PACE: Adding Quality for Those Living in the Community

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Objectives:

At the end of this presentation, the participant should be able to:

1. Define PACE.
2. Discuss PACE associated services.
3. List PACE eligibility criteria and enrollment process.
4. Discuss reimbursement for PACE services.
5. Identify 4 Quality Measures that support the value of PACE services.

What is PACE?

- **P**rogram of **A**ll-Inclusive **C**are for the **E**lderly
- Provider-based Medicare & Medi-Cal managed care program
- Serves seniors (55+) who have chronic care needs
- Full continuum of preventive, primary, acute, and long-term care
- 40+ years success record of supporting frail elders

History of PACE Model

- **1970s**
  On Lok Senior Health Services created in San Francisco, CA by Dr. William L. Gee and Marie-Louise Ansak *"Happy Home"*

- **1994**
  National PACE Association formed to include 11 PACE organizations in 9 states
- **2013**
  Brandman Centers for Senior Care (BCSC) opens as part of the Los Angeles Jewish Home
- **2016**
  122 PACE programs operating in 31 states, 40,000 + Participants (11 Programs in California)
- **2017**
  Brandman Centers for Senior Care (BCSC) serves 213 participants every day

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NPA Vision

- PACE Model of Care is recognized among consumers, healthcare providers, and government leaders as the most innovative, accessible, valuable and effective model of care promoting the highest level of independence for individuals with significant healthcare needed

Brandman Center Philosophy

- Help frail seniors remain as independent as possible, living safely in their community and home

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PACE Model

- **Develop** a comprehensive patient assessment that includes a complete review of all medical, psychosocial, lifestyle and values issues.
- **Create and implement** an evidence-based plan of care that addresses all of the patient's health needs.
- **Communicate and coordinate** with all who provide care for the patient.
- **Promote** patient, family and/or caregiver engagement in the patient's own health care.

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Eligibility

- 55 year of age or older
- Resides in the service area of the PACE Organization
- Determined by the State Administering Agency to meet the level of care required under the state Medicaid Plan for coverage of Nursing Facility Services
- At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her heath or safety

Some Qualifiers for Meeting SNF LOC

Typically has a combination of medical complexity, cognitive impairment, and functional impairment/difficulties

- Has chronic illnesses/diseases that require skilled monitoring:
  - Cardiovascular disease – HTN, CHF, CVA, Atrial Fib, Angina
  - Diabetes with chronic complications – on oral medications and/or insulin
  - Dementia/Alzheimer's or other Memory Impairment
  - Neurological disease – Parkinson's, Multiple Sclerosis, CVA.
  - Respiratory disease – COPD/Asthma, use of inhalers or oxygen.
- Needs Assistance or is Dependent in 2 or more ADLs/IADLs
- Needs assistance with medication management – forgetting to take meds, double dosing
- Has impaired/unsteady gait, frequent falls – uses assistive device
- Has made several visits to the ED in a 6 month period.

