



Philly Program Integrates Services in Care Homes for Low-Income, Chronically Ill Elderly

Demonstration of an integrated care program for chronically ill residents in personal care homes

SUMMARY

From November 1998 through July 2003, staff at [Albert Einstein Health Care Network](#) and its project partners developed, implemented and evaluated the Personal Care Partnership Program. It is an integrated acute and long-term care program in Philadelphia for chronically ill, low-income, elderly individuals living in personal care homes—a type of assisted living facility without skilled nursing care.

The project was part of the Robert Wood Johnson Foundation (RWJF) *Building Health Systems for People with Chronic Illnesses* national program.

Key Results

- As of November 2001, the program reached a peak enrollment of 213 residents in 18 personal care homes. However, as of February 2006, further enrollment required statutory change by the Pennsylvania legislature. Because of state budget shortages, that change had not yet occurred. By February 2006, enrollment had diminished to 47 residents in nine personal care homes.

Key Findings

- Residents who received Personal Care Partnership Program services exhibited improved clinical and functional outcomes, while outcomes for members of a comparison group of residents that did not receive such services remained unchanged.
- Interviews with personal home proprietors and focus groups with program staff revealed that the program reduced unnecessary hospitalizations and nursing home placements. Delaying entry into a nursing facility for 11 residents saved an estimated \$232,075 in placement costs.

Funding

RWJF supported this project with two grants totaling \$598,780. The first grant was for the demonstration project and the second to support a two-year evaluation requested by

the state of Pennsylvania as it considered moving the Personal Care Partnership Program from a demonstration phase to a permanent long-term care alternative program.

THE PROBLEM

Personal care homes, which in Pennsylvania are licensed by the state's Department of Public Welfare, provide daily meals, assistance with medication, housekeeping and some support services; residents usually require lesser levels of medical care than those in nursing homes.

In the 1990s, staff at Albert Einstein Health Care Network, a health care system in Philadelphia, found that although an acute hospital event often precipitated placement of a person in a personal care home, health care delivery for residents once they were at the homes was sporadic and crisis-driven. This often resulted in the use of hospitals and emergency departments for regular health care needs.

According to the project director, integrating acute and long-term care for chronically ill elderly individuals living in the personal care homes was a major challenge facing Pennsylvania and other states. A 1996 report released by the Pennsylvania Intra-Governmental Council of Long-Term Care urged that the role of personal care homes be expanded as part of the restructuring of the state's long-term care system.

THE PROJECT

Under a grant from RWJF (ID# 035627), awarded in November 2004, staff at the Albert Einstein Health Care Network worked with staff at the Philadelphia Corporation for Aging (the local Area Agency on Aging that plans, coordinates and administers services for older and disabled Philadelphians) and that of 18 personal care homes. They sought to develop, implement and evaluate the Personal Care Partnership Program, an integrated acute and long-term care program for chronically ill elderly individuals living in personal care homes in Philadelphia.

The project had five main goals:

- Improve health outcomes for residents.
- Demonstrate cost savings.
- Avoid or delay the unnecessary transition of residents to more intensive sites of care.

- Establish pooled funding by integrating funds from Supplemental Security Income¹, Medicare capitation² and Medicaid waivers³.
- Present the personal care home as a viable and vital health care delivery site within the continuum of care.

Demonstration Phase

The partnership obtained an amendment to the Home and Community Based waiver (1915c) from the federal Health Care Financing Administration (now called the Centers for Medicare & Medicaid Services) to allow services such as personal care aid, meal supplements, durable medical equipment and adult day care to be offered to residents living in personal care homes. The waiver covers these services in the community, but not in personal care homes. The amendment extended these waiver benefits to the homes participating in the partnership.

The project team established interdisciplinary care management teams consisting of a nurse practitioner working in conjunction with Area Agency on Aging care managers, community physicians and other providers to plan, coordinate and deliver services.

The nurse practitioners served as clinicians and educators and provide care and case management in concert with personal care home staff and others. Nurse practitioners also trained staff members at the personal care homes about personal hygiene, medication, infection control and caring for people with chronic illnesses. In addition, they tracked residents who require hospitalization to avoid inappropriate nursing home placements.

