



## Fallon Health NaviCare and Summit ElderCare Programs

Fallon Health offers an array of plans and programs for seniors, including two comprehensive programs designed to help seniors age in place: NaviCare, a Senior Care Options/Medicare Advantage Special Needs Plan, and Summit ElderCare, a Program of All-Inclusive Care for the Elderly (PACE).<sup>5</sup>

Fallon Health is the only health plan in Massachusetts and one of only a few in the U.S. that sponsors its own PACE.

### BACKGROUND:

#### An Early Start in Alternative Models of Care

Fallon Health's **Summit ElderCare** PACE program started in 1995 and now has five PACE centers and teams across central and western Massachusetts. The program provided care to 1,151 participants in 2014, making it the seventh-largest PACE program nationally. Summit ElderCare offers comprehensive care and coverage to area residents who are 55 years or older and meet Medicaid eligibility for nursing home care. The PACE model abides by the belief that seniors with chronic conditions should be served in a community setting.

**NaviCare** was introduced as an additional Fallon Health solution for independent living in 2010. NaviCare currently has about 4,400 enrollees across Massachusetts, 95 percent of whom are dual-eligible. About 65 percent of NaviCare's enrollees are nursing-home eligible. Through NaviCare, enrollees who are 65 or older receive all Medicare and MassHealth Standard (Medicaid) benefits, services and items. They also receive such community-based home and personal care services as adult day health, home-delivered meals or help with bathing and dressing needs.

### HOW THE PROGRAMS WORK: Comprehensive Team Support

Fallon Health leaders say that one of the keys to

#### NaviCare and Summit ElderCare: At a Glance

- NaviCare offers a Special Needs Plan for dual-eligible individuals and a Senior Care Options plan for Medicaid recipients over age 65. In each case, members receive team care including home visits.
- Summit ElderCare is a PACE plan offered to nursing-home qualified people 55 and older. They need not be Fallon Health members.
- Fallon Health owns Summit ElderCare, so the health plan provides, coordinates and insures care.
- Summit ElderCare includes five PACE adult day health centers, with a sixth currently under construction.
- Both NaviCare and Summit ElderCare are designed to keep members at home as long as possible.

better outcomes for both programs is effectively addressing psychosocial and economic determinants of health, including the individual's safety at home, transportation, socialization and other daily requirements.

<sup>5</sup>PACE (Program of All-Inclusive Care for the Elderly) is a program that meets health care needs in the community instead of in a nursing home. Care is provided in the home, the community and at the PACE center, where seniors can gather during the day to be with others and receive all of their care needs in one location, including physical therapy, meals, social work, nutritional counseling, administration of prescription drugs and medical care provided by a PACE physician.

Participants in **Summit ElderCare** receive the full spectrum of care primarily at PACE centers, at home and in inpatient settings when needed — which supports retention of independence at home. Care is coordinated by an interdisciplinary team of health care professionals with geriatric expertise. Transportation is available to and from the PACE centers. Most participants spend several days a week at a center, which provides opportunities for socialization, recreation, rehabilitation therapy, medical and nursing care, and meals. In-home support includes help with bathing, dressing and meal preparation; medication management; and light housekeeping.

For **NaviCare** enrollees, care is overseen and coordinated by a primary care team comprising their primary care physician, nurse case manager, behavioral health clinician and geriatric support services coordinator (for those who live at home) or facility liaison (for those in assisted living or long-term care facilities). Perhaps most important is the “navigator,” a key player who oversees and coordinates all aspects of the enrollee’s services. This navigator is a single point of contact for both the patient and the provider.

Upon joining the plan, NaviCare enrollees receive a home visit by the primary care team comprising the nurse case manager, geriatric social worker and

navigator, as well as a behavioral health clinician, if appropriate, who perform a complete cognitive, environmental and physical assessment. The results are reviewed with the enrollee’s primary care physician and an individualized care plan is drafted to share with the individual and family, if appropriate. The care team and the navigator are responsible for executing the care plan. They regularly contact enrollees, and the navigator also organizes and coordinates benefits and services, advocates for appropriate care, helps schedule medical appointments and arranges for transportation if needed. The primary care team follows the patients through transitions of care.

## RESULTS: Utilization Down, Satisfaction Up

**NaviCare** data show enrollee satisfaction rates at 98 percent for four years running.

The plan has made the following observations of positive results as compared to Medicare Fee for Service beneficiaries<sup>6</sup>:

- Acute admissions per 1000 are lower by 13 percent.
- Skilled Nursing Facility (SNF) admits per 1000 are lower by 13.4 percent.
- SNF days per 1000 are lower by 28.2 percent.
- PM/PM cost savings are estimated at \$128.20.

**Summit ElderCare** PACE participants are also highly satisfied, with 100 percent willing to recommend the program to friends or family. One hundred percent of PACE participants have advance directives and the plan has advance care planning discussions documented for 85 percent of its participants.

A state-sponsored study<sup>7</sup> of PACE plans found they save money and delay nursing home placement by at least 20 months for PACE participants, compared to non-PACE participants. Median length of stay in the program is 27 months, but has been as long as 10 years. All participants are nursing facility certifiable yet the 2014 30-day readmission rate is only 15.7 percent compared to a SNF return to the hospital rate of 23.5 percent and general Medicare population readmission rate of 18.4 percent.<sup>8,9</sup>

### Choosing NaviCare or Summit ElderCare

Fallon Health outreach staff for NaviCare and Summit ElderCare helps prospective individuals to choose the most appropriate plan. The choice may be based on an existing relationship with a primary care physician, sometimes on geography, or on special needs. Both programs offer comprehensive, coordinated care and in-home support, with the key difference being that the Summit ElderCare interdisciplinary care team provides all the clinical care for participants.

<sup>6</sup> Compared to the Centers for Medicare and Medicaid Services, 5 percent Worcester County sample dual eligible 65+ weighted for Fallon Health mix of institutional/non-institutional and adjusted for utilization and intensity.

<sup>7</sup> JEN Associates, Inc. Massachusetts PACE Evaluation Nursing Home Residency: Summary Report (July 24, 2014). Retrieved May 8, 2015, from National PACE Association website, [http://www.npaonline.org/website/download.asp?id=6253&title=Massachusetts\\_PACE\\_Evaluation\\_Summary\\_Report\\_7.31.14](http://www.npaonline.org/website/download.asp?id=6253&title=Massachusetts_PACE_Evaluation_Summary_Report_7.31.14).

<sup>8</sup> Toles M, et al. Restarting the cycle: incidence and predictions of first acute care use after nursing home discharge. *J Am Geriatr Soc* 2014;62:79-85

<sup>9</sup> Mor V, et al. The revolving door of rehospitalization from skilled nursing facilities. *Health Aff (Millwood)* 2010; 29:57-64