PACE
Program of All-Inclusive Care for the Elderly
Striving to keep frail older adults in their community
An Interdisciplinary Approach to Care

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Overarching Goal of PACE

“The Program of All-Inclusive Care for the Elderly (PACE) model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.”

Source: National PACE Association (NPA)

What is PACE

- PACE is a national healthcare model that blends medical and social components of care and needs to support the mission of aging in place (in the community)

Centered around:
- Interdisciplinary team approach to care
- Comprehensive and coordinated care
Data for aging population: (a fast growing population)

- US population continues to age
- 2013: > 65: 14%
- 2030: > 65: 20%
- 1 in 5 Americans will be > 65
- Largest subset 2030-2050: > 85
- Dual eligible:
  - 9 million in US
  - MI: 275,000
- High risk factors for hospitalization/nursing home placement:
  - 2012: 33% with at least 1 AD
  - Multiple Chronic Diseases
  - Most previously living alone

The frailest population, needs the most care and the most coordination:

**PACE Participants Have Multiple Medical Conditions: Average Number of HCCs**

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<th></th>
<th>PACE</th>
<th>SNP - Dual</th>
<th>SNP - Institutional</th>
<th>Medicare FFS</th>
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CMS Manual System - Department of Health & Human Services (DHHS)

Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual
Centers for Medicare & Medicaid Services (CMS)

30.2 - PACE Care Planning and the Interdisciplinary Team

PACE care planning is the responsibility of the IDT members that deliver direct care to participants in the PACE center they attend and/or in alternative settings such as their homes or inpatient facilities when dictated by their healthcare needs. A key component of the PACE model is the IDT's identification of participant needs in all care domains (medical, psychosocial, physical, cognitive, functional, and end-of-life) and the IDT's coordinated response to these needs. Each member of the team acts within his/her authorized scope of practice, in accordance with participant preferences, working in concert with other IDT members to meet the identified needs and achieve each participant's optimal outcomes. Optimal outcomes will differ for each participant, but the plan of care is the roadmap to meet the participant- and team-defined outcomes as measured after implementation of focused interventions over a prescribed period of time.
The IDT will promptly consolidate the eight discipline-specific assessments into a single individualized plan of care for each participant. The full IDT team collectively develops the care plan through discussion and consensus at a formal care planning meeting. The IDT must implement, coordinate, and monitor the plan of care whether the services are furnished by PACE employees or contractors. When goals and interventions for a particular problem are overlapping, the team may decide to combine actions into more appropriate strategies. Conversely, the team may find that a problem is unique and needs to be addressed by a specific discipline. Whether a problem manifests as multi-faceted or singular in nature, the IDT incorporates the problems into a single plan of care that is collectively monitored and evaluated by the team. Although the PACE center director, driver, and personal care attendant do not perform assessments, they contribute valuable information about participants and should be included in care planning discussions.

Who is Eligible for PACE
- 55 years of age or older
- Living in a PACE service area
- Nursing home eligible: must meet the Michigan Nursing Home Level of Care criteria (often the most frail)
- Able to be supported safely in the community with PACE services
Other services PACE offers...

- Dental, vision, audiology, podiatry and all specialty
- Day Health Center with full activities and meals
- Transportation to and from the Day Center, outside medical appointments and delivery of medications to the home
- Social Services, psychiatric services, behavioral health
- Home delivered meals
- Home Health including care in the home (dressing, bathing, grooming, home chore services, laundry)
- Respite for caregivers
- A sense of COMMUNITY

Program of All Inclusive Care for the Elderly – The Model

PACE Integrated Care Model
The PACE Interdisciplinary Team

Models of Care

PACE Hospital Interdisciplinary coordination

- PCP Communication with Team within 24 hours of admission
- Decreases duplication
- Gives inpatient team baseline
- Transfer to contract facility ASAP
- Discharge plan to start on admission
- Case Manager/Social Work Team Communication with inpt Case Manager
- Transfer of information with the patient from another facility
- Confirm code status
- Early Comfort Care discussion when warranted
- Innovative use of nursing homes for continuation of care
**PACE Post-Hospital**