To be eligible to enroll in the partnership, residents had to be:

- Over 60.
- At risk for nursing home placement.
- In need of a nursing home level of care.

¹ **Social Security Disability Insurance (SSDI)**—A federal "insurance program" for workers who become unable to work. It is administered by the Social Security Administration, funded by "FICA" (Federal Insurance Compensation Act) tax withheld from workers' pay and by employer contributions, and pays qualifying disabled workers both cash and health care benefits. Workers who have worked and paid FICA tax for at least 5 of the 10 years prior to onset of their disability typically are covered by SSDI.

² **Capitation**—A method for payment to health care providers that is common or targeted in most managed care arenas. Unlike the older fee-for-service arrangement, in which the provider is paid per procedure, capitation involves a prepaid amount per month to the provider per covered member, and is usually expressed as a PMPM (per member per month) fee. The provider is then responsible for providing all contracted services required by members of that group during that month for the fixed fee, regardless of the amount of charges actually incurred.

³ **Waiver**—Formal governmental (usually federal) permission to have certain requirements for programs disregarded.

- Either competent or, if incompetent, represented by a legal proxy (next of kin, legal guardian, etc.).

They also had to meet the financial eligibility criteria under the waiver program of the Pennsylvania Department of Aging, which has oversight of all Medicaid-funded home- and community-based services.

In addition, a state advisory committee for the project placed a 50 percent cap on the number of clients with significant mental health problems that could reside in each home, because committee members did not want the initiative to become a mental health demonstration project. The state advisory committee was an ad hoc committee, composed chiefly of representatives from the Pennsylvania departments of aging and welfare, convened to provide state input into the development of the program and determine whether it should move beyond the demonstration stage and be certified as a permanent long-term care alternative program.

In 2001, project staff approached two managed care companies to solicit their interest in providing capitated⁴, managed care to the program enrollees. According to the project director, the program was not able to provide data that the managed care companies needed to assess their interest in developing a pooled-funding approach, and both companies declined to participate.

Evaluation Phase

To help determine whether to move the Personal Care Partnership Program from a demonstration phase to a permanent program, the state advisory committee requested an evaluation that was far more rigorous than the evaluation envisioned in the original proposal.

To cover this unforeseen work, RWJF provided an additional grant (ID# 042438). The evaluation design called for a study group and a comparison group.

- The 125 residents in the study group—who met eligibility criteria for Medicaid and admission to nursing homes and subsequently enrolled in the program—received Personal Care Partnership Program services for a maximum of 24 months.
- The comparison group consisted of 50 residents who lived in a personal care home, identified as at risk of requiring nursing home level of care, but who did not receive the Personal Care Partnership Program model of care.

⁴ **Capitation**—A method for payment to health care providers that is common or targeted in most managed care arenas. Unlike the older fee-for-service arrangement, in which the provider is paid per procedure, capitation involves a prepaid amount per month to the provider per covered member, and is usually expressed as a PMPM (per member per month) fee. The provider is then responsible for providing all contracted services required by members of that group during that month for the fixed fee, regardless of the amount of charges actually incurred.

Methodology

Project staff used validated survey instruments (MDS-Home Care and the Conroy Quality of Life Scale) to collect data, along with chart reviews and interviews and focus groups with personal care home staff and residents. Project staff also conducted a comprehensive review of the literature about serving the personal care home population.

Other Funders

The Pew Charitable Trusts (\$90,000), the Pennsylvania Department of Public Welfare and the Pennsylvania Department of Aging (\$50,000) and the Albert Einstein Society (\$25,000) provided supplemental funding for the project. The public agencies involved provided in-kind support.

RESULTS

During the demonstration grant:

- **The project created the Personal Care Partnership Program, an integrated acute and long-term care program for chronically ill elderly individuals living in personal care homes in Philadelphia.**
- **As of November 2001, 213 residents had enrolled in the partnership and 17 personal care homes had been recruited into the program.** Although the number of participating homes increased to 18 the following year, in 2003 the number was reduced to 12, in part due to the difficulty some homes had maintaining enrollment.

