

Key Components for Successful LTSS Integration: Case Studies of Ten Exemplar Programs

Erickson Living

Jennifer Windh
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Long-term services and supports (LTSS) integration is the integration of medical, behavioral health and LTSS benefits in a single capitated program. This case study is part of a larger research project that hypothesizes that LTSS integration has the potential to improve outcomes and lower overall costs of care for people with substantial functional limitations and complex care needs. This body of research is intended to inform business decisions by health plans and other risk-bearing organizations considering LTSS integration, and to contribute to policy discussions on financing LTSS.

Ten programs that are experienced and successful in integrating medical care and LTSS were selected for this study. The programs vary in structure, population served, and geography in order to reflect the diversity of successful approaches to LTSS integration. Each case report provides an in-depth description of program characteristics and operations, as well as a discussion of key integration strategies and outcomes.

Background Information

Erickson Living operates 19 continuing care retirement communities (CCRCs) in 11 states, serving more than 24,000 residents. Each Erickson campus offers a complete continuum of housing options to support residents as they age: independent living apartments, assisted living apartments, memory care and skilled nursing rooms. Each community also offers a full range of services to support residents in their apartments, including emergency response services, housekeeping, personal care, and certified home health.

Erickson's extensive on-campus medical services are central to their approach to integrating medical care and long-term services and supports (LTSS). Each community has a medical center staffed by primary care physicians and nurse practitioners who provide outpatient care for residents in the clinic and oversee care in the skilled nursing facility.

Erickson also offers several Medicare Advantage plans for residents through a joint venture with UnitedHealth Group. Across all communities, there are nearly 4,800 members enrolled in one of Erickson's Medicare Advantage plans, which represents about 20 percent of residents. There are five plans: Erickson Advantage Signature without Drugs (179 members); Erickson Advantage Signature with Drugs (2,281 members); Erickson Advantage Freedom (255 members); Erickson Advantage Champion,

a Chronic Condition Special Needs Plan (SNP) for residents with dementia, diabetes, and/or HIV/AIDS (1,721 members); and Erickson Advantage Guardian, an Institutional SNP open to residents in the long-term care facility (237 members).

For this case study, we spoke with members of Erickson's leadership team, as well as the staff at Oak Crest, an Erickson community in the suburbs of Baltimore. The first residents moved into Oak Crest in 1999. There are 2,200 residents at Oak Crest, 479 of whom are enrolled in an Erickson plan.¹ The community has 1,518 independent living apartments, 133 assisted living apartments, and 200 beds in a long-term care building that is dually certified as a nursing facility (Medicaid) and skilled nursing facility (Medicare). The residents at Oak Crest are a relatively high-need population: the average age is 84, the typical resident has 6 chronic conditions, and 15 to 20 percent of residents have some cognitive impairment. As has been the case for the senior living industry broadly, the average age of residents living in Erickson communities has gone up over the past twenty years.

Organizational History and Culture

Erickson was founded in 1981 by John Erickson, pioneering a new model for the senior living industry. Erickson communities are designed to appeal to and be affordable for middle income retirees. The representative Erickson resident is a retired schoolteacher or factory worker who owned their own home and has some pension income.

Erickson's basic pricing model is an entrance fee plus a monthly service fee for room and board. Most residents pay the entrance fee using the proceeds from the sale of their home, and use a combination of social security and pension income to pay the monthly service fee. Three key aspects of how Erickson's communities are designed drive affordability. First, the company's developments are much larger than other CCRCs, with approximately 1,000 units in each development. The typical CCRC has fewer than 300 units.² The larger size allows communities to benefit from economies of scale. Second, residents pay à la carte for supplementary services like personal care, home health, and housekeeping. This holds fees down compared to other communities where residents pay an all-inclusive monthly fee. Finally, there are different monthly fees for independent living apartments, assisted living apartments, and beds in the skilled nursing facility. This reflects the differences in cost across these settings, and means that independent living apartments are less expensive than in CCRCs that charge a single fee across all levels of care.

Erickson's philosophy of care is based on the Rowe-Kahn model of "successful aging." According to this model, successful aging entails three components: avoidance of disease, high cognitive and physical functional capacity, and active engagement with life.³ The communities are also designed to support the "six dimensions of wellness" articulated by Hettler: physical, emotional, spiritual, intellectual,

¹ As of July 2016. Source: Correspondence with Erickson.

