

# On Lok SeniorHealth: a national model of community-based long-term care in the USA

SSW Cheng<sup>1</sup>, MSW, LCSW (OR)

**ABSTRACT** On Lok is a well known national model of long-term care for the frail elderly in the United States. It is the prototype for PACE—Program of All-Inclusive Care for the Elderly. On Lok began as a programme addressing local needs in 1973, then evolved to a national demonstration project, and in 1997 became a permanent federal- and state-funded programme. As a health plan and health services provider, On Lok serves the frail elderly through neighbourhood-based community centres that offer primary care, adult day health care, and home care. On Lok's interdisciplinary teams provide psychosocial and medical case management, rehabilitation therapies, nutrition services, recreational therapies, and transportation services. Seniors and their families partner with On Lok in decision making on care plans, establishing advanced planning directives, and documenting health care wishes. We illustrate a case providing an overview of the On Lok long-term care model, focussing on end-of-life issues and comfort care plans enabling a Chinese elderly man to maintain his quality of life and dignity till death.

**Key words:** community health centers; health care facilities, manpower, and services; long-term care; palliative care; patient care team; quality of life

<sup>1</sup> Mrs Sabrina Siu-woon Cheng, Social Worker, On Lok SeniorHealth Services in San Francisco, California, USA

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*Correspondence to: Mrs Sabrina Siu-woon Cheng, On Lok SeniorHealth Services in San Francisco, California, USA. E-mail: sabrina@onlok.org*

## INTRODUCTION

On Lok provides comprehensive medical, social, and rehabilitation services to the frail elderly who need acute or long-term care. As most elderly people do not prefer expensive institutional care in nursing homes or board and care homes; and as other services are either limited or fragmented, On Lok's community-based service has become an option of choice. On Lok's goal is to provide quality long-term health care for the frail elderly and to maintain their independent living arrangements to prevent premature placement in nursing homes.<sup>1</sup> On Lok integrates all care into one health delivery system which is funded by the federal Medicare and the state Medicaid programmes as well as private payments. Funds from these capitated reimbursements and private payments pay for all health and related services for On Lok enrollees. With these capitated reimbursements, On Lok is required to make risk assessments and strategic use of resources,

assuming full financial risk and responsibility for comprehensive services for frail elderly enrollees.<sup>2</sup> In 1997, Congress passed legislation making the On Lok programme a permanent part of the Medicare system. On Lok has become a national model of community-based long-term care for the elderly.

There are now 35 Program of All-Inclusive Care for the Elderly (PACE) sites in the US replicating the On Lok programme over the past 30 years.<sup>3</sup> On Lok and the PACE programmes provide all elder care including medical care, social work, rehabilitation therapy, home care, etc. Enrolees may be transferred to hospitals and nursing homes when they need skilled nursing care. Specialists are contracted to provide specialty care such as optometry, ophthalmology, audiology, podiatry, dentistry, psychiatry, etc. Other care services include transportation, a nutritious meal programme, personal care, recreational therapy, etc. On Lok enrollees with both Medicare and Medicaid benefits

do not need to pay co-payments or other fees.

## PROFILE OF ON LOK SENIORHEALTH SENIORS

On Lok's target population are seniors, 55 or older, who live in the San Francisco or Fremont areas and have multiple medical problems that make it difficult for them to live at home without assistance. On Lok currently serves over 1000 seniors in 7 day health centres in San Francisco, and one expanding day health centre in Fremont. In 2005, the mean age of enrollees was 83 years. About 4% of those at the Powell Center were over the age of 100. 74% were females, 26% were male. 59% were widowed and 20% were married. A multi-ethnic population is served: the majority are Asians (62%) and the others include Caucasians (19%), Hispanics (12%), and African-Americans (7%). The numbers of Korean, Filipino, and Russian enrollees are on the rise.<sup>4</sup>

