Social Worker’s Role in Care Coordination in a PACE Program
On Lok Lifeways

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CalSWED Aging Initiative Summit
September 19, 2012
On Lok’s Mission

• On Lok in Chinese

• Mission:
  “To provide quality and affordable care services for the well-being of the frail elderly.”

• Take practices that meet the needs of the consumer and work towards policy changes.
Background and History

- Founded in 1972 as an ADHC in San Francisco’s Chinatown and North Beach neighborhoods, one of the country’s first, and the first in California
- Added health service component in 1979 as part of HCFA (now CMS) demonstration project
- Developed On Lok/PACE model with waivers from both HCFA and CA DHS in 1983, testing a new financing system
- Launched the PACE demonstration in 1987 in partnership with HCFA, State Medicaid agencies, and foundations
Background and History

• Expanded throughout San Francisco in 1996, to Fremont in 2002 and to San Jose in 2008
• While PACE Providers are exempt from Knox Keene, On Lok decided to obtain a license in 1999 and became a Health Plan, the only PACE site to have done so in California
• November 2003, On Lok became a permanent PACE provider under Medicare and Medicaid
• November 2003, waiver approved for contracts with community physicians as PCPs
# History of the PACE Model

<table>
<thead>
<tr>
<th>Event</th>
<th>Year</th>
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<tbody>
<tr>
<td>Legislation Authorizing PACE Demonstration</td>
<td>1986</td>
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<tr>
<td>First Demonstration Sites Operational</td>
<td>1990</td>
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<tr>
<td>Congress Authorizes Permanent Provider Status</td>
<td>1997</td>
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<tr>
<td>Publication of Interim Final PACE Regulation</td>
<td>1999  (Nov)</td>
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<tr>
<td>First Program Achieves Permanent PACE Provider Status</td>
<td>2001  (Nov)</td>
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What is PACE?

Program for All-Inclusive Care for the Elderly (PACE) is an integrated system of care for the frail elderly that is:

- Community-based
- Comprehensive
- Capitated
- Coordinated
The PACE Model Philosophy

Honors what frail elderly want:

• To stay in familiar surroundings
• To maintain autonomy
• To maintain a maximum level of physical, social, and cognitive function
The PACE Model: Who Does It Serve?

• 55 years of age or older
• Living in a PACE service area
• Certified as needing nursing home care
• Able to live safely in the community at the time of enrollment
Frailty

- Dependent in 3 ADL’s
- Cognitive impairment
  - Plus dependent in 1 - 2 ADL’s

- Medical frailty
  - Advanced stages of chronic disease: congestive heart failure, chronic obstructive lung disease, diabetes mellitus
  - Frequent visits to the ER
  - More than one hospital stay within 6 months
Principles of PACE Model

• Serves Frail Elderly
• Comprehensive Service Package
• Integrated by Interdisciplinary Team
• Capitated Financing by Medicare and Medi-Cal, with Provider (i.e., On Lok’s) Assumption of Risk
• Designed to meet the needs of consumers, caregivers, payers and providers
On Lok’s Participant Profile

• Profile of Typical Participant
  • Female; average age of 84
  • 10.9 medical conditions
  • Dependent in 3 ADL’s (bathing, dressing, etc.)
  • Has some degree of cognitive impairment (53%)
  • Dually-eligible for Medicare & Medi-Cal (93%)
  • Enrolled in Program last 3-4 years of life

• Serves culturally and linguistically diverse population
  • 63% Asian/Pacific Islander, 19% Caucasian,
    12% Hispanic, 6% African American, 0% American Indian or
    Alaskan Native, 0% Other
Ten Most Common Diagnoses Among PACE Enrollees (nationwide)

- Hypertension: 61%
- Eye Diseases: 48%
- Arthritis: 52%
- Dementia: 46%
- Depression/Anxiety: 35%
- Stroke: 30%
- Diabetes: 32%
- Ear Diseases: 28%
- Coronary Artery Disease: 19%
- Peripheral Vascular Disease: 21%