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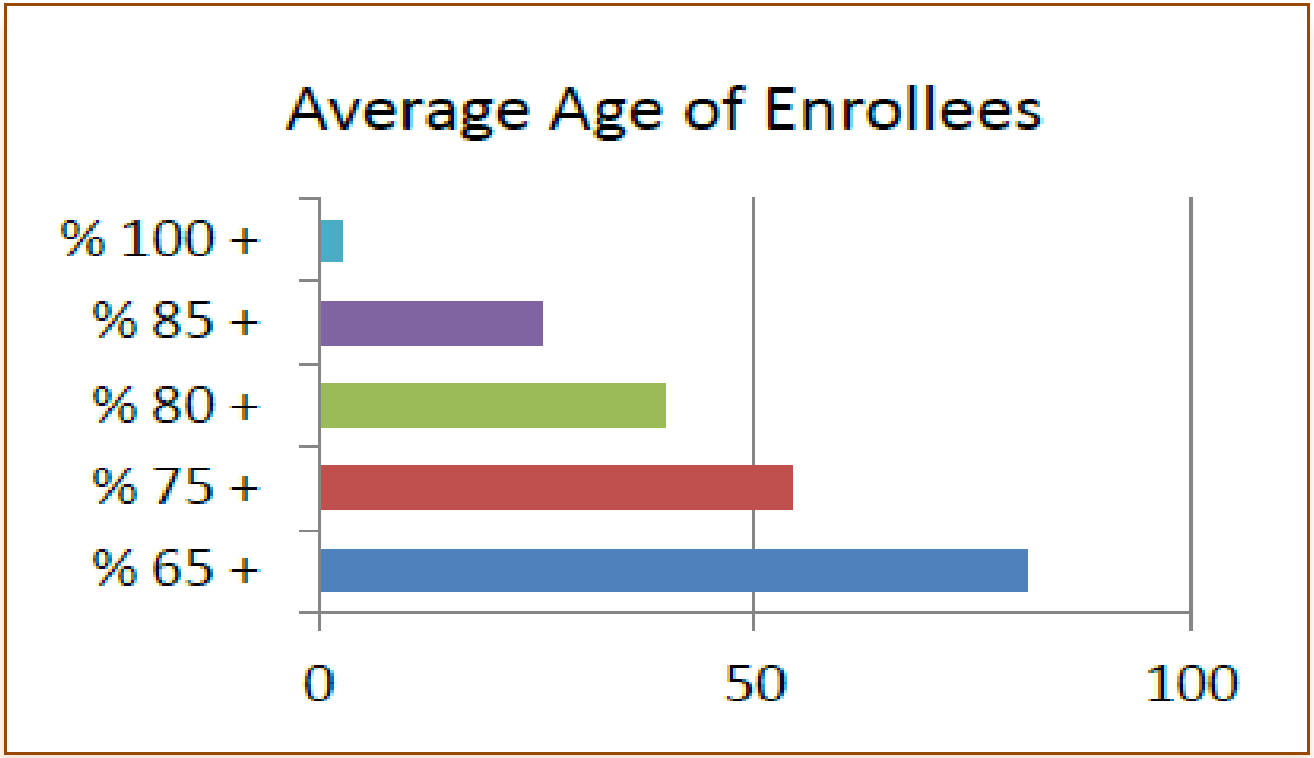
Enrollee Characteristics (CalPACE)



