

# Partnering Managed Care and Community-Based Services for Frail Elders: The Care Advocate Program

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**OBJECTIVES:** To describe a demonstration program that uses master's-level care managers (care advocates) to link Medicare managed care enrollees to home- and community-based services, testing whether referrals to noninsured services can reduce service usage and increase member satisfaction and retention.

**DESIGN:** Using an algorithm designed to target frail, high-cost users of Medicare insured healthcare services, the program partners PacifiCare's Secure Horizons and four of its medical groups with two social service organizations.

**SETTING:** Three care advocates located in two community-based social services agencies using telephone interviews to interact with targeted elders living in the community.

**PARTICIPANTS:** Three hundred ninety PacifiCare members aged 69 to 96 receiving care from four PacifiCare-contracted medical groups.

**INTERVENTION:** The 12-month intervention provides telephone assessment, links to eight types of home- and community-based services, and monthly follow-up contacts.

**MEASUREMENTS:** Sociodemographic characteristics of intervention participants, types of service referrals, and acceptance rates.

**RESULTS:** Lessons learned included the importance of building a shared vision among partners, building on existing relationships between members and providers, and building trust without face-to-face interactions.

**CONCLUSION:** The program builds on current insured case management services and offers a practical bridge to community-based services. *J Am Geriatr Soc* 51:807–812, 2003.

**Key words:** chronic care; care management; consumer directed care; coordinating home- and community-based services

Frail elders, often high users of health care because of chronic illness, face a number of barriers in the current approach to health services. These include fragmentation of service delivery, lack of chronic and custodial care services, and little emphasis on preventive care.<sup>1,2</sup> In addition, a major schism exists between Medicare-funded acute care services and home- and community-based care, funded by an array of federal, state, and local programs and consumer out-of-pocket payments.<sup>3</sup> One approach to address this problem is to improve the linkage between acute care and home- and community-based services through care management that includes information about and improved access to home- and community-based services. Unlike Medicare-covered services which focus on medical treatment, home- and community-based services concentrate on disease and injury prevention (e.g., nutrition programs, home modification and repair, health screening, and socialization), linkages to a range of services (e.g., information and referral, transportation services, and case management), and custodial care (e.g., personal care services, chore services, day care, and respite for caregivers).<sup>4</sup> Home- and community-based services that focus on care and prevention can play an important role in reducing hospitalizations, emergency room visits, and nursing home days, particularly for the 5% to 10% of high-risk older persons who incur 60% to 70% of costs.<sup>5,6</sup> Yet many older adults are unaware of the range of community resources available to them.<sup>7,8</sup>