The frailty level of the seniors served by On Lok is comparable to those living in a nursing home. Most have 8 or more acute and chronic medical conditions, such as arthritis, cerebral vascular disease, coronary artery disease, dementia, hypertension, Parkinson's disease, diabetes, depression, and/or stroke. Approximately 60% of the seniors have some cognitive impairment. About half are incontinent of either bladder or bowels or both. Most are at risk for falls, have mobility problems and are unable to manage their activities of daily living (ADL) independently. Most need daily assistance: 77% with bathing, 48% with walking, 41% with transferring, 64% with grooming/hygiene, 58% with dressing, 45% with toileting, and 22% with eating. Over 90% need help with instrumental ADL such as meal preparation, shopping, chores, laundry, taking medication and/or transportation.<sup>4</sup> More than one third suffer from depression and/or anxiety. A significant problem within their families is caregiver burnout.<sup>5</sup>

## SERVICES AND OPERATIONS

What makes On Lok SeniorHealth different from other health maintenance organisations is the comprehensive, integrated services it provides, which address all primary, acute, and long-term care needs. On Lok's interdisciplinary team of physicians, nurses, physical and occupational therapists, social workers, dietitians, recreational therapist, and geriatric aides

provides:

- primary medical and nursing care
- physical and occupational therapy
- psychosocial services including individual and family counselling, health education, case management including financial and bureaucratic management
- in-home attendant and homemaker services
- in-home health care and personal care
- recreational therapy and activities such as cultural events and outings
- meals (special diets as needed), nutritional counselling and home-delivered meals
- transportation

Each On Lok centre is about 8000 square feet with an average daily attendance of 75 and a capacity of 150. All centres operate 5 days a week, except one that is open 7 days a week to provide care and safety for higher risk participants who need supervision and acute medical care. The centre is a second home for the seniors. They go to the centre two to three times each week to socialise with friends, to participate in recreational activities, to do therapeutic exercises, to eat healthy meals, to receive personal grooming, to have their laundry done for them. When they don't feel well, On Lok will arrange a pickup service to the centre's medical clinic. When they have questions or concerns, the social workers will provide answers, support, counselling or other services to meet their psychosocial needs.

## INTERDISCIPLINARY TEAM ASSESSMENT AND CARE MANAGEMENT

What makes On Lok unique is the interdisciplinary team care management. The team emphasises a holistic, whole-person approach and utilises internal resources to meet the needs of participants as opposed to traditional case management that is limited to coordinating outside resources, resulting in fragmented care. Geriatric assessment is the multidimensional process designed to assess an elderly person's functional ability.<sup>6</sup> The interdisciplinary team approach to assessment and care can be more effective than each specialty working alone.<sup>7</sup> Each member of the team assesses the participants' functional abilities and needs; works together to integrate an appropriate treatment plan, allocate appropriate resources, deliver the needed services, monitor the effectiveness of the care plan and make

adjustments as needed to provide individualised quality care for each unique participant.<sup>8</sup>

A comprehensive and thorough interdisciplinary team assessment is performed for every On Lok senior at enrolment. The On Lok interdisciplinary team conducts comprehensive assessments and evaluations quarterly or semi-annually, and coordinates care 7 days a week, 24 hours a day. A physician and an administrator are on call during non-business hours to provide urgent care. The team meets every morning to report any changes and to adjust treatment plans accordingly. The social workers play a significant role in bridging the communication of needs and concerns between the team and the participants and their families. The social workers work with physicians to discuss case plans, advance health care directives and end-of-life care issues with participants and their families. They advocate for participants, who are also represented on the Ethics Committee, as well as the Health Plan Advisory Committee.