² J Zarem (2010) "Today's Continuing Care Retirement Community (CCRC)," Report prepared for LeadingAge and the American Seniors Housing Association and National Investment Center.

³ J. Rowe and R. Kahn (1997) "Successful Aging," *The Gerontologist* 37(4):433-440. Available at: <http://gerontologist.oxfordjournals.org/content/37/4/433.full.pdf+html>

environmental and social.⁴ Over time, Erickson has integrated healthcare in each community as a way to support successful aging and wellness for residents. Erickson is focused on keeping residents healthy, active and socially engaged, so that they can live independently for as long as possible.

Erickson's healthcare capabilities have evolved over time. When a new community opens, relatively young and healthy individuals move into independent living apartments. As the community matures, residents age in place and often become more frail. Erickson's communities have responded to this by adding capabilities to meet residents' increasing need for care. Broadly speaking, there are four components to Erickson's healthcare capabilities.

1. The full continuum of supportive care. Each Erickson community offers certified home health (in some instances contracted out to an external provider) and outpatient therapy to support residents in independent living apartments. Each community also has assisted living apartments and skilled nursing rooms where residents can move if they can no longer safely live independently.
2. On-campus medical centers. In 1990, Erickson added the first on-campus medical center at their Charlestown, Baltimore location. Each medical center employs full-time primary care physicians and nurse practitioners, and hosts a wide range of visiting specialists on a weekly or monthly basis.
3. Electronic medical records. In 2003, Erickson implemented an EMR platform that is used by all Erickson providers and includes a record for each resident. The company continues to invest in IT to support their model of care, and is currently in the process of implementing a new, updated EMR system.
4. Health insurance. In 2005, the company launched their first Medicare Advantage plan, with a unique CMS waiver allowing them to enroll exclusively Erickson residents.

Care Management Approach

One of the strengths of Erickson's approach to integration is the presence of a wide-range of providers on campus.

- Medical center: At the Oak Crest medical center, there are six physicians, two nurse practitioners, two mental health providers, and a podiatrist on staff. A range of specialists, including a cardiologist, orthopedist, and dermatologist, see residents in the medical center during weekly or monthly visits.
- Home health and private-duty home care: Oak Crest has a Medicare-certified home health agency and a private duty nursing and personal care service that cares for residents in independent living.
- Continuing care: Additional nurses and therapists work in the continuing care wing, providing a higher level of nursing and medical care to residents in assisted living and long-term care.
- Outpatient therapy clinic: Oak Crest rehabilitation staff provide physical, occupational, and speech therapy for residents in a clinic co-located with the medical center.

⁴ W. Hettler (1984) "Wellness: Encouraging a lifetime pursuit of excellence," *Health Values* 8(4):13-17.

- Social work: A team of 10 social workers work at Oak Crest, providing care management for all residents, including a dedicated social worker for every 500 residents in independent living, two social workers in assisted living, and three social workers in the long-term care facility.

Every resident has access to a basic level of care management and supervision by virtue of living in an Erickson community. Every resident is assigned a social worker who checks in with them periodically and can provide day-to-day care management. For residents of independent living, this care management can include educating residents about supportive services, referring them to community resources, completing risk assessments, performing crisis interventions, and facilitating transitions to higher levels of care, among other responsibilities. On-campus security and emergency response services provide another level of oversight to residents. Each resident has an emergency cord in their apartment that will alert security if pulled, as well as a sentry latch on their front door that is checked during security rounds twice each day. If the resident has not flipped the latch when security comes by, staff will enter the apartment to check on them. All Oak Crest residents also benefit from the care of an “acute care coordinator nurse” if they are hospitalized. This nurse is an Erickson staff member whose full time job is to visit and coordinate the care of community residents in local hospitals.

Every resident has access to primary care physicians with extensive geriatric expertise and a higher level of care management through the on-campus medical center. Access to the medical center is included in residents’ monthly service fee—there is no additional charge that might act as a disincentive to using the service. As a result, the medical center is one of the most popular services on campus. 79 percent of residents use an Erickson physician as their PCP, and another 10 percent use the medical center occasionally. Many of the occasional users eventually become active patients. New patients in the medical center have an hour-long initial appointment that includes a baseline assessment and establishes their record in the EMR system. Appointments for existing patients are scheduled to be thirty minutes long.⁵ The medical center also provides same-day appointments and call-backs. This level of access necessitates a high level staffing—each Erickson physician has a panel of about 350 to 400 patients, while a typical panel for a primary care physician in private practice is 2,300 patients.⁶ As a result, Erickson physicians are able to get to know their patients well, spend the amount of time necessary to manage the complex needs of the population, see their patients quickly in emergencies, follow-up with patients personally, and participate in care team meetings and communicate with other providers.