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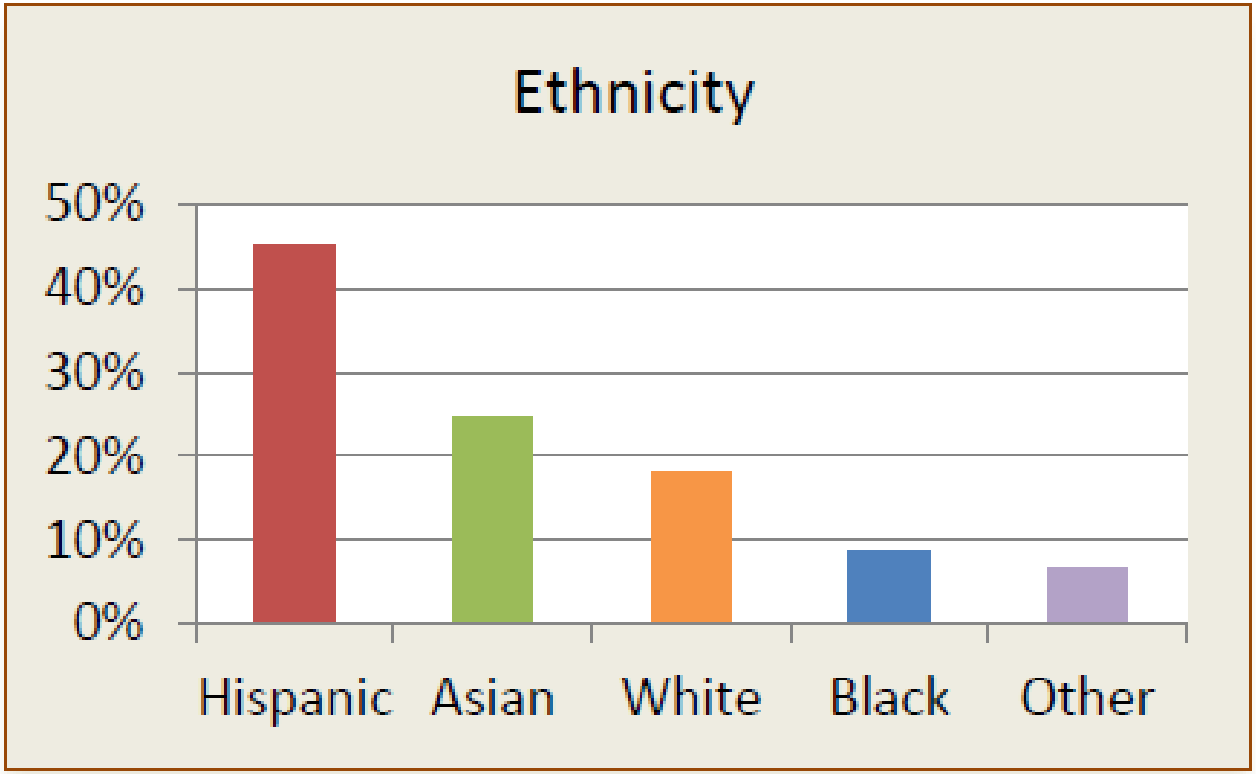

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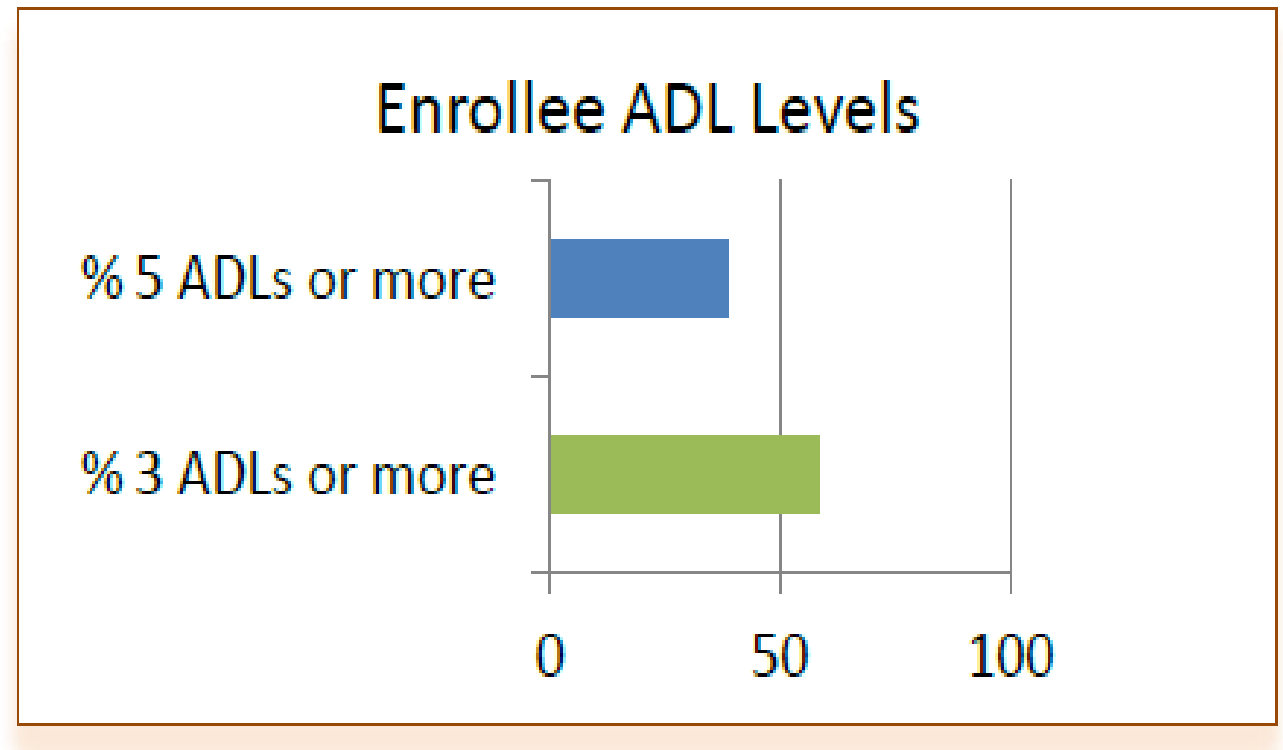

