; the average cost for an On Lok participant in the last six months of life was $2,899 per month.

PACE is unique in that the organization is both a medical provider and health plan, allowing greater continuity and vertical integration of the care planning and service delivery continuum. Beyond the IDT and other direct care services, On Lok contracts with a broad range of specialty providers including medical specialists, acute and long-term care institutions (hospitals and nursing homes), ancillary services and other contract providers. On Lok's intimate and constant communication with even these external contracted services ensures the highest quality of care for participants across all settings. On Lok remains determined to provide innovative services that meet the evolving needs of the participants. Over the past three years, On Lok has developed new direct care program services in response to the increasing needs of the seniors in our community. Those services include both a chaplaincy program and a mental behavioural health program. IDTs have greater support and access to specialized skills and services for developing care plans that allow the participants to remain living in the community for as long as possible.

Why PACE?

What remains true is that On Lok and PACE provide quality services that are efficient and cost-effective in meeting the needs of high-risk and frail senior populations. The success of On Lok is centred on participants receiving high-touch, person-centred, integrated, team-based care. A model founded on the vision of creating a solution of integrated care for older persons with chronic needs and who expressed the desire to live as independently and for as long as possible, in their community, On Lok through PACE is a successful way to help older persons age at home.

For more information about On Lok or PACE, please visit the following websites:

- **On Lok, Inc.**: www.onlok.org
- **On Lok PACE Partners**: http://www.pace-partners.net/
- **National PACE Association**: www.npaonline.org
- **US Department of Health and Human Services, Centers for Medicare and Medicaid Services**: http://www.cms.hhs.gov/PACE/

Reference

Lehning, A.J. 2008. *On Lok: An Organizational History of a Pioneering Long-Term Care Organization 1971–2008.* Berkeley, CA: University of California Berkeley.

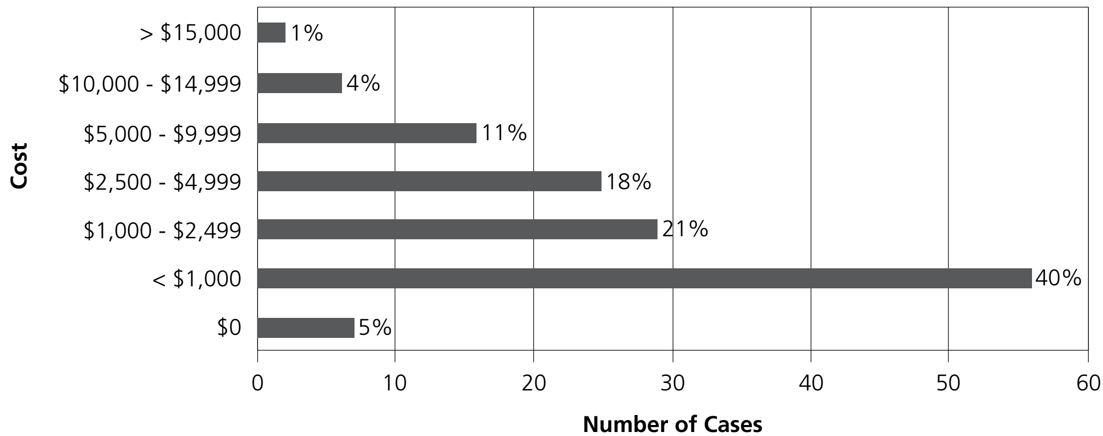
Appendix 1. Hospitalization rates

Utilization Measure	On Lok FY 2007–2008	Medicare FFS 2007	Medicare Advantage 2007
Acute days/1,000	1,429	2,034	1,497
ALOS	4.4	5.7	5.1
ER visits/1,000	267	Not available	316

ALOS = average length of stay; ER = emergency room; FFS = fee-for-service; FY = fiscal year.

Appendix 2. Cost controls: care model avoids end-of-life cost excesses

Last Six Months of Cost for Deaths Occurring between 10/06 and 09/07 (*n* = 141), On Lok	
Average cost per month	$2,899
Median cost per month	$1,754
Range in cost per month (excluding $0)	$2–$34,901



By comparison: $3,900 = average monthly cost of care (Medicare A and B per month for the last six months of life for Medicare-eligible patients with one or more chronic conditions (San Francisco, 2003).