Every week, the full care team has an interdisciplinary team meeting—called the “Transitions Meeting”—to discuss residents who are experiencing a higher level of need. In attendance are the community social workers; representatives from home health, home care, and the medical center; the community director; the Erickson Advantage nurse coordinator; and security. Participants discuss

⁵ The typical primary care office visit lasts 20 minutes, according to M Shaw et al. (2014) “The Duration of Office Visits in the United States, 1993 to 2010,” *American Journal of Managed Care* 20(10):820-826.

⁶ G. Alexander et al. (2005) “Physicians in retainer (“concierge”) practice: A national survey of physician, patient, and practice characteristics,” *Journal of General Internal Medicine* 20(12):1079–1083.

residents who are in transitional stages, for example those completing a rehab stay in the long-term care facility, discharging from the hospital, or moving from independent living to assisted living or long-term care. Team members also discuss any other individuals about whom they are concerned. Outside of these meetings, the care team also communicates frequently in a more informal way. Team members see each other on a daily basis and their offices are often just across the hallway from one another. Every team member is connected through Erickson's EMR, which has processes for communicating about residents' needs.

The community knows immediately whenever a resident is hospitalized. If a resident pulls the emergency cord in their apartment or activates an emergency response button on their person, Erickson's in-house security and emergency transport service responds. If the resident calls 911, security will be alerted when the ambulance arrives, because access to the property is controlled. This early notification of hospitalizations gives Erickson's medical team the best possible opportunity to manage transitions.

At any time, there are ten to fifteen Oak Crest residents staying in one of six nearby hospitals. When a resident is hospitalized the community's acute care coordinator nurse visits them every day. This nurse communicates with family members and the Erickson medical team on a daily basis, updating the care team on the resident's progress. The nurse also manages the discharge back to the community, ensuring all services are in place to support the member as soon as they arrive home. The nurse coordinator role is key to Erickson's success in managing hospitalizations, especially given the challenges of interacting with so many different facilities in the Baltimore area.

The care of residents who transition to the long-term care facility is managed more intensively. Clinical oversight is provided by physicians and NPs from the medical center, as well as an NP permanently staffed to long-term care. This means that many residents in long-term care are cared for by an Erickson PCP with whom they already have a long history. Each long-term care patient is overseen by a core team that consists of a nurse manager, physician or NP, and a social worker. This core team meets face-to-face on a regular basis during rounds to review their patients. The nurse manager forms a close relationship with the resident and their family—often a spouse who lives in the community and sees the care team every day. The care team has an open line of communication to residents' families.

Care Management for Erickson Advantage Members

In general, residents enrolled in one of Erickson's Medicare Advantage plans receive the same treatment as other residents. There are, however, a few additional benefits for residents who enroll.

The most significant additional benefit is a dedicated Erickson Advantage nurse coordinator in each community who supports plan members. This nurse coordinator provides care management in addition to what is already being provided by the community's social workers, acute care coordinator nurse, and medical center physicians. When an Erickson Advantage member is having issues, the nurse coordinator communicates with members' doctors, reviews medical records, does in-home assessments, creates care plans, and organizes family meetings. In the event of a hospitalization, the nurse coordinator works with the acute care coordinator nurse on discharge planning and gets

approvals for post-discharge services like durable medical equipment (DME) and home health. Members of Erickson’s plans also have access to a member services representative in each community, who helps with enrollment, accessing benefits, filing paperwork, and answering questions.

The interdisciplinary care team has additional tools to manage residents who are enrolled in an Erickson plan. Unlike individuals with traditional Medicare, Erickson Advantage members can access skilled nursing care without a three-day inpatient hospital stay. This gives the care team considerable flexibility in meeting the needs of members with the most complex care needs, and prevents hospitalizations through direct admissions to the skilled nursing unit when necessary. The care team also has access to more extensive data on plan members, in particular utilization data. This data can be leveraged as part of Erickson’s comprehensive quality strategy, discussed in further detail below.