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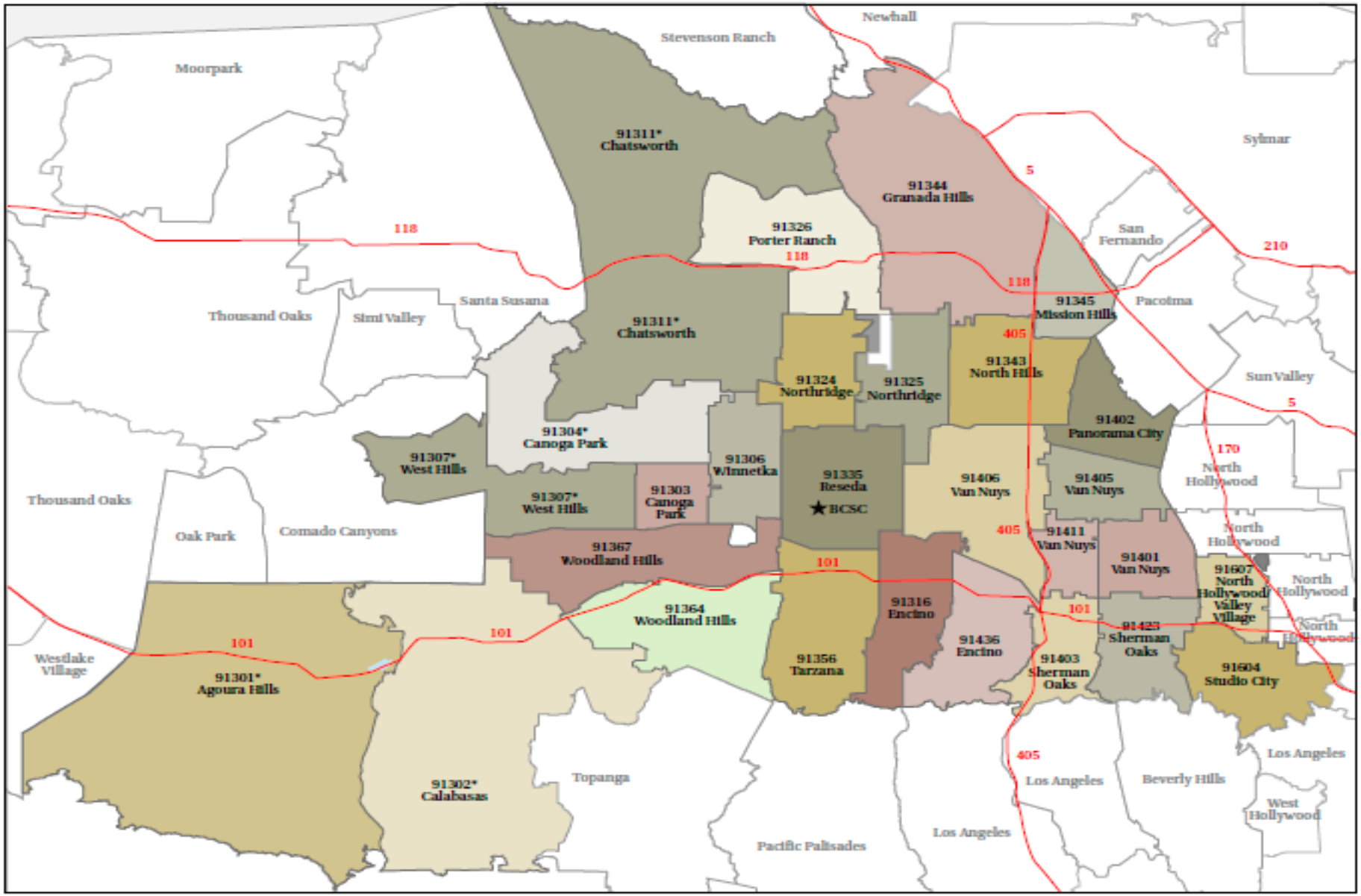
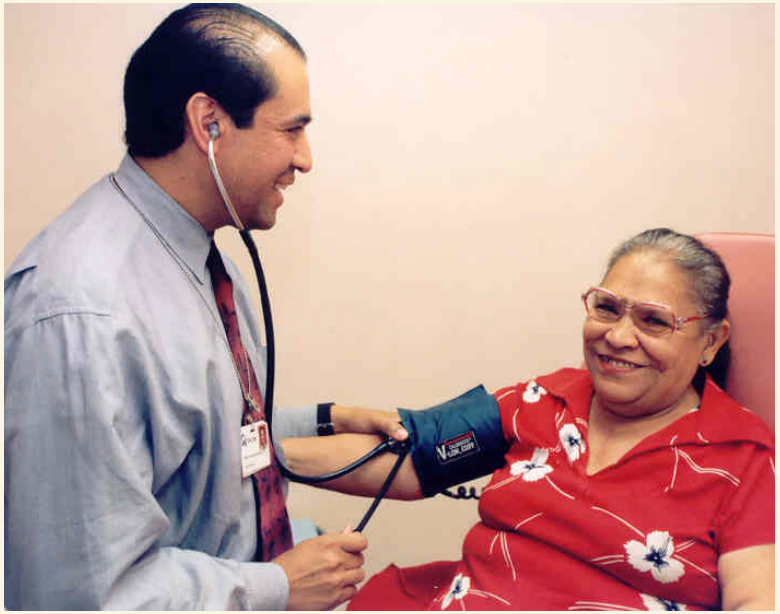
BCSC - PACE Service Area Zip Codes



