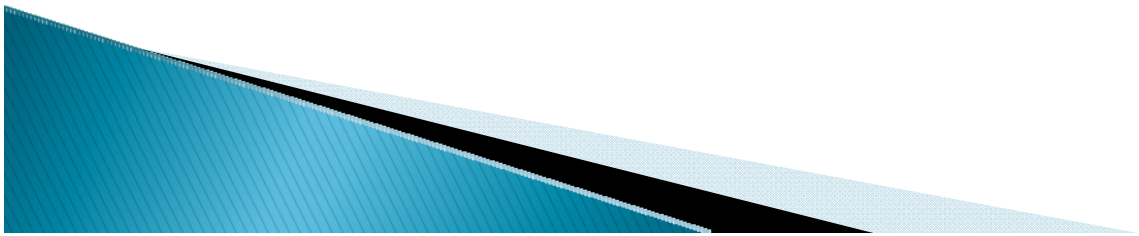
St. Paul's PACE

Program of All-inclusive Care for the Elderly
Celebrating 2 years in San Diego

Discussion Topics

- Overview of PACE Model
- PACE Benefits
- The Interdisciplinary Team
- Care Planning
- Outcomes
- Challenges and Responses
- Capitation
- Program expenses and innovative cost savings
- Case studies



PACE Mission

Provide a caring network of services that promotes independence and dignity enabling San Diego's frail elderly to remain at home and in their community.

PACE Nationally

- 72 PACE Organizations
- 30 States
- 20,000 + PACE Participants
- 100 + Organizations Considering PACE
- 1997 PACE Provider Act (Medicare / Medicaid)
- Over the 2 years we have been open, PACE San Diego has served almost 200 seniors

PACE Eligibility

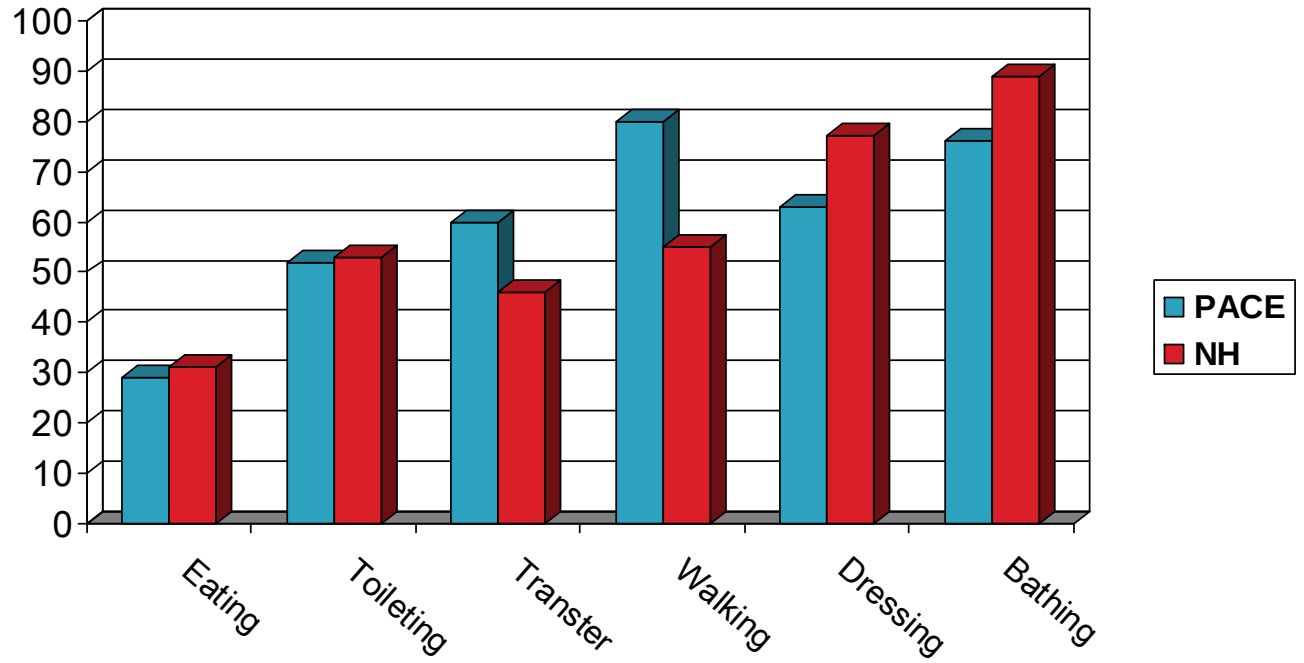
- At least 55 years of age or older
- Living in a designated PACE service area
- Medi-Cal, Medi/Medi combo OR private pay
- Able to live in a community setting without jeopardizing your health or safety with the service of the PACE organization
- Be certifiable for nursing home level of care