Financial Integration

Financial Alignment

Erickson has financial alignment—that is Erickson receives funding to provide both medical care and LTSS—for those residents who are enrolled in one of their Medicare Advantage plans. Every Erickson resident is paying out-of-pocket for at least some LTSS and care management that is embedded in the monthly residential fee. For Erickson Advantage plan members, the communities receive a capitation payment to provide virtually all of their Medicare benefits. Erickson can provide many of these benefits in-house through the medical center, but members are also able to see network providers outside the community if they choose. Medical center physicians do not act as gatekeepers or try to limit enrollees utilization of specialist or other care. Erickson strives to prevent hospital admissions and readmissions, but cost-driven utilization management is not the focus of their insurance products.

For residents who are not enrolled in an Erickson plan, there is still some degree of financial alignment if they choose to use the medical center. The medical center accepts traditional Medicare and many other Medicare Advantage and retiree insurance plans, and so does receive revenue for the medical services provided.

Erickson has structured internal budgets to further align incentives to provide the best, most appropriate care to residents who are enrolled in their Medicare Advantage plans. Each community’s medical center receives a capitated rate from the plan, within which they are responsible for managing all of a member’s care. The medical center receives a 15 percent incentive in their capitation rate if they achieve specific quality benchmarks. In addition, 5 percent of the capitation is at risk based on medical costs. Each community receives a separate capitation for all other Medicare services—home health, skilled nursing care, transportation and outpatient therapy. Of this capitation, 20 percent is at risk based on total costs. This internal capitation structure was implemented to align the incentives between different members of a community’s care team: the Erickson Advantage nurse coordinator, the leaders of the skilled nursing facility (SNF), outpatient rehab, and the home health department. Instead of the members of each unit (long-term care, home health, Erickson Advantage, etc.) potentially worrying about their unit’s budget results, the only consideration in determining a resident’s plan of care is the best outcome for that individual. Capitation has changed the financial

structure of the arrangement so that treatment decisions (e.g., whether to discharge a resident to home health or keep them in the SNF longer), do not impact the relative financial performance of the different units involved.

Comprehensive Benefits and Flexibility in Use of Funds

Erickson has the ability to offer a comprehensive range of services and supports provided that the resident is willing to pay for these out-of-pocket. Residents sometimes reject care team recommendations for additional services due to financial or other concerns. This puts Erickson at somewhat of a disadvantage relative to Medicaid plans in which LTSS is a covered benefit and included in the capitation.

Quality Metrics and Performance Management

Erickson has a comprehensive quality strategy led by the medical group. Since their establishment, the primary focus of on-campus medical centers has been to provide the highest quality geriatric care. Direct revenue was not the primary consideration, and for many years the costs of the centers outweighed their revenues. Their value has been in distinguishing Erickson from other CCRCs by the quality of the healthcare available to residents.

Erickson's clinical leadership monitor a dashboard of quality metrics for all active medical center patients across the organization's 19 communities. The dashboard tracks the share of patients who have received recommended preventive care (vaccinations, cancer screenings, depression screenings), management of chronic diseases (diabetes, depression, hypertension), medication management (Coumadin, medications to be avoided in the elderly, antipsychotics and sedatives), and evidence-based care (advance care planning, exercise counseling.) For members of Erickson's Medicare Advantage plans, the dashboard also tracks hospital admissions, readmissions, and lengths of stay. Performance is compared across communities and all are expected to perform well above national benchmarks. A share (15 percent) of each medical center's Erickson Advantage capitation rate is at risk contingent on meeting these benchmarks.

Erickson's long-standing efforts towards a comprehensive quality strategy have positioned the organization to take advantage of many opportunities in the Affordable Care Act and other legislation promoting value-based payment for healthcare. Erickson Advantage is one of only 17 Medicare Advantage plans nationwide with a five-star quality rating in 2016.⁷ The organization is also participating in—and benefiting from—the Physician Quality Reporting System, the Medicare and Medicaid EHR Incentive Programs (i.e., “meaningful use”), and the Comprehensive Primary Care Initiative. Additionally, Erickson is currently pursuing certification as a Patient-Centered Medical Home. The clinical leadership team continuously looks for new opportunities to participate in Medicare quality initiatives.

⁷ B Herman (2015) “Medicare Advantage Star Ratings Reveal Mix of High, Low Performers,” *Modern Healthcare*. Available at: <http://www.modernhealthcare.com/article/20151008/NEWS/151009922/medicare-advantage-star-ratings-reveal-mix-of-high-low-performers>

Person-Centeredness

Erickson communities are committed to supporting healthy aging for all residents, regardless of whether they enroll in their Medicare Advantage plans. However, unlike a PACE program or Medicaid plan, Erickson does not have the same resources or authority to determine a member's service package. Although the care team may determine that a resident needs in-home personal care to decrease the risk of hospitalization, the resident must elect to pay for those services themselves. The Erickson team can only make recommendations. Members of Erickson Advantage plans see themselves as customers, and expect to be treated accordingly. In this model, the resident drives the care plan and is the final decision-maker for the service plan.