0% 10% 20% 30% 40% 50% 60%
PACE Comprehensive Services

- Interdisciplinary Coordination
  - On Lok Participant
  - Coordination
- In-Home Services
- Day Health Care
- Primary Care
- Acute Hospital Care
- Laboratory X-Ray Ambulance Service
- Skilled Nursing Facility Care
- Medical Specialty Services
- Restorative/Supportive Services
Integrated, Team Managed Care

Interdisciplinary Team

- Home Care
- Social Workers
- Pharmacy
- Recreation Activities
- Primary Care/Nursing
- Transportation
- Program Manager
- Nutrition
- Personal Care
- OT/PT

Lifeways
PACE Center

• PACE organization must operate PACE Centers with sufficient suitable space and equipment for
  • Primary medical care
  • Interdisciplinary Team meetings
  • Treatment
  • Therapeutic recreation
  • Restorative therapies
  • Socialization
  • Personal care
  • Dining
Primary Care

Each person has a primary care physician
Nursing Services

Monitor status of chronic conditions

Provide medication management
Specialty Services

Dentistry

Optometry
Each person is assigned to a social worker
Physical and Occupational Therapy

Assisted or Individual treatments
Meals at the Center

Warm lunch is served daily
Recreation and Exercise
Personal Care: Home or Center
Home Care
Transportation

Transportation is provided to and from center and medical appointments
Participant Evaluations

• Each On Lok Lifeways participant receives a comprehensive team assessment upon enrollment and semi-annually.

• Participants who have experienced a significant change during the preceding quarter (e.g., stroke, hospitalization, etc.) or whose chronic conditions are unstable will receive a complete, in-person assessment each quarter.
Assessment in an Inter-Disciplinary Comprehensive Long Term Care Model

- Enrollment assessment
  - care planning
    - service delivery
      - Re-assessment

Service providers are all at the discussion table.
Care Planning

• Advantages of service providers who are employees of the same agency
  • Rich knowledge of participant
  • Consistency
  • Same goal
  • Care management made simple

• Increase effectiveness and efficiency of decision making as well as service delivery and monitoring process
Care Planning

• Interdisciplinary Teams (IDT) are responsible for assessing needs, developing care plans, and delivering and managing services for participants.
• Care Plans: by individual disciplines and by team
• Care plans are modified as needed and reflect the program’s flexibility in meeting the ongoing and ever-changing needs of our participant population.
Social Work Department

- 22 social workers serving 8 centers in San Francisco, Fremont and San Jose
- 20 Center-based
- 2 Float
- 3 Social Work Aides
- 21/24 are bilingual in Chinese, Spanish, Korean or Farsi
- Length of employment: 4 months to 40 years
Role of Social Worker

• Clinician
• Counselor
• Advocate
• Case manager/Liaison
• Team player
• Financial manager
• Interpreter/Translator
• Someone who listens and helps
Social Worker Plays a Key Role in Care Coordination

• Team driven issues
  • Day to day care plan changes e.g. attendance, transitional care, social respite
• Level of care changes
• Safety issues
• Placement
• Family conference
• Intervene when direct communication between a discipline and prt/caregiver becomes problematic
Social Work in Care Coordination

• Beyond IDT within PACE
  • Marketing and Enrollment
  • Health Plan
• Administrative Services (Health insurance, claims)
• Contract Management
• Accounting
• Housing Manager
• Mental Behavioral Health Team
Partnership with Caregivers

Diagram:
- Participant
- Caregiver
- Team
- SW

Interactions:
- Participant to Caregiver
- Participant to Team
- Caregiver to Team
- SW to Participant
- SW to Team
Partnership with Caregivers

- Regular contact for updates and support
- Caregiver groups
  - Support group
  - Education
  - Workshops
  - Newsletter
- Advance care planning – Advance Directive and POLST
- End of life care
Care Coordination with External Community

• External/Community Referral
  • Authorities
  • Public agencies
  • Community agencies
• Housing/Placement
• Referrals for caregiver support
• Referrals for discharge planning
• Thank You!