PACE Participant Profile

- Average Age: 73 (youngest 55, oldest 99)
- 54% Women (nationwide is 75% women)
- Average # ADL deficits: 3.5
- 80+% Have cognitive impairment
- Average # of diagnoses ~ 9.0
- Identical to Nursing home patients
- Average Life Expectancy: 3-4 years (vs 1-2 yrs in NH)

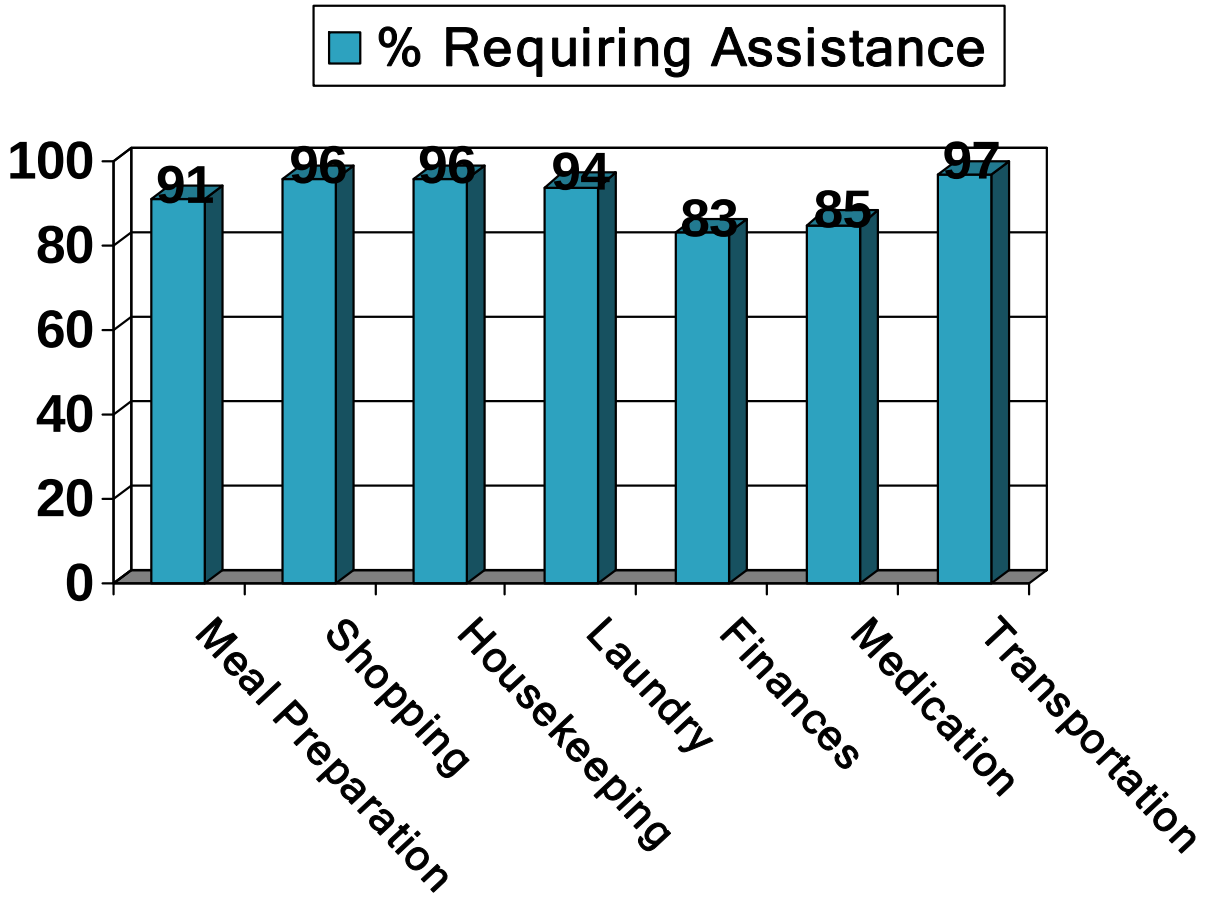
Dependent ADL's (%)