When individuals have to pay for LTSS themselves, the decision-making process changes dramatically. For example, residents are cost conscious in increasing their service package. A major reason Erickson residents reject care team recommendations is a reluctance to spend more money on their care. Family members sometimes oppose recommendations for additional services due to concern that the resident's estate will be diminished, or that the care team's guidance is influenced by profit considerations. The Erickson care team works to mediate these conflicts through meetings with the resident and their family that focus on the resident's goals and well-being—using techniques like motivational interviewing to help residents make the best decision for themselves.

Disagreements between the care team, resident, and their family regarding the best plan of care are particularly difficult when the resident is beginning to suffer from cognitive impairment. Often there is not a distinct moment when an individual is clearly incompetent. Instead, cognitive decline is gradual and uneven, and an individual's competence may be ambiguous. Erickson care teams grapple with these practical issues on a daily basis, and noted that it is one of the most challenging situations for the care team to manage. More conceptual work is needed on what constitutes person-centered decision making in the context of cognitive impairment.

Key Integration Strategies and Outcomes

Erickson's leadership credit the on-site medical centers as the most important contributor to their success in managing outcomes and cost. The ability for residents to have daily and immediate access to their primary care physicians is central to their ability to prevent avoidable hospitalizations. The success of the medical centers hinges on three operational design features: (1) same-day appointments, (2) thirty minute visits, and (3) physical proximity to patients.

Another factor in Erickson's success is the opportunity for physicians to collaborate with the full interdisciplinary support team, including social supports. One physician described Erickson as a "Disneyland for geriatricians" because of the ready access to social workers, security, and home care providers.

The environment of an Erickson community also contributes to quality and cost outcomes. Many of the most impactful interventions for preventing dementia and other chronic conditions are not medical.

Instead, it is the level of physical activity, mental activity, and socialization encouraged by the community that leads to positive health outcomes for residents.

Erickson has achieved considerable quality outcomes for residents who are enrolled in their Medicare Advantage plans. The plan is one of only 17 in the country to achieve a five-star quality rating. The organization's communities perform well above national average on the wide range of quality metrics they are measuring for patients in the medical center. Although it is more difficult to quantify, leadership also report that they are able to support very frail residents in independent living who might otherwise have to be institutionalized.

The commitment to integrating medical care and LTSS has also paid off financially for Erickson. The rehospitalization rate for Erickson Advantage members is five percent. Additionally, the communities' occupancy rates are 96 percent—well above the industry average of 90 percent.⁸ The company believes that the high level of integration has been central to achieving these results.

Erickson leadership emphasized that the level of integration in their communities can only be achieved with a significant investment of time and resources. The company's founder believed in the value offered by a primary care geriatric model, and made a long-term commitment to implementing the vision. That willingness to dedicate resources up-front and diligently work on execution has paid off many years later. As a result of these investments, Erickson is now in a strong position to take advantage of the shift to a value-based healthcare system.

⁸ National Investment Center for Seniors Housing & Care (2016) "Analysis: Senior Housing Nearly 90% Occupied Nationwide." Available at: <http://www.nic.org/news-press/analysis-senior-housing-nearly-90-occupied-nationwide/>

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Long-Term Quality Alliance

Long-Term Quality Alliance (LTQA) is a community of organizations aimed at improving outcomes and quality of life for persons and their families who are managing functional limitations due to chronic health conditions. It draws member organizations from the full range of health care and social services delivery systems involved in provision, administration, innovation, policymaking, and advocacy for quality long-term services and supports (LTSS).

Organizations come together in the Alliance to share knowledge and experience needed to advance development and continuous improvement of high-quality systems of integrated, person- and family-centered LTSS. The Alliance serves as a convener of disparate private-sector and governmental organizations, with an eye to identifying and resolving the most significant challenges and advancing the replication of successful models that demonstrate the potential for more widespread adoption of person-centered LTSS integration.

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Contact

Long-Term Quality Alliance
(202) 452-9217
info@ltqa.org
www.ltqa.org

*Advancing high-quality, person- and family-centered,
integrated long-term services and supports*