*BCSC can only service the Los Angeles County portion of these zip codes.

List of PACE Services

- Adult day healthcare
- Primary medical care and medical specialty services
- Prescription drugs
- On-site vision, dental, audiology, podiatry, and psychiatry/psychology
- Laboratory and diagnostic services
- Medical supplies and equipment



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List of Services (cont.)

- Nursing and preventive health
- Physical, occupational and speech therapy
- Nutritional counseling
- Social Work Services
- Home health care / Personal care
- Transportation to/from the Center and for medical appointments
- Emergency care, urgent care, hospitalization

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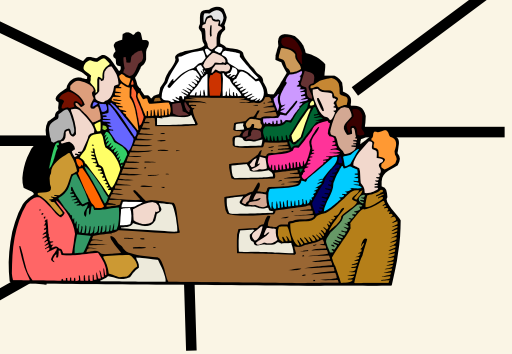
LIL& ANNA GRAYCELL
MEDICAL CLINIC


EXIT

Interdisciplinary Team (IDT)

- The IDT is a group of professionals that are **geriatric care experts**.
- They **work together** to create comprehensive, individualized care plans for participants.