PACE = NH frailty



Source: CDC Nat Center for Health statistics; Int Soc Quality in Health Care vol 16 no 4

IADL Deficits in PACE



PACE Services

Home care:

- Nurse visits
- Therapy
- Meals delivery as needed
- Home help such as:
  - light cleaning
  - bathing
  - laundry
  - grooming
  - meal preparation

- Transportation
- Primary medical care
- Medications
- Specialty medical services
  - Dentistry
  - Podiatry
  - Physiology
  - Psychiatry
- Physical and Occupational Therapy
- Dietary support
- Durable medical equipment
- Day Center and Meals

PACE Benefits

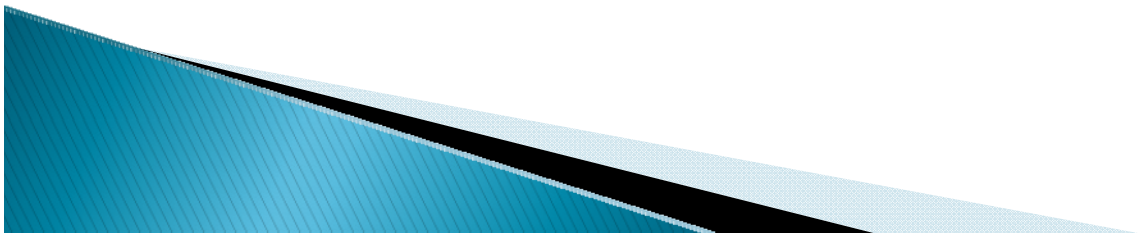
- Doctor to patient ratio is very low.
- Doctors and medical teams specialize in geriatric care.
- Coordinated Plan of Care which creates "one stop shopping" for participants and caregivers.
- Caregivers are able to take time out from 24/7 care.
- No more setting appointments, arranging transportation etc. to multiple medical facilities and no more long waits in waiting rooms.
- St. Paul's PACE provides preventive care.
- With the support of PACE, the participant can continue to live in the least restrictive environment.
- Reduced hospitalizations and Urgent Care visits.
- Reduced length of hospital stay.
- Increase % of passing in the home vs. skilled nursing or hospital.