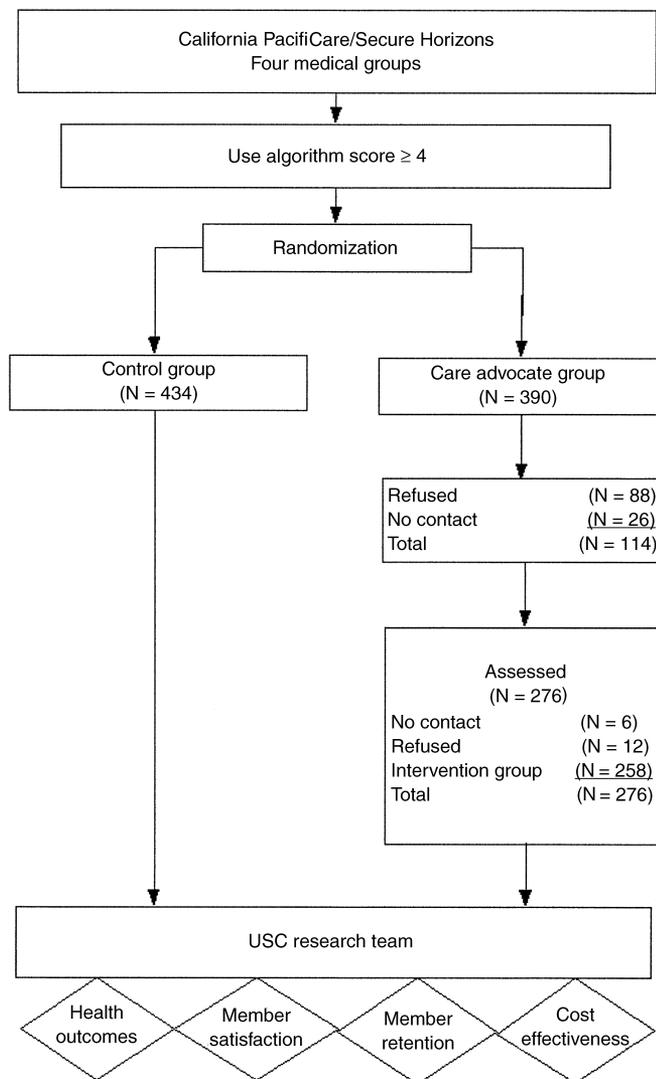
## THE CARE ADVOCATE PROGRAM: THE PROCESS OF CARE DELIVERY

The Care Advocate Demonstration Program was developed to improve access to noninsured personal care and social services for high-risk older adults enrolled in Medicare managed care. Launched in January 2000, the demonstration partnered a large Medicare-risk plan (PacifiCare's Secure Horizons) with two home- and community-based social service agencies: Jewish Family Service of Los Angeles (JFS) and Jewish Family and Children's Services of Long Beach/West Orange County (JFCS). The partnership included four medical groups with which PacifiCare contracts to deliver Medicare services: Cedars Sinai Medical Network, Harriman Jones Medical Group, Health Care

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**Figure 1.** Model of the care advocate program evaluation. Participants were selected from PacifiCare's Medicare risk program. Eligible participants achieved a score of four or more using a healthcare usage algorithm and were randomly assigned to control ( $n = 434$ ) and care advocate groups ( $n = 390$ ), with the control group receiving the usual and customary care and the care advocate group receiving the study intervention (assessments and 11 monthly information referrals). Researchers at the University of Southern California performed evaluations to determine levels of member-health outcomes, satisfaction, and health plan retention pre- and postintervention, and the cost-effectiveness of the program.

Partners/United Physicians of South Bay, and Talbert Medical Group.

Researchers from the Andrus Gerontology Center at the University of Southern California are evaluating the program (Figure 1). The program's overarching goal is to determine whether frail older adults experience improved care while reducing their use of high-cost acute care services by accessing home- and community-based services. Corollary questions are, "To what extent does the Care Advocate Program affect member satisfaction?" and "Does the intervention affect member retention in the health plan?"

## Structural Aspects of the Program

Three full-time, grant-funded care advocates staff the program. Employed by and housed within the social services agencies (JFS and JFCS), each care advocate has a master's degree in social work or family counseling and prior experience working with older adults. Care advocate caseloads averaged about 29 (range = 24–35) members per month during the first year of the intervention ( $n = 70$ ) and about 63 (range 49–76) members per month during the second year ( $n = 188$ ). Greater caseloads during the second year reflected a slower-than-anticipated start-up period, the addition of a fourth medical group to increase member participation in the study, refinements in the recruitment process, and rolling enrollment periods that allowed for overlapping 12-month interventions. Based on their experiences in this study, care advocates reported that active caseloads of 75 to 100 members per month were reasonable.

In addition to the care advocates, several individuals from PacifiCare staff the project. These include the principal investigator (5% time) who provides overall direction, a program manager (50% time), and a project coordinator (90% time). Most of PacifiCare's contribution is administrative. Staff contributes about 20% of this time to address the research requirements of a demonstration project. For example, the program manager is responsible for oversight of the project, budget management, and ensuring that necessary plan data are encrypted and submitted to the research team and serves as liaison to all partners, including the foundation, and the program office. The project coordinator assists with the budget and serves as the liaison to the care advocates. The project coordinator also maintains the project's database and coordinates team meetings. PacifiCare draws on its resources in areas such as consumer satisfaction surveys and mailing services.

## Participant Enrollment

To be eligible for the program, individuals must be aged 65 and older and enrolled for a minimum of 1 year in PacifiCare's Medicare risk program, excluding long-stay nursing home residents. All members who achieved a score of four or more (scale of 0–11) using a healthcare usage algorithm developed to qualify participants for the Care Advocate Program (Table 1) were eligible for the demonstration program. Staff from PacifiCare developed the algorithm, based on a review of the literature, preliminary data, and an analysis of the PacifiCare Member Health Questionnaire, which indicated a positive association between algorithm-generated past healthcare use and future use. The algorithm assigns scores based on age 85 and older, number of hospitalizations in the past year, emergency room visits in the past year, and number of current medications.