Adult Day Health Care

Nursing
Social service
OT / PT
Speech
Nutrition
Recreation
Personal care
Pharmacy
Transportation

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Who Pays for Services?

IF THE PATIENT IS ELIGIBLE FOR:	THEN THE PATIENT WILL PAY:
Medi-Cal (with no share of cost) and Medicare	No Cost
Medi-Cal (only) with no SOC	No Cost
Medi-Cal (only) with SOC	Monthly Fee equal to your share of cost payment to PACE
Medicare (only)	Monthly Premium (cover Medi-Cal costs)

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Enrollment Process

- Referral is provided to BCSC representative for follow up
- BCSC Marketing Representative will contact referral and evaluate for PACE criteria
- If eligible and good match for program, initiate enrollment process

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Enrollment Process (cont'd)

- RN evaluates the PACE candidate
- RN submits LOC to state
- State approves LOC
- PACE candidate is notified of approval, continues with IDT assessments and care plan is developed
- PACE candidate enrolls 1st of the month
- Enrollment process approximately 20-30 days

JAMA Article

- **"Comprehensive Primary Care for Older Patients With Multiple Chronic Conditions: Nobody Rushes You Through"**

  ✓PACE had **significantly fewer hospital admissions** and preventable hospital admissions/thousand patients/month, as well as **fewer total and preventable emergency department visits**

  ✓Another study found that "PACE participants had **less pain** and **fewer unmet needs for assistance** in bathing, dressing and getting around."

  ✓"A 5-year cohort study found **longer median survival** among individuals enrolled in PACE than in those who received case management and community services. The difference was statistically significant among patients with high mortality risk at baseline.

Boult, Chad, *et al. Journal of the American Medical Association,* 304(17): M1936, 2010.

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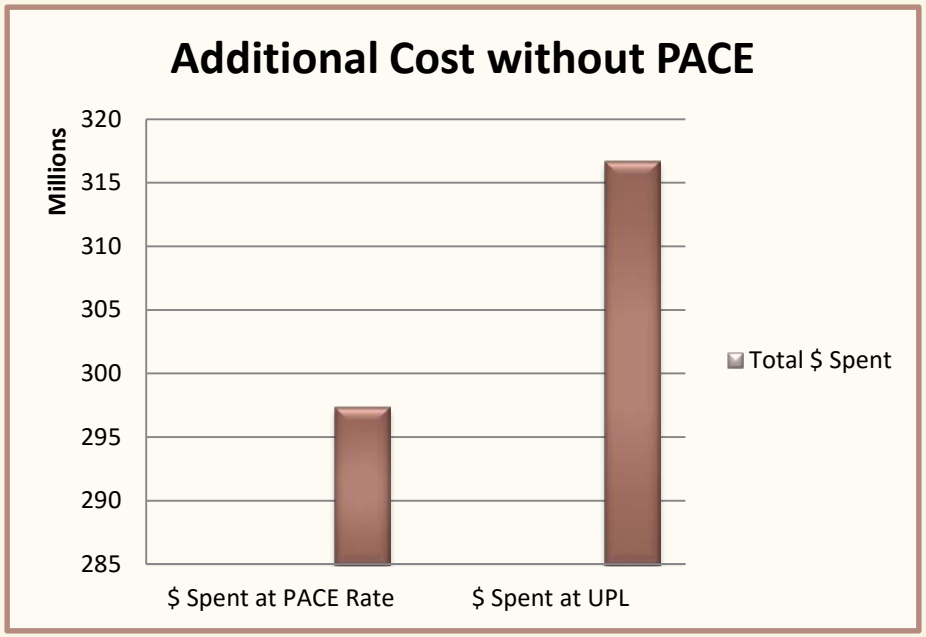
PACE Quality Reporting and Monitoring

- Enrollments and Disenrollments
- Grievances and Appeals
- Advanced Care Planning
- Medication Management
- Falls – with and without injuries
- Emergency visits/Hospitalizations/Rehospitalizations
- Infections
- Immunizations

Proven Benefits

- Cost Effectiveness



In 2015, CA paid $19.3 Million less than it would have if all current PACE participants were served outside of PACE.