PACE is Managed Care

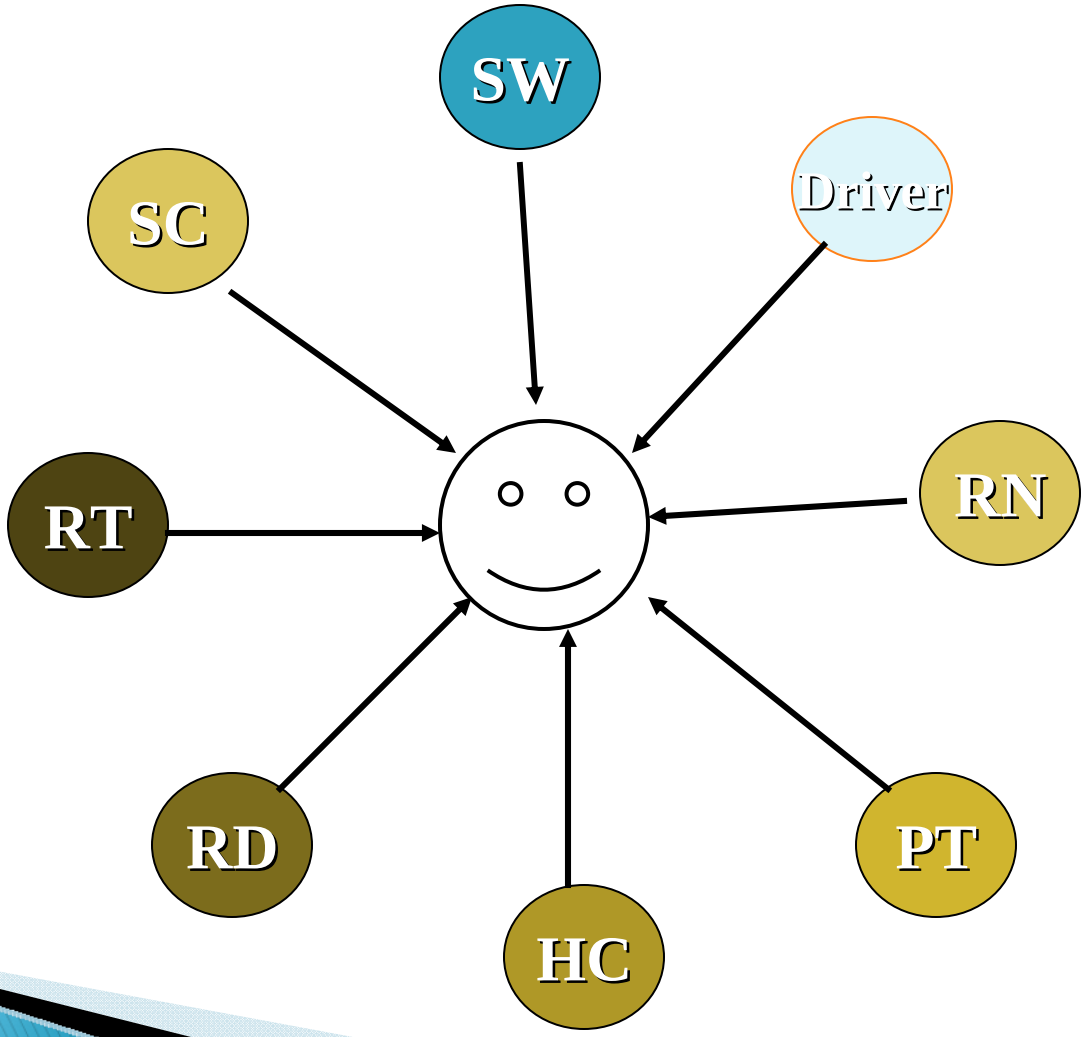
"Managed care as it is supposed to be."

- Team-managed care vs. case manager
- Continuous process of assessment, care planning, service provision and monitoring
- Focus on primary, secondary, tertiary prevention
- Full risk-bearing by PACE for outcomes