The interdisciplinary team members use standardised instruments to evaluate the medical conditions, cognition, function, and psychosocial needs of the participants. The physicians conduct physical examinations, lab tests and look into medical histories to prescribe medical treatments and medication. The nurses check vital signs and provide nursing care. They use the Braden Scale<sup>9</sup> for predicting participants' pressure sore risk. The physical therapists assess the participants' risk of falls using the Tinetti Balance and Gait Scale<sup>10</sup> and design exercise maintenance programmes. The physical therapists also recommend assisting devices or safety measures such as hip protector pants, diabetic shoes, etc. The occupational therapists use the Activities of Daily Living Index<sup>11</sup> and Instrumental Activities of Daily Living scales<sup>12</sup> to assess the participants' needs for personal care, and abilities to do cooking, shopping, laundry, chores, etc. They also conduct personal and home safety assessments to recommend measures such as high-low hospital beds, landing mattress or bed/chair alarms, safety strips on floors, etc to minimise injuries. The home care nurses assess levels of self-care deficits and develop a home care programme to help maintain participants' ability to live at home. The social workers administer the Mini Mental Status Exam<sup>13</sup> and the Short Portable Mental Status

Questionnaire<sup>14</sup> to evaluate the cognition (memory, orientation, reasoning, and attention span) and the dementia levels in the participants. The Geriatric Depression Scale<sup>15</sup> is used to evaluate mood and behaviour (affect, depression, anxiety, fear, and thought disorder). The social workers also conduct spiritual needs assessments and risk assessments as well as individual and family interviews to assess participants' psychosocial needs, coping skills, housing needs, and support systems in order to work out treatment plans for the participants. The social workers work with physicians to refer participants for psychological counselling or psychiatric consultation if necessary. The interdisciplinary team members work well under the leadership of the programme manager who conducts a team meeting every morning and an intake and assessment meeting every week to ensure effective communication among team members about participants' needs and any changes to treatment plans.

On average, each participant attends the adult day health centre ten times a month, receives about 35 hours of home care, sees the physician or nurse practitioner twice for health maintenance, and receives nursing care seven times a month. The geriatric aides maintain participants' personal hygiene. The participants come to the gym to do maintenance exercises or receive rehabilitative therapies one to three times a week. The social workers ensure clear communication with participants and their families. This partnership between the family and On Lok staff is important to make the system work and thus accomplish On Lok's mission to provide comprehensive long-term care for the elderly.

## QUANTIFIABLE OUTCOMES

On Lok's success can be demonstrated in quantifiable outcomes. The mean period of a participant's enrolment is 4 to 5 years. There is a 15% turnover annually, mostly due to death, with about 3% moving outside of On Lok's service area and some disenrolment. Only 9% of On Lok participants are placed in a skilled nursing facility at any one time, although all of On Lok's participants are nursing home eligible. Hospital utilisation rates are markedly reduced. The number of hospital days per 1000 used by our frail seniors per annum is 1400 days. The general population aged 65 years and older uses 2000 hospital days per 1000. This demonstrates a

considerable reduction in hospital usage costs by On Lok because the general population aged 65 years and older includes healthy seniors while the On Lok population is made up entirely of frail elders. The mean hospitalisation rate for On Lok's participants in 2005 was 6%. The cost savings to the federal and state governments is at least 15% because the government has already calculated a 15% reduction of capitation as payments to On Lok.

On Lok's long-term care model is a win/win situation for participants, their families, and taxpayers. On Lok's participants have lower hospital and nursing home utilisation rates, and remain healthy in their homes. Their dignity and autonomy are respected as they enjoy quality care. With Medicare and Medicaid funding, the On Lok participants receive additional benefits beyond health care, such as nutrition services, transportation, recreation therapy, etc. Families' burdens can be shared and lessened by On Lok's services. Families can return to their employment or continue their daily lives with peace of mind.

### **A CASE STUDY ON END-OF-LIFE ISSUES**

The following case is an illustration of how On Lok staff worked with family members to provide quality care for an elderly man—Mr K—who maintained his dignity and integrity till death.

Mr K was born in Kwangtung, China in the 1910s. Most of his childhood and adult years were war torn. His first wife deserted him and their three children during the Second World War while he worked abroad as a seaman and was unable to return home. His ship ended up in San Francisco and he worked several jobs there until he was granted amnesty and became a US citizen. He sponsored his children and sister to immigrate to San Francisco. Then he went to Hong Kong in the 1960s to marry his second wife. They had a daughter, Q, who came to San Francisco in the 1970s. Mr K retired as a seaman at 65 years. He continued to live in single room occupancy (SRO) in Chinatown by himself after his daughter Q moved out.