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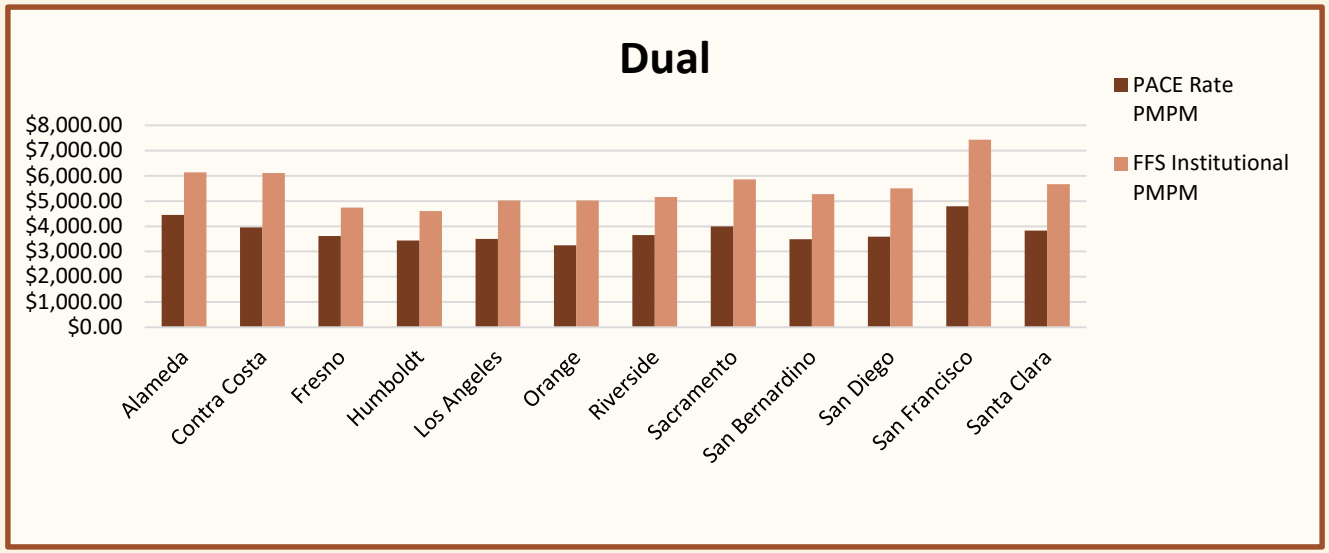
Proven Benefits

- Cost Effectiveness



In 2015, the monthly PACE capitation rate is on average 31% less than the cost of institutional care for a Dual eligible beneficiary, 24% less for a Medi-Cal beneficiary.

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Proven Benefits

- **Cost Effectiveness**
  - ✓ Hospital Readmission rates for BCSC participants at 8%
- **Participant Satisfaction Ratings (BCSC 2016 Data)**
  - ✓ Overall Satisfaction 89% (CalPACE 89%)
  - ✓ Recommend to others 97% (CalPACE 94%)
  - ✓ Rate the care received 100% (CalPACE 95%)

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Proven Benefits

- Case Presentations

Future Directions

- Increase community awareness
- Seek additional legislator support for PACE Programs
- Development of other PACE Programs
- Approval of Draft PACE Federal Regulations
- Revised PACE Audit Process
- PACE Pilot Programs

Contact Information

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