Findings

The evaluation yielded the following findings:

- Residents who received Personal Care Partnership Program services exhibited improved clinical and functional outcomes over 24 months, while outcomes from the comparison group remained unchanged. Study group members showed stabilized health conditions, decreased weight loss and withdrawal behavior (i.e., lack of interest in long-standing activities or being with family or friends).
- Interviews with personal home proprietors and focus groups with program staff revealed that program services reduced unnecessary hospitalizations and nursing home placements. Delaying entry into a nursing facility for 11 residents saved an estimated \$232,075 in placement costs.
- Chart reviews revealed that the program's nurse practitioner facilitated hospital visits that personal care home staff would not have pursued, resulting in appropriate and timely medical intervention for residents in the program.

- The study group's medication utilization declined by an average of 0.24 medications from the first to the last assessment period (approximately 24 months); the change in the comparison group was not as marked. Of 35 study group chart reviews, 20 charts cited one or more instances of nurse practitioner intervention to correct medication problems.

Communications

Project staff made approximately 24 presentations on the project before professional groups, including the American Society on Aging/National Council on Aging Joint Conference.

LESSONS LEARNED

1. **Be aware of the challenges of managing a project through two lead agencies—Albert Einstein Health Care Network and the Philadelphia Corporation for Aging—that are geographically separated and that have different internal structures.** These challenges often made it difficult to coordinate decision-making and move forward in a timely manner. (Project Director)
2. **Establish a sound framework to move forward on a complex project involving two agencies and multiple providers.** In particular, the project was advanced by efforts to ensure that goals and objectives were well understood by all interested parties, and that potential ethical issues were anticipated and channels to address them were established. (Project Director)
3. **Be prepared to compromise with state agencies, when negotiating evaluation designs.** Due to multiple and constantly changing requests from the Pennsylvania Department of Aging and Department of Public Welfare (whose staff kept changing due to political turnover), negotiations over the evaluation design were complex and extended. The final result was costly in terms of both time and dollars. However, the project director notes that "it is unlikely that without the agreement to mount such a complex evaluation plan the program would have ever been implemented." (Project Director)
4. **Anticipate the time and effort it takes to build trust and a shared agenda.** Although there was initial agreement that this project had its merits and would be implemented, the time it took to gather the stakeholders together and actually move to implementation greatly exceeded the expectations of project staff at Albert Einstein. (From the perspective of the state agency partners, however, implementation occurred more quickly than usual.) To build trust around an evolving and complex project, the project director recommends continually assessing the communication needs of the group, slowing down the process of decision making to ensure full buy-in by all participants, and making an effort to ensure that written communication is clear. (Project Director)

5. **Find a champion—or at least a high-level contact person—from among the partnering state agencies, when state advisory committees get too large and unwieldy.** In an attempt to build trust and openness, the membership for the state advisory committee was left open and fluid, which ultimately impaired its ability to move through issues and come to resolution. Since the project spanned a number of state agencies, no one clear champion of the project emerged to drive the project from the state's point of view. In lieu of a champion, an "inside" contact person for the state could have helped coordinate meetings and resolve issues pertaining to complex reporting relationships in the government departments. (Project Director)
6. **Meet with new stakeholders to orient them to project, to avoid problems caused by staff turnover.** There were multiple changes in key state administrative positions throughout this project, caused by staff turn over and change of party affiliation in state government. Project staff as able to continue to sustain the interest of all state agencies through regular meetings and with a commitment from leadership that the program should continue. (Project Director)

AFTERWARD

In 2004, the state advisory committee approved moving the Personal Care Partnership Program beyond the demonstration phase and certified it as a permanent long-term care alternative program. This allowed the program to continue serving its existing clients. However, enrolling new clients requires statutory change by the Pennsylvania Legislature and, due to budget limitations at the state level, this has not yet occurred. As of February 2006, enrollment had diminished to 47 residents in nine personal care homes.

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