Mr K was referred by his daughter Q for enrolment in On Lok SeniorHealth at the age of 89 after suffering a stroke resulting in left hemiparesis and total blindness in his left eye. He had hypertension with congestive heart failure (CHF). His gait was

very unsteady; he could not manage the 41 stairs leading to his SRO. He was at high risk for falls and was homebound for several months. Family members noticed that he had progressive memory loss, was forgetting to eat and was lying in bed all day. He became more confused and lost 20 lbs in one month.

Mr K entered the On Lok programme but insisted on doing what he liked and was against certain treatment plans. Sometimes he walked down the many stairs to the bank to cash his pension cheques and bought fish and rice porridge for meals. He did not like On Lok meals, saying that they had no taste. He liked to make his own soups, but many times forgot to turn off the stove. On Lok SeniorHealth's comprehensive care and services for Mr K included attendance three times a week at the senior day health centre using On Lok transportation, for supervision, medical care in the clinic, social work services, a maintenance physical therapy programme, personal care and hygiene, a good nutrition programme, recreational activities, home care services, and a home safety programme. Due to Mr K's strong personality and non-compliance with treatment, the social worker spent a lot of time providing individual counselling for him, and involved family members as partners with staff in his care; especially when Mr K had severe oedema in both legs due to CHF after eating too much dim sum or restaurant food.

Poor family dynamics were identified as a problem. Although Mr K's four children were committed to his care, visited regularly, and brought him home-cooked foods, the communication between them was minimal. Daughter Q did not get along with her three older siblings because of the generation gap and language barrier. Daughter Q could not speak Chinese well as she was raised in the United States. The three older children were more traditionally Chinese, while daughter Q was more Americanised. Mr K appointed daughter Q to be his Durable Power of Attorney, healthwish spokesperson, and financial manager. Practically and legally the older siblings had to listen to their youngest step-sister's decisions for their father. With his increasing dementia and delusions, Mr K was unwilling to listen to his family members, sometimes, even accusing daughter Q of taking his money and 'dumping' him in On Lok. He refused to take showers or change his clothes. His family were

frightened by Mr K's hot temper and uncooperative behaviour. Daughter Q asked her boyfriend to shower him and buy him fish porridge, but he refused help sometimes. The family frequently sought On Lok staff's advice because they wanted their father to receive care. The social worker and the primary physician provided consultation, education, and support to help family members understand Mr K's dementia, personality, and medical care needs including his supervised housing needs.

When Mr K could no longer live in his SRO in the community due to falls, self-care deficit and dementia, he was placed in supervised housing in a double room located above the day health centre and clinic. Mr K could not make soup any more and asked the social worker to buy him oranges. Every day, he came down to the centre using his walker to see the social worker. The social worker took the opportunity to provide counselling while peeling oranges for him. A relationship based on trust was hence established between Mr K and his social worker to the extent that he asked the union company to send his monthly pension cheque to his social worker, knowing that his social worker would give him the pension cheque on time and would help him cash the cheque upon request. When Mr K was no longer able to use his walker, he was wheeled to the day health centre and clinic for care. The social worker facilitated several family conferences to prepare the family for Mr K's comfort care especially when Mr K refused to eat and refused medical care, such as daily wound dressing changes, medication, intravenous fluids (IVF), immunisation shots, etc.

Although the concept of comfort care was explained to Mr K's family members, when the time came for decision making, the family members became quite anxious because Mr K's older children wanted Mr K to be hospitalised, to have tube feeding, IVF, aggressive treatment, and even resuscitation if Mr K could not breathe on his own. They thought it was the right thing, expressing their filial piety to their father. However, daughter Q did not want any invasive treatment or hospital transfer. She wanted her father to have oxygen and pain management to keep him comfortable since he even refused to get out of bed to eat. She knew her father did not want any pain from invasive treatments. He just wanted to rest peacefully in bed. The social worker again reiterated what comfort care and quality of life

meant to Mr K's family members. According to the Bioethics Committee of Laguna Honda Hospital in San Francisco, California, comfort care is defined as active and holistic treatment to enhance quality of life once rescue and life-sustaining medical interventions are no longer desired or beneficial, as recovery is unattainable. Comfort care is not "giving up" or "doing nothing". In fact, every effort is made to ensure the comfort and well-being of the patient and family. Treatment is directed at physical symptoms which cause discomfort; and at the emotional, psychosocial and spiritual distress which cause suffering.<sup>16</sup>

