Summit ElderCare

a Program of All Inclusive Care for the Elderly

October 11, 2012
About PACE

- Program of All-inclusive Care for the Elderly
- Federally recognized model of care
- Started in 1970’s in San Francisco, CA
- Participating States act as State Administering Agencies to oversee compliance with the Federal PACE Provider regulation. In Massachusetts, this is the Executive Office of Elder Affairs
- Nationally, there are 87 PACE programs in 29 States caring for approximately 26,000 individuals.
PACE Overview

- Insurance, medical care and social support program—all in one package
- Comprehensive Medical coverage including Part D Medicare Rx benefits
- Adult Day care services
- Proactive interdisciplinary geriatric care management focused on medical and long term care supports
- Support in the home such as assistance with bathing and dressing
- Family Caregiver resources and support
Who is eligible?

- 55 years of age or older
- certified by a State appointed aging service agency as nursing home eligible
- capable of living safely in the community as determined by the PACE interdisciplinary team
- residing within the approved PACE service area.
National data indicates the following:

- Average age is 81 with over 30% age 85 or older
- 90% are dual eligibles
- Despite meeting nursing home level of care criteria, only 10% reside in long term care facilities.
PACE at FHCP

- Established PACE program in 1995
- Initiated a PACE expansion strategy in 2004
  - Charlton – 2006
  - Leominster - 2007
  - Grafton Street, Worcester – 2008
  - Western Mass-Target early 2013
- Additional expansions are planned
The Belief

- Older adults with chronic care needs are better served by living at home and in their communities when possible.

- Focus on improving quality of life for the participant and caregivers leads to effective and efficient care.
Key Principles

- Home-based Model of coordinated care
- Alternative to Nursing Home placement
- Interdisciplinary team approach to care management
- One team focusing on one cohort of participants
- Individualized care plan for each participant
- Discipline specific assessments integrated into an interdisciplinary plan of care
Coordination of Care and Coverage

- Aligned Incentives
- Pooled Funds
- Participant Centered
- Flexibility to solve problems; eliminate silos
- Co-localization of the IDT
Interdisciplinary Team

- Physicians
- Nurses
- Nurse practitioners
- Triage nurses
- Rehabilitation Therapists
- Activities Staff
- Health Aides

- Case managers
- Home care providers
- Social services
- Transportation
- Nutrition
- Administration
Team Interaction

Daily team meetings
24-hour family/caregiver emergency access to interdisciplinary team
Positive advantages for both Participants and Caregivers
Massachusetts PACE Info

- 88% of PACE participants live in community settings\(^2\)
- 80% of PACE enrollees are age 75 or older\(^2\)
- >80% at high risk for falls\(^2\)
- Average Medicare risk score of 2.33\(^3\)
- 2% of PACE participants residing in long term care were hospitalized compared to a Massachusetts overall rate of 16.5\(^2,4\)
- 5.8% of community dwelling PACE enrollees were hospitalized compared to a Massachusetts overall rate of 31.4\(^2,4\)
Massachusetts PACE Info

- 16.7% all cause 30 day Mass PACE re-admission rate (not risk adjusted) compared to a Massachusetts rate of 19.3 – 21.4% and a national dual eligible age 65 and older rate of 22.9%\(^5,6\)
- 93% of PACE participants are immunized for flu\(^2\)
- Proactive identification and management of fall risks helps to prevent or minimize potential for injury
- End of life planning and care promotes alignment with participant and caregiver goals
- Nearly 100% of participants and caregivers report high satisfaction with the PACE model of care
References

1 National PACE Association (NPA)

2 Manual data collection effort among the Massachusetts PACE programs.

3 National PACE Association (NPA) sponsored PACE Data Analysis Center (PDAC) January 2012 Predicted Risk Scores. PDAC is a collaborative analysis resource, based out of the University of Rochester that is facilitated by the NPA for its participating members.


5 National PACE Association (NPA) sponsored PACE Data Analysis Center (PDAC) Hospitalization study conducted in 2011.

6 CMS presentation on 6/12/11 at the Annual Research Meeting sponsored by Academy Health. The title of the presentation is Geographic Variation in Readmissions and Potentially Avoidable Hospitalizations by Allison Oelschlaeger, et al., Policy & Data Analysis Group, Center for Strategic Planning, CMS.