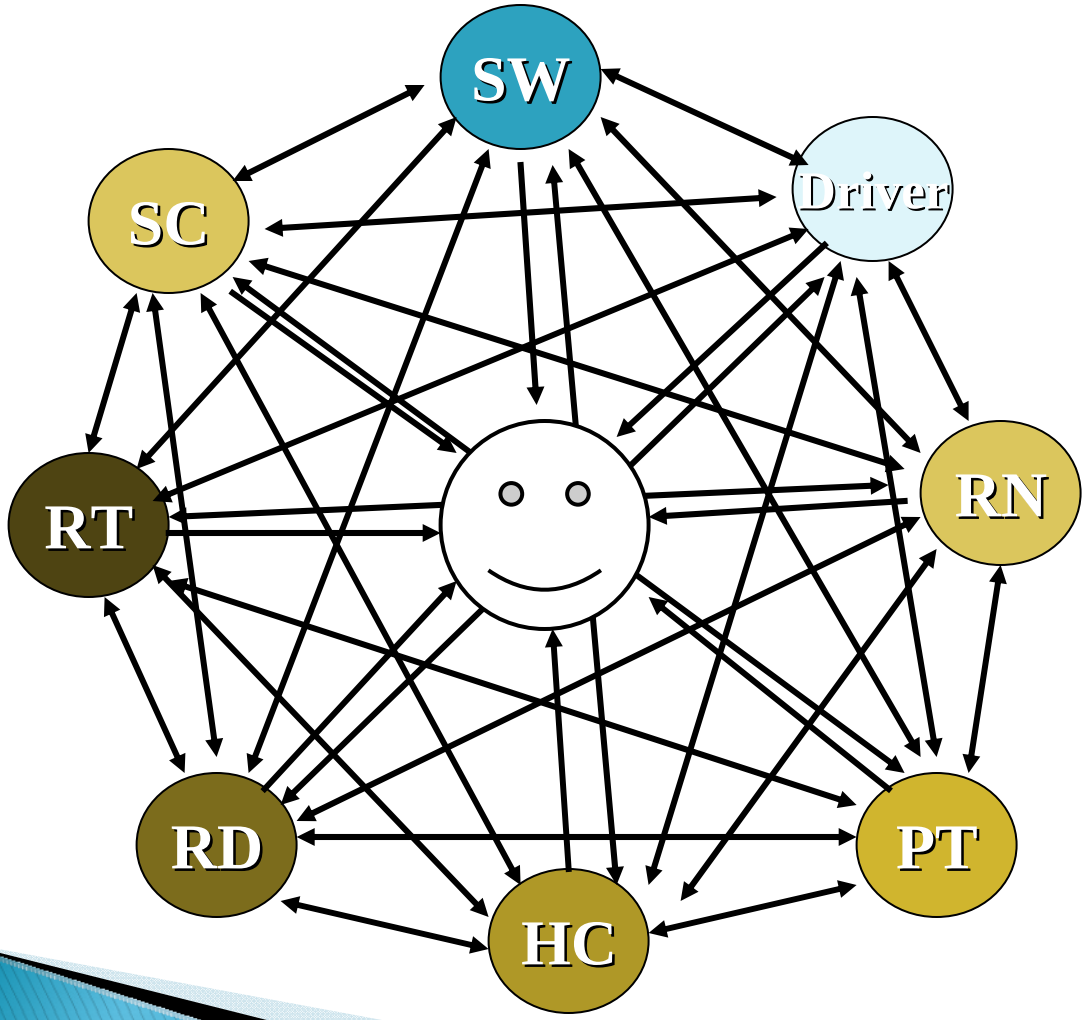
Interdisciplinary Team



Multidisciplinary Team



Interdisciplinary Team (IDT)



INFORMATION SHARING
EDUCATION
PROBLEM SOLVING
CARE PLANNING
OUTCOME MONITORING

PACE Interdisciplinary Team

- Meet daily
- Internal authorizations
- Consensus based/medical necessity
- Review urgent cases and act upon
- Working care plan document
- Assess every 6 mos. or with significant health changes