## Assessment

Those eligible for the program receive a letter and, if needed, as many as two follow-up letters inviting them to participate by returning a signed consent form. Care advocates contact and schedule those who respond for an initial telephone assessment. Care advocates use a standardized assessment instrument, developed by JFS and JFCS.

The 83-question assessment instrument measures

**Table 1. Usage Algorithm to Determine Program Eligibility**

1) Baseline score		0
2) Aged 85 or older		add 4*
3) Hospitalizations in the past year:	1	add 1
	2+	add 2
4) Emergency room visits in past year:	1	add 1
	2+	add 2
5) Current medications from pharmacy records:	1-2	add 1
	3-4	add 2
	5+	add 3

\* Score of 4 or more (11 maximum) qualifies plan member for Care Advocate Program.

sociodemographic characteristics (age, sex, marital status, education, living arrangement, income, primary language), current medical conditions, service usage over the past year, and current pharmacy usage. It employs a brief cognitive screen (name, date, birth date, age) and uses the Katz index of independence in activities of daily living to

assess performance in bathing, dressing, toileting, transferring, and continence.<sup>9</sup> Lawton's instrumental activities of daily living scale assesses participant's need for assistance with cooking, cleaning, shopping, money management, transportation, use of telephone, and medication administration.<sup>10</sup> Care advocates also ask about alcohol use, smoking habits, and self-reported quality of life. Consumer preferences are an important component of the study; consequently, care advocates ask participants what services interest them and incorporate those suggestions into their recommendations.

Those not able to respond by phone at the initial assessment receive a one-time home visit. Criteria for a home visit are that the client is unable to provide information to a care advocate or is unable to use/access a referral from a care advocate due to physical, cognitive, or emotional disabilities. The care advocate makes this determination based on participant responses to the assessment questionnaire. Problems that triggered home visits include hearing loss, emotional/mental illness, significant dementia, or any medical conditions that preclude telephone assessment. Twenty-two percent of those contacted ( $n = 60$ ) met these criteria and received an in-home assessment.

**Table 2. Care Advocate Program Referral Categories**

1. In-home care	6. Supportive services
Home chores (laundry, shopping, cleaning, meal preparation, medication management)	Case management
Personal care (bathing, grooming, toileting, incontinence care, 24-hour supervision)	Money management
2. Nutrition	Legal referrals
Congregate meals	Advanced directives
Grocery delivery	Housing referrals
Home-delivered meals	Adult day health care
Nutritional supplements	Support groups
3. Home safety	Advocacy groups
Emergency response system	Community groups
Alzheimer's association safe return	Recreation
Medic-alert	Exercise
Telephone reassurance	Adult protective services
Uninsured durable medical equipment	Employment
Bath safety equipment	Volunteering
Rearranging home to improve safety	Financial assistance
Outdoor safety equipment	Counseling
4. Transportation	Dental referrals
Taxi voucher	Information and referral
Curb-to-curb transport	Friendly visiting
Escort	Medicare
Volunteer transport	Burial information
Department of motor vehicles disability placard	Medi-Cal
5. Adaptive equipment	7. Medical services
Hearing-adaptive phone	Primary care physician
Hearing aids	Case management at medical group
Incontinence pads	Medical specialists
Visual aids	Skilled nursing facility
Wheelchair pads	Hospice
Diabetic supplies	Respite care
Home therapy supplies	Physical therapy
	Occupational therapy
	8. Member services
	Any benefit-related questions.
	Advocacy services

## Interventions

Using the assessment as a starting point, care advocates offer referral information and direct linkage to eight categories of services. Table 2 displays the eight referral categories and related subcategories. At termination from the program, all participants receive a final list of referrals that anticipate possible future needs.

After the initial assessment, care advocates send participants a letter that includes specific referral information discussed during the assessment interview. They also send a letter to each participant's primary care physician describing service recommendations. After 1 week, a care advocate contacts the participant to be sure that the referral letter was received and that the linkages were appropriate.

Care advocates contact participants by phone each month for the next 11 months to monitor their progress, ensure that they are able to access referred services, answer questions, provide support, monitor any changes, and encourage participants to make their own care arrangements (within the limits of their ability to do so or with the support of family members or friends). In cases where the initial assessment indicates that the participant requires insured services, the care advocate (after obtaining consent) contacts the case manager from the participant's medical group. Medical group case managers are registered nurses or licensed vocational nurses who primarily provide telephone assistance for members with acute conditions, assist members who need help obtaining durable medical equipment, and help with referrals to insured services.

