Program of All-Inclusive Care for the Elderly (PACE): Integrating Health and Social Care Since 1973

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ABSTRACT

According to the Centers for Medicare & Medicaid Services (CMS), the future of older adult care in the United States has arrived in a provider-sponsored health plan model that integrates medical, behavioral, and social care for frail elders. This approach gives the provider complete control over patient outcomes and total cost of care and enables participants to live safely in the community – rather than a nursing home – for an extra four years, on average. This article reviews the Program of All-inclusive Care for the Elderly (PACE) model, whose roots go back to the 1970s in California, and offers case studies on two PACE-RI participants with chronic healthcare needs. In both examples, the patients reduced hospitalizations and increased mental and physical health, all while alleviating caregiver stress. With the older population slated to double by 2060, the time has come to expand PACE to more people.

A few years ago, the acting administrator of the Centers for Medicare & Medicaid Services (CMS) said he was "glimpsing into our future" when he visited a provider-sponsored health plan that integrated medical, behavioral, and social care for frail elders, allowing them to remain in the community rather than live in a nursing home.[1]

This approach to aging services successfully braided Medicare and Medicaid funding and gave the provider complete control over patient outcomes and total cost of care over a significant period – the key elements to delivering "value-based care."

What is noteworthy is that this program of the "future" has been in Rhode Island since 2005 and in other parts of the country since 1973! It helps its medically complex participants live at home for an extra four years on average and retain a much higher quality of life, all while controlling associated costs for the government through capitated payment arrangements.[5]

The program is called PACE – short for Program of All-inclusive Care for the Elderly – and it is a comprehensive and community-based model of care that coordinates medical, behavioral, and social services for individuals ages fifty-five and older who have high care needs but can remain safely in the community. PACE is currently offered in 31 states.[2] The model is backed by the National PACE Association and serves 50,000 seniors in 126 sponsoring organizations at 260 PACE centers across the country. While PACE has already had some success at scaling its integrated services, emerging demographics and heightened outreach poise the program for significant growth.

THE GAP

In the United States, people 65 and older account for more than 20 million hospital visits yearly.[1] Many visits are to the Emergency Room (ER). The rate of ER visits per 100,000 population for those ages 65 and up, rose from 53,833 in 2014 to 56,803 in 2015.[2] This number is so high in comparison to Emergency Room (ER) visits of other age cohorts that emergency medicine has shifted to accommodate the spike in older patients. In fact, the American College of Emergency Physicians (ACEP) has released its own geriatric emergency department guidelines.[3] The frequent hospital visits not only affect the quality of life for older adults, but they can also worsen an older person's health. According to a study in the Annals of Emergency Medicine, six months after visiting the ER, seniors were 14 percent more likely to have acquired a disability than adults of the same age who had a similar illness and had not been to the ER.[3] Not only is this phenomenon detrimental for the health of the elderly, but it also costs the government billions per year.[2]

One cause of the increase in hospital visits for American older adults are gaps in the coordination of care for our aging population. Many seniors do not have family or friends who are local and willing to assist. For those who do, caregiver stress is extreme. Further, because most older adults opt for a fee-for-service insurance program, they are not optimizing the payment and coordination of their treatment.

Seniors often struggle to access much-needed resources such as transportation to and from medical appointments, daily meals, and social interaction. Coordination of medical appointments, public resources, and day center attendance should be done by a professional, and regular access to a trained social worker is critical.

THE SOLUTION

PACE is both the insurer and the medical team. When enrolled, participants receive cost-effective, comprehensive,

preventive care. The program delivers primary, acute, and long-term care services tailored specifically to the needs of the individual.[5] The tailored care plan begins being formulated, with collaboration from the caregiver, upon the first interaction with the enrollment team. The robust enrollment process includes a medical evaluation with the PACE doctor and a home assessment so the interdisciplinary team can readily address any underlying concerns. Once enrolled, PACE takes care of all the older adult's health needs using a holistic approach, including primary & acute services, pharmacy, rehabilitation services, homecare, transportation, adult day services, and more.

The PACE model is designed to provide the right support at the right time by way of the interdisciplinary team dedicated to the improvement of the health and overall quality of life of their participant. The team is comprised of doctors, nurses, social workers, CNAs, day center and health center directors, transportation providers, and life enrichment activities personnel. They meet every morning to review patient panel needs, rooted in the belief that, if physically able, living in the community is where people are happiest, most comfortable, and most likely able to maintain good health. Having a supportive care team allows the health of PACE participants to be closely supervised, helping them to avoid ER visits and hospitalizations. As their insurer, should they need to enter a hospital or skilled nursing facility, PACE covers the cost.

Staying in one's community provides easier access to resources needed to thrive, such as transportation to and from medical appointments and daily meals. PACE coordinates their own buses to provide reliable transportation, and PACE programs across the U.S. serve up 13,666 meals a day.[6]

ELIGIBILITY

To qualify for PACE, a person must be age 55 or over, live in a designated service area, and be certified by the state to need nursing home-level care. There is no income eligibility requirement for participating in PACE. Programs often attract those with high level of care needs, as nursing homes do. The difference is, however, more than 90% of PACE participants live in the community and only 7% live in skilled nursing facilities.