When Mr K was bed-bound and did not want any service, the physician, home care nurse, social worker, and geriatric aides checked on him to make sure he was comfortable with all his ADL and instrumental ADL. His family members were updated about his condition and were encouraged to visit him more often, preferably spending time by his bedside. Mr K, though weak and not able to talk much, was able to gesture to his family members that he did not want to be bothered. When his oldest daughter brought her 3-year-old grandson to his bedside to greet him as 'great-grandpa', Mr K opened his eyes, looked at his great grandson and smiled. The social worker provided counselling to assist family members to express their feelings and to release their anxiety or guilt. They were pleased that their father was fortunate to be able to maintain his quality of life at On Lok. He was able to live the way he wanted till the end of his life. All family members understood what comfort care was and were able to cope with Mr K's end of life and to accept his dying process.

Mr K passed away peacefully in his sleep after 2 months of comfort care. His family was grateful that he had a good death after a long life of over 90 years, having many grand children and great grandchildren. Most appreciated of all was the way Mr K had retained his dignity and integrity throughout his life, right until the end. He had insisted on the way he wanted to live, and On Lok staff members were able to accommodate his desires. Finally, the interdisciplinary team was successful in helping the family to understand and accept the comfort care plan for Mr K. The interdisciplinary team's recommendation of comfort care helped to:

- (1) alleviate the family's emotional, psychosocial, and physical stress by giving tangible and

- emotional support;
- (2) end the bickering among the family members, helping them to come to terms with one another with the help of the social worker acting as the mediator;
  - (3) preserve family relationships and financial stability as family members could continue gainful employment with peace of mind, knowing that their parent was in good hands.

## CONCLUSION

The word 'On Lok' reflects both the organisation's roots and philosophy of care. The above case depicts the true spirit of On Lok, which in Chinese means "peaceful and happy abode", in other words, "a place of peace and happiness" for all, even end-of-life patients. Depression is the most prevalent mental health problem among the elderly, especially if they live alone.<sup>17</sup> Elders from ethnic minorities tend to underutilise services able to enhance their health and quality of life.<sup>18</sup> On Lok, as a community-based long-term care voluntary organisation in the San Francisco Bay Area, serves a multi-ethnic group of seniors. The staff not only speaks a variety of languages such as English, Chinese, Spanish, Tagalog, Vietnamese, Korean, Russian, etc, but also understands the cultural needs of the participants. A high percentage (90%) of On Lok participants and families are satisfied with the On Lok programme and quality of care given by the staff. By coming to On Lok, participants are relatively happier, less depressed, and live longer and healthier lives with less hospitalisation and fewer nursing home admissions. Families and caregivers are therefore less likely to burn out; their relationships with their older parents and relatives are hence improved.

Is On Lok's model of long-term care relevant to providers in other communities such as Hong Kong, China, and other countries with similar contexts and challenges? On Lok is successful in its approach as a local experiment to promote provider initiative and government support. With proven accountability on quality of care, operational efficiency, and effective cost control, On Lok was able to induce national policy change on elder care in the United States. For policy and research considerations, comprehensiveness and integration of medical and social services are key to addressing the multiple needs of frail elders. The question is how to begin

the necessary infrastructure development to enhance flexible use of resources to provide care to the growing elderly population? Can capitation be easily implemented or applied as an effective cost-saving tool, irrespective of types and locations of services? More research and study on the comparative effectiveness and appropriateness of medical and social services at the local levels, as well as tests of generalisability and feasibility are needed before the implementation of policy changes to serve the world's increasing number of older adults and the ageing baby-boomers of the 1940s.

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