Pennsylvania’s Living Independence for the Elderly (LIFE) Program

Jonathan Bowman/Joan Bradbury
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Governor’s Long-Term Care Council
Agenda

- LIFE History
- LIFE Program Eligibility
- Access to LIFE Services
- LIFE Model of Managed Care
- LIFE Services
- Interdisciplinary Team (IDT)
- Clinical Integration
- Addressing Housing Needs
- Questions
LIFE History in Pennsylvania

• Implemented in Pennsylvania (PA) in 1998
• Called the LIFE Program in PA
  – Living Independence for the Elderly
• Nationally known as PACE
  – Program of All-Inclusive Care for the Elderly

Mission since inception in pilots 40 years ago:
“Enable frail, older adults to live in the community as long as medically and socially feasible.” (42 CFR 460.4)
LIFE Program Eligibility

- Age 55 and older
- Determined Nursing Facility Clinically Eligible (NFCE)
- Determined financially eligible or able to pay privately
- Can live safely in community setting at time of enrollment (with the support of LIFE).
- Reside in area served by LIFE Provider
Access to LIFE Services

• LIFE is the enrollment alternative to Community Health Choices, if available and if the individuals are eligible
• LIFE included in transition information
• Outreach and education efforts will discuss the LIFE program
• IEB will provide LIFE education
• To enroll or for more information:
  – call LIFE provider directly
  – IEB will refer individual to LIFE provider
Click here to locate a LIFE program in your area:
http://www.palifeprograms.org/locate-a-life-program/
LIFE Model of Managed Care

• Focus on the frail elderly – “nursing home eligible”

• Integrates Medicare and Medicaid funding through monthly capitation payments to providers

• Risk based model – assumption of full financial risk is incentive to keep the participant as healthy as possible

• An Interdisciplinary Team approach to care management and service delivery. The LIFE Provider IDT is responsible for coordinating and managing all of the participant’s health and supportive service needs.
Available Services (determined by IDT):
- Primary Care
- Community-Based Social Work (MSW)
- Interdisciplinary Care Management
- Acute care
- Long-term care (at home, or in a facility if needed)
- Pharmaceuticals
- Behavioral health services
- In-Home Care and home modifications for accessibility
- Day Health Centers with rehabilitation, recreation, and personal care services
- Transportation
LIFE Program Eligibility

LIFE PROGRAM ELIGIBLE

Clinical Eligibility
- Individual Age 55+
- AND
- Individual is Nursing Facility Clinically Eligible
- AND
- Individual can reside safely at home in community

Financial Eligibility
- Individual has Medicare & Medicaid Benefits
- OR
- Individual has Medicaid Only Benefits
- OR
- Individual is able to pay privately
LIFE Program Model and Services

LIFE PARTICIPANT

THERAPIES & REHABILITATION:
Physical, Occupational, Recreational Therapies

ACUTE CARE SERVICES:
Skilled Nursing, Hospitalizations

PRESCRIPTION COVERAGE & MEDICATION MANAGEMENT

DAY SERVICES & SOCIALIZING:
Adult Day Services, Fellowship, Spiritual Services, Respite Care

PHYSICIAN & SPECIALISTS:
Primary Care, Nursing, Dentistry, Podiatry, Optometry, etc.

PERSONAL CARE SERVICES:
bathing, grooming, dressing, house chores, meal prep

MEALS & NUTRITION SERVICES

TRANSPORTATION

SOCIAL WORK
Distinguishing Components of LIFE

- The participants’ health provider (LIFE) insures and manages all care across every setting, whether Medicare or Medicaid covered services.

- The Care Manager is a full interdisciplinary team.

- The LIFE organization provides most of the LTSS with its own staff.

- Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply. Allows the right care at the right time.
# Interdisciplinary, Coordinated, In-Home

<table>
<thead>
<tr>
<th>IDT Members (Minimum)</th>
<th>Care Coordination (as a team)</th>
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<tbody>
<tr>
<td>Primary Care Physician</td>
<td>• Initial and ongoing assessment</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>• Routine and episodic care planning</td>
</tr>
<tr>
<td>Master of Social Work</td>
<td>• Home assessment and visits</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>• Daily update meetings</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>• Coordinating with other providers</td>
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<tr>
<td>Registered Dietician</td>
<td>• Service coordination and set up</td>
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<tr>
<td>Recreation Therapist</td>
<td>• Manage care transitions</td>
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<tr>
<td>Home Care Coordinator</td>
<td>• Medication Reconciliation</td>
</tr>
<tr>
<td>Personal Care Attendant</td>
<td>• Providing Care and Treatment</td>
</tr>
<tr>
<td>Driver</td>
<td>• Patient/Family Education &amp; Training</td>
</tr>
<tr>
<td>LIFE Center Manager/Director</td>
<td>• Night/weekend on-call</td>
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LIFE Integrates Primary Care with LTSS

• Physician immediately knows of problems/changes of condition from caregivers – family, aides, drivers, etc. Likewise, all the above are aware of and alert to changes in patient status and needs from the physician perspective

• Physician knows lifestyle, family and cultural issues from a variety of sources, and can tailor care planning to be highly individualized

• Nursing involved in every case, doing triage, medication reconciliation, home visits, assists MD/NP

• Provider knows patients more thoroughly; time for conversations about goals, to repeat information, gain trust

• LTSS can be tailored to best advantage of preventing nursing home and hospital admissions/readmissions

• PCP/nursing responsible for managing care across settings - participants followed in the hospital and post-acute settings
LIFE Integrates Primary Care with LTSS (cont)

- PCP coordinates care among medical specialists
- Participants have real time access to the center staff and can be brought in to see the physician or others on short notice
- Shift from disease management to symptom management to end of life happens naturally. Palliative care available even though it is not a reimbursable service. Hospice is an open decision rather than an all or nothing option. Studies show this makes people more likely to accept palliative/EOL
- On-call access to primary care at all times
- PT/OT visits home
Innovative ways in which some LIFE Program Providers address housing needs:

– Community partnerships

– Co-location arrangements

– Services and supports agreements

– Public Housing Authority agreements

– HUD Housing arrangements

– Nursing Home Transition (NHT) program
Link to LIFE Program Video

http://www.dhs.pa.gov/citizens/alternatives tonursinghomes/lifelivingindependenceforthetheelderly/
LIFE Program Information

• DHS website (keyword “LIFE”)
  – www.dhs.pa.gov

• Pennsylvania LIFE Provider Alliance
  – www.palifeprograms.org

• National PACE Association
  – www.npaonline.org

• Centers for Medicare & Medicaid Services
  – www.cms.hhs.gov/PACE