## RESULTS

The mean age of those who agreed to participate in the Care Advocate Demonstration (N = 276) was 82.3, ranging from 65 to 99. Sixty-eight percent were women. Thirty-five percent completed high school, and 32.6% attended at least some college. Fifty-nine percent of participants were widowed, 41% lived alone, 34% were married, and all spoke English as their primary language.

Table 3 provides referral data from the care advocates. For the eight categories of care advocate referrals, the overall acceptance rate was 77.6% (2,584 of 3,330). In the Care Advocate Program, acceptance of a referral means that participants have taken referral information during a phone call or received a letter from a care advocate with requested referral information. Use of referrals occurs when a participant contacts a home- and community-service provider and uses referred services. Care advocates track acceptance or refusal of referrals and use of referred services and enter this information in the referral database. Analyses of usage data are not complete at this time.

### Program Implementation—A Case Study

Mrs. M, an 85-year-old widow, lived alone in a small apartment, was physically frail, used oxygen 24 hours a day, and walked with the aid of a walker. No longer able to drive, she felt "cooped up" and dependent, occupying her time with crossword puzzles and making tapestries for her grandchildren. Her daughter, who lived about 30 minutes away and worked full time, took her grocery shopping and helped with housekeeping chores on the weekends. Concerned that she was a burden to her daughter,

**Table 3. Eight Categories of Intervention Referrals: Ranked by Number Accepted**

Referral Type	Referrals*	Accepted†	Acceptance Rate (%)
Supportive services	905	675	74.5
Medical services	629	536	85.2
In-home care	497	405	81.5
Transportation	454	352	77.5
Home safety	262	150	57.3
Nutrition	243	159	65.4
Member services	213	196	92.0
Adaptive equipment	127	111	87.4
Total	3,330	2,584	77.6

Note: Intervention participants (N = 258); 18 participants withdrew from study after assessment.

\* Referrals to multiple services based on participants' expressed needs and care advocate's observations.

† Some referrals are duplicative in that, when the participant initially refused, care advocates offered the same referrals during a follow-up call.

Mrs. M enrolled in the Care Advocate Program. After the initial assessment, the care advocate identified and discussed with Mrs. M four community services that could benefit her, including Dial-A-Lift, senior center activities, Lifeline Service, and friendly visiting. Mrs. M decided only to enroll in the Dial-A-Lift program, and the care advocate guided her through the application process. Mrs. M used the service regularly for shopping, getting to her doctor's appointments, and going to the bank. After 9 months in the program, Mrs. M was hospitalized and subsequently diagnosed with end-stage liver cancer. Because Mrs. M was not a candidate for cancer treatment, the care advocate discussed hospice care options with Mrs. M and her family and referred her back to the medical group. After her family discussed end-of-life options with her physicians, Mrs. M was transferred from the hospital to a hospice care center, where she died within a week. Soon after, the care advocate received a letter from Mrs. M's daughter thanking her for providing emotional support and for introducing Mrs. M to transportation that offered her a "feeling of independence all the way until the end of her life."

### Lessons Learned

Although a formal evaluation of the full program is pending, a number of lessons have been identified to date.

### Building a Shared Vision

The study was launched with committed partners from dissimilar organizational cultures with different missions, goals, and implementation strategies. For example, care advocates championed a flexible, case-by-case approach to decisions and advocated strongly in favor of a liberal and individualized policy for determining the need for home visits. Representatives from the health plan proposed limiting home visitation in favor of telephone-based intervention, reflecting their cost-sensitive return-on-investment approach and the case management norms of the health plan. The research team pressed the partners to develop consistent criteria for home visits. To identify procedural issues, address differences, and monitor the demonstration

project, the partners met monthly. These sessions were used to build trust, learn each others' terminology, gain a better understanding of the constraints each partner faced, and develop solutions to identified problems.

### *Building Interest Among Plan Enrollees*

A second lesson involved effectively marketing the program by developing an appropriate letter to invite participation of those who were eligible for the study. Response to the initial letter, which was lengthy, legalistic, and overly technical, was poor. This necessitated rewriting the letter to be clearer, more concise, and more inviting. A focus group consisting of older adult consumers evaluated the revised letter and recommended additional changes to improve its clarity and appeal.