POPULATION

An average participant is 77 years old, female and has about eight medical conditions. Common chronic medical conditions of participants are diabetes, dementia, coronary artery disease and cerebrovascular disease. Common behavioral health conditions of participants include major depressive, bipolar, and paranoid disorders. Additionally, nearly 47% of PACE enrollees have some form of dementia.[6] Thirty-five percent of participants need help with 3–5 "activities of daily living," which include dressing, bathing, transferring, toileting, eating and walking.[7] Fifty-four percent of PACE-RI participants speak a primary language other than English.[7]

PAYMENT

PACE programs are financed by combined Medicare and Medicaid prospective capitation payments, though some participants opt for private pay.[5] This payment is a set monthly amount provided to each local PACE organization to provide all of their required care.[5] PACE programs assume full financial risk for all the health care services provided.[5] Private pay participants often find the PACE monthly fee is less expensive than the out of pocket expenses (co-pays, over the counter, etc.) they otherwise would incur.

Combining dollars from different funding streams allows PACE organizations to provide fully-integrated, comprehensive care that is customized to the participants' need. This customization is proven to minimize hospitalization and nursing home admissions. PACE pools Medicare and Medicaid funding, allowing the program to eliminate cost shifting, which can result from conflicting incentives of multiple payers.[5]

HISTORY

The PACE Model of Care was founded as a solution for caring for the Asian-American population in San Francisco. Placing elders in nursing homes was not culturally acceptable in that community, as they preferred to keep their aging family members at home while they received care. In 1973, to meet this community and cultural need, On Lok Senior Services ("On Lok" is Cantonese for "peaceful, happy abode") was opened. The program was an innovative way to offer what PACE currently does - comprehensive medical supervision, physical and occupational therapies, nutrition, transportation, respite care, socialization and other needed services using home care and adult day settings.[7]

Thirteen years later, in 1986, the Robert Wood Johnson Foundation provided funding for six sites, in addition to On Lok, to develop PACE demonstration programs. In 1997, with the passage of the federal Balanced Budget Act, PACE was granted provider status under Medicare, and state Medicaid agencies were given the option to include PACE as a benefit.

On December 1, 2005, the PACE Organization of Rhode Island opened its doors in Providence with a mission of preserving and sustaining the independence of older adults in the state. The organization has since grown to three locations and over 300 participants. In 2013, PACE-RI acquired the Adult Day Center of Westerly, allowing two options of care: traditional adult day or, as care needs progress, enrollment in PACE. In 2016, PACE-RI opened its Woonsocket day center, the first building fully designed by the organization. With these three centers, the organization services the aging population across the entire state.

WHO DOES PACE HELP?

The two case studies below showcase the population that PACE serves and how we provide comprehensive wrap-around services to assist them.

Joseph

Joseph is a 68-year-old gentleman who lives alone in senior housing. He is estranged from his family and has multiple, complex medical co-morbidities. They include diabetes with complications, major depression, high blood pressure, high cholesterol, heart disease, spinal stenosis, end-stage kidney failure requiring hemodialysis 3 times a week, and he is legally blind. He ambulates with a walker.

Before enrollment, he was in and out of emergency rooms and hospitals. Most of these visits were attributed to his inability to keep follow-up appointments with his doctors. His medications were not refilled on time due to lack of adequate home care and transportation to the pharmacy. He had been referred to the Division of Elderly Affairs by the apartment manager for self-neglect, but he was adamant about not wanting to go to a nursing home.

With PACE, he is provided with a certified nursing assistant (CNA) and home health care aide in the morning, noon and evening to help with grocery shopping, preparing meals, medication cuing, monitoring for unusual symptoms, and to help with transportation to get him to appointments with PACE doctors. He is transported by the PACE buses. He also receives home visits by the community registered nurse, social worker and primary care team. Medications are delivered to his home every two weeks by our vendor pharmacy.

He continues to live at home with stable medical conditions and he rarely has had ER visits or hospitalizations.

AltaGracia

AltaGracia is a 90-yar-old old Hispanic woman with Alzheimer's dementia and severe end-stage COPD, requiring continuous oxygen. She lives with her daughter who works full-time. She had multiple falls and behavioral symptoms of dementia with aggression and frequent night-time awakenings. Like most of our participants, she was at the brink of a nursing home placement. Her daughter was exhausted from stress and worry.

With PACE, she attends the day center six days a week, participating in our memory care program and purposeful activities, as well as receiving CNA supports at home both in the morning and at night. She receives geri-psych follow up at the PACE center, which has led to a decrease in dementia-related behavioral symptoms. Her daughter gets respite care services so she can go on occasional vacations and get some personal time while keeping her mother at home and minimizing strain.

RESULTS

Below is a sampling of PACE-RI successes:

- Average enrollment (living at home rather than in a nursing home) = 4.3 years
- PACE-RI participants having no hospitalizations since enrollment = 31 %
- ER visits per 100 than RI Medicare FFS = 11 % fewer
- Influenza immunization rate = 93 %
- Participants would recommend PACE-RI to family or friends = 90 %

CONCLUSION

The PACE model of creating a personalized care plan with the individual and their loved ones and coordinating every aspect of their health care has proven to give participants what they want: to live safely at home, to stay out of the hospital and emergency room, and to reduce strain for their caregivers. PACE participants have seen an improvement in their behavioral health, mental health, and quality of life as well.

With the percentage of the population 85 years and older projected to increase nearly 10 percent from 2016 to 2025, and more than double by 2060, we can anticipate an increased need for programs like PACE.[8] The model was built to sustain a growing aging population and our goal to spread the word about its impact so even more people can benefit and change what it means to age successfully.

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