Care That Works: Elder Partnership for All-Inclusive Care (ElderPAC)

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This is the fourth in an occasional series highlighting promising strategies for person-centered care for people with complex care needs.

What is ElderPAC?

ElderPAC – a home-based primary care program – was developed and implemented in Philadelphia more than 20 years ago by the University of Pennsylvania Health System (UPHS) in partnership with the Philadelphia Corporation for Aging (PCA). Its purpose is to deliver a comprehensive blend of medical care and home and community-based services (HCBS) to frail elders with multiple complex chronic conditions and functional impairments in their homes. Participants are either dually enrolled in Medicaid and Medicare or enrolled in the Pennsylvania Options program (a non-Medicaid HCBS program funded through the Aging Block Grant). All participants have been evaluated to be eligible for nursing facility level of care.

Quick Facts about ElderPAC

- ElderPAC serves more than 200 patients within a five-mile radius of the University of Pennsylvania academic medical center[1]
- ElderPAC provides participants with comprehensive care for complex medical conditions as well as supportive services to maintain residence in the community
- Average age of participants is 82[4]
- On average, participants need help with three or more activities of daily living[4]

Eligibility Criteria

- Home Bound
- Certified as needing a nursing facility level of care

The ElderPAC professional team includes nurse practitioners, physicians and social workers from UPHS; service coordinators from PCA; and registered nurse case managers from the University of Pennsylvania home health agency. For participants who need assistance with activities of daily living, the team also includes a home care worker. The inter-agency team communicates on a daily, weekly and monthly basis, including weekly meetings between medical, social work and nursing staff; monthly team meetings with the PCA case managers; and daily real-time phone, email and text messages amongst team members. The team uses care plans formulated by PCA and home health agency staff to guide delivery of services. Nurse practitioner–physician teams visit participants every 6-8 weeks (6 NP/2 MD visits/yr.) to assess and manage medical needs. PCA case managers are in frequent, often weekly, phone contact with participants to respond to requests for HCBS; a nurse case manager visits weekly.

The ElderPAC model has demonstrated positive results:

- Two five-year evaluations between 1998-2009 showed a 40-50% reduction in Medicare costs, 20 additional months of survival in the community compared to matched home and community-based care controls and a four-fold decrease in months participants spent in nursing homes, resulting in 23% lower Medicaid costs.[1]
- Mean survival for ElderPAC participants is 47 months, including 44.3 months residing in the community. Survival for comparable non-ElderPAC participants is 31.9 months, with just 24.2 months in the community. [2]

- Total 5-year Medicaid costs were $7.5M for ElderPAC participants versus $15.6 million for a comparison group, with a much smaller proportion spent on nursing home care for ElderPAC participants.[2]
- ElderPAC has resulted in a 40% increase in participant survival and length of time residing in the community as compared to standard delivery of home- and community-based services.[1]
- ElderPAC reduces average monthly costs compared to similar patients – by 24% when compared to individuals covered by Medicaid who were not ElderPAC participants and by 32% when
- compared with dually eligible individuals.[2]

The Consumer Experience: Ms. Wilma Gray

Ms. Wilma Gray (right) with her home health nurse, Jill Ellenton.

Wilma Gray – a resident of Philadelphia since 1948 – has had a long relationship with the ElderPAC team. As she says, "they've been coming to see me as long as I've been sitting in this chair." After retiring in 1991 from her 31-year career as a machine operator at a children's clothing factory, Ms. Gray developed heart disease that slowly worsened to the point where she was almost completely incapacitated and sitting in her recliner most of the time. Her symptoms were not well controlled, resulting in frequent hospitalizations. She made do with assistance from family and friends, but she did not have the support she needed to meet her daily needs. Becoming an ElderPAC participant improved her health and quality of life.

Ms. Gray credits the communication skill of the ElderPAC team for the effectiveness of the program. In her case, the team includes a physician, nurse practitioner, PCA service coordinator, two home care aides and a registered nurse, Jill Ellenton. She says "My team sits down and talks with me –

that's the best kind of medicine. They talk to me about my family, my eating habits and tells me about what I should and shouldn't do. If doctors talk to people in the right way, you can feel what they're talking about…you can tell if a person really cares."

Elder PAC provides person-centered care through:

- An integrated, cross-agency, interdisciplinary team
- Frequent, barrier-free communication amongst team members
- The combination of medical care with home- and community-based services
- Participant-centered communication and goal-setting
- Manageable case loads

Two years ago, Ms. Gray was hospitalized for congestive heart failure. Her ElderPAC doctor visited her at home after her hospitalization and found her to be short of breath. To improve Ms. Gray's comfort and avoid another hospitalization, the doctor asked Jill to work with Ms. Gray on medication management and implementing dietary changes. Ms. Gray says "Jill got through to me. She worked with me on my diet and my medicines – taking the right ones and taking them on time. I made big changes in my diet; I stopped adding salt to my food and eating take out." With proper medication management, dietary changes, physical therapy and the support of the ElderPAC team, Ms. Gray lost 70 pounds and now is able to move around more easily. She says "Before I was just moving from my recliner, where I sleep, to my chair. Now I can move around better. I don't ache like I did."

Ms. Gray also benefits from the HCBS offered by ElderPAC. She says, "I call my service coordinator if I need something. I call her and she sees that I get it, for example, if I need a commode or Meals on Wheels. Also, I have 7.5 hours per day of home care, seven days a week from my aides. They help me bathe, get dressed, comb my hair, do my nails, cook and do housekeeping." Ms. Gray is grateful that she is able to continue living at home. She says "I never want to go to a nursing home. ElderPAC made me stronger and made me believe in myself."

Jill, the RN case manager who works with Ms. Gray, has a case load of between 20 and 25 patients. Another nurse assists Jill with visits to patients who need more than one visit per week, and patients are seen between one to five times per week, depending on their condition. Jill is able to spend time with each patient, to teach them about their conditions and talk with them about their goals and a plan to reach them. She says, "One of the things I love about this job is helping patients figure out how to manage at home." The integrated nature of ElderPAC enables her to work with the whole person – social, physical, behavioral and functional – and gives her a way to address any needs she identifies. She believes the greatest benefit of ElderPAC is that it helps people who do not want to live in a nursing home to stay in the community longer. She says, "My work with patients often ends with them passing away, but at least they have been able to stay in their home and community."

She credits the ease of communication among team members as one of the features that makes the program work so well. If she identifies a medical need when she is in a patient's home, she has the nurse practitioner and physician's cell phone number and can text or call her/him to address the need immediately. If she identifies a need for HCBS, she says "I know exactly who to call and trust that it's going to happen. For patients who are not ElderPAC participants, I have to hunt down the right agency or person, figure out the telephone number, and wait until I get a call back."

In Ms. Gray's case, having dedicated home care workers who provide services is also beneficial. Ms. Gray has an iPad tablet, a scale and a blood pressure cuff provided to her through ElderPAC. The aides help Ms. Gray manage her symptoms by checking her weight and blood pressure every day and entering the measurements into the iPad. They also help Ms. Gray check her blood sugar. Jill says, "I can't be there every minute, so having the help of home care workers makes my job a lot easier."

With her improved health, Ms. Gray was able to move back to Troy, AL, her birthplace, in September 2018, to be near her four remaining siblings, aged 72-82. She commends the ElderPAC team for helping her get there saying, "The team has been great! I love them, and I hope they love me."

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