### *Building on Existing Relationships*

A related lesson involved building on name recognition and existing relationships to enhance consumer trust in the program. The health plan, PacifiCare/Secure Horizons, wrote the original letter; the final, revised letter went out under the letterhead of the patient's medical group, signed by the medical director, a physician. An alternative would have been for each patient's primary care physician to sign the letter, but the large number of physicians involved and time constraints made this approach impractical for the demonstration.

### *Building Trust without Face-to-Face Interactions*

As they have with other professionals who work in health care, fiscal realities have pressured social workers to shed traditional approaches to care management, including the luxury of developing face-to-face relationships over an extended period. In the present program, care advocates needed to build relationships over the phone, recognizing that members' responses to service recommendations are not always enthusiastic. Some potential participants seemed at risk, but for reasons of denial, fear of becoming dependent, or fear of losing control, they refused to participate. Others, who accepted the referrals, told care advocates that they appreciated having the referrals in case they needed the information later. The care advocate's role was to assess needs and present available options, recognizing that people will not change until they are ready.

Changing behavior per se is not a goal of the intervention. Some participants use the information when offered. Others use the services after some delay. Indeed, some who decide not to use the recommendations may use recommended home- and community-based services in the future. For these participants, the care advocates act as a link in a chain of events culminating with future referral usage. An evolving lesson is learning how to support and encourage members to make effective decisions within a consumer choice model.

### *Duration of the Intervention and Termination*

Another important lesson was to understand the importance of monthly care advocate contacts to some members and the significance of terminating the calls. Care advocates noted that the duration of the intervention could vary considerably if the demonstration became permanent. For example, some participants are ready to terminate af-

ter receiving and discussing the initial referrals and recommendations, but most accept referrals slowly or, as the case study illustrates, have changing needs during the 12-month period. Some might continue using services indefinitely. Regardless of when they leave the program, it is important to provide participants with resources they can use after termination should their needs change. Termination referrals include referrals to the care advocate's community-based organization, the participant's medical group, and the participant's health plan. If a managed care organization were to adopt the demonstration program, participants could recontact the care advocate at any time for additional referrals and information.

### **Limitations**

In addition to the lessons learned (areas where modifications were made to improve the project), limitations should be noted: the need to improve targeting by identifying those who could most benefit from the service and the generalizability of findings.

### *Identifying Those Who Could Benefit from the Intervention*

More work needs to be done to identify and effectively recruit those who could benefit from improved access to home- and community-based services. Current technology for targeting services is inexact. The algorithm used in the current study to identify those who were at risk of high usage appears to be a good beginning. Risk screening instruments considered for post hoc at-risk analysis include the chronic disease score,<sup>11</sup> which uses pharmacy data to predict mortality and hospitalization rates, and the probability of repeated admission instrument,<sup>12</sup> which predicts future hospital admissions based on self-reported health status and service usage in the past year.

Nevertheless, it is important to note that measures of high usage and frailty are not measures of a participant's readiness to accept services. It is likely that some participants targeted in the demonstration were too ill to use services; others, who were healthier, did not currently need services. Moreover, there was little information available to predict how many individuals were familiar with home- and community-based services or how many might already have been receiving services from a social service organization. The care advocates have suggested that involving primary care physicians to identify those in need of services and encourage participation would strengthen the program.

### **Generalizability**

The demonstration uses only one managed care plan, in one geographic area of the country, but the use of four medical groups improves the generalizability of study results. In addition, PacifiCare is the largest Medicare-risk provider in the United States, insuring about one of six older adults enrolled in Medicare managed care.

### **CONCLUSIONS**

The present model has several advantages; it is simple, it builds on current insured case management services, managed care and social service partners designed it, and it offers a practical bridge to community-based services—an area that is seldom tapped by managed care. Given these

strengths, if the care advocate program's goals are attained, in addition to PacifiCare, the demonstration should interest other managed care providers who may wish to consider it for their frail, elder populations.

The Secure Horizons' Care Advocate Demonstration Program offers a small step toward improving the integration of chronic care services, but if it proves effective, it will be an important step toward bringing two disparate parts of the healthcare continuum together. Future research should focus more explicitly on how improved choice and access to services affects the wellness and health outcomes of high-risk older persons.

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