- Post hospital visit with PCP within 48 hours
- HAP (IDT Team)
- Med reconciliation (Pharm, PCP, RNCM)
- Home visit (SW, RNCM)
- Discharge note
- Teach back with pt and caregiver
- Subspecialty f/u appointments
- EMR

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**Behavioral Health Care**

*(integrated care model within PACE program): Changing needs for a changing population*

- In general, older adults with mental illness have been identified as receiving an inadequate amount of care (Hogan, M. F., 2003)
- PACE, intended to manage an older frail population, is now beginning to see increasingly younger dual eligible participants with mental illness due to this population living longer, becoming less marginalized and demonstrating a need for an alternative form of care
- This requires a new approach to holistic and integrated care:
  - Training existing staff to promote awareness, reduce stigma, dispel common misinformation and provide education regarding mental health issues, ultimately better preparing them to care for this population

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**Behavioral Health continued...**

- Behavioral Health: Mental health activities performed within a primary care setting:
  - Offers assistance when habits, behaviors, stress, worry, or emotional concerns about physical or other life problems are interfering with a person’s daily life and/or overall health.

- Integrated Primary Care Behavioral Health:
  - A collaborative model in which BH and PCP’s work together in a shared system.
  - The behavioral health provider functions as a member of the primary care team to address the full spectrum of problems the patient brings to the PCP.
## COMFORT CARE

### Hospice
- Expert medical care
- Pain management
- Emotional support
- Spiritual support
- Focus on caring not curing
- Patient and family
- Establish new provider
- Payment requirements
- Life expectancy

### PACE Southeast MI – Comfort Care
- Expert medical care
- Pain management
- Emotional support
- Spiritual support
- Focus on caring not curing
- Participant and caregiver
- Continuity of care
- No payment requirements
- No life expectancy requirements
- Expert IDT approach

## PACE WORKS!

- Participants stay in the community longer
- Reduction in use of ER and hospitalizations
- Better medication adherence
- Significantly decreased isolation/loneliness
- Regain a sense Community
- Less likely to “fall through the cracks”
- Improved mobility
- Happier, more satisfied participants
- Caregiver support and relief
- Full end-of-life care

## RESULTS/DATA using PACE model of care/coordination compared to like population:

- Rate of hospitalizations: 539/1,000 (PACE) vs. 962/1,000 (dual eligible, Disabled waiver)
- 30 day readmission: 14.9% (PACE/2014) vs. 22.8% (national population of dual eligible)
- PACE: Hospitalizations and readmissions - 44% lower than dual eligible nursing home population

What does a PACE participant “look” like: LOCD

- The State of MI uses a document called the Level of Care Determination (LOCD) to determine nursing home eligibility.
- The tool is used for PACE, nursing home and MI Choice Waiver eligibility.
- There are 7 “doors” to qualify for nursing home level of care.
- A person only needs to qualify through one “door” to qualify for a nursing home level of care.

What does a PACE participant “look” like – Door 1

Door 1 is all about MOBILITY.

According to the LOCD physical assistance is not required daily but every few days.
What does a PACE participant “look” like – Door 2

Door 2 is COGNITIVE PERFORMANCE (memory and/or decision making).

What does a PACE participant “look” like – Door 4

Door 4 is ONGOING MEDICAL TREATMENTS such as:

PACE Medicaid Eligibility & Cost

- PACE will prepare Medicaid application and all redetermination paperwork for family
- Expanded Eligibility: Gross monthly: $2199
- No spend-down, co-pays or premiums in PACE
- Asset criteria: $2,000
- Program is at no cost for Medicaid eligible participants
Process for enrollment:

- Referral to PACE
- PACE staff will complete an assessment in the home (interdisciplinary assessment initially with Nurse and SW)
- All PACE services/program explained
- Potential participant visits PACE site
- Interdisciplinary team collaborates for needs and builds a care plan
- Enrollment paperwork is signed (once all financial paperwork is in order)

**NOTE:** may be some small variation in the process from PACE site to PACE site

Questions?