PACE Interdisciplinary Team

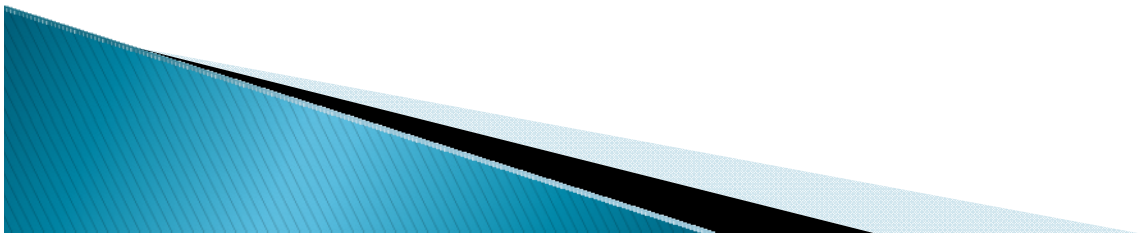
- Primary Care
  - MD
  - PA
- Nursing
  - Day Center Nurses
  - Clinic Nurses
  - Home Care Nurses
- Rehabilitation
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
- Social Work
- Recreation
- Nutrition
- Pharmacy
- Transportation
- Health Aides

The Heart of the PACE Model

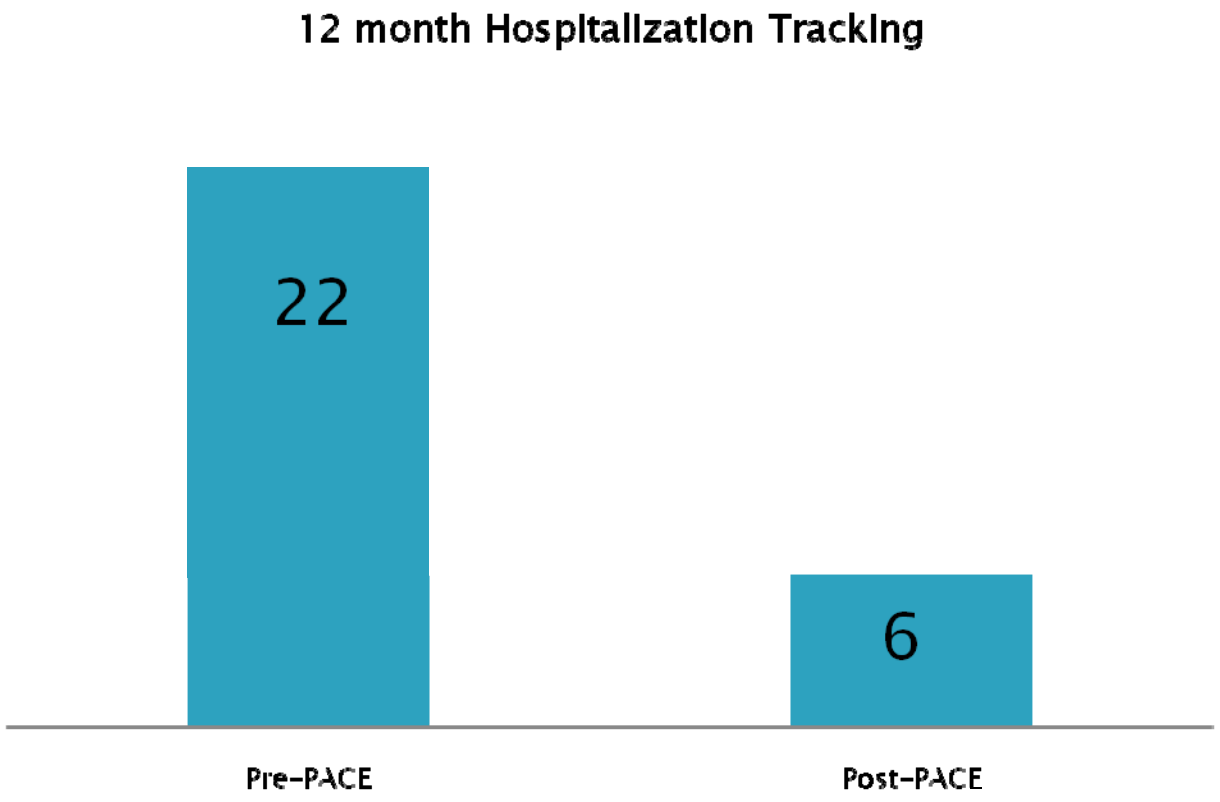
Interdisciplinary Team – meets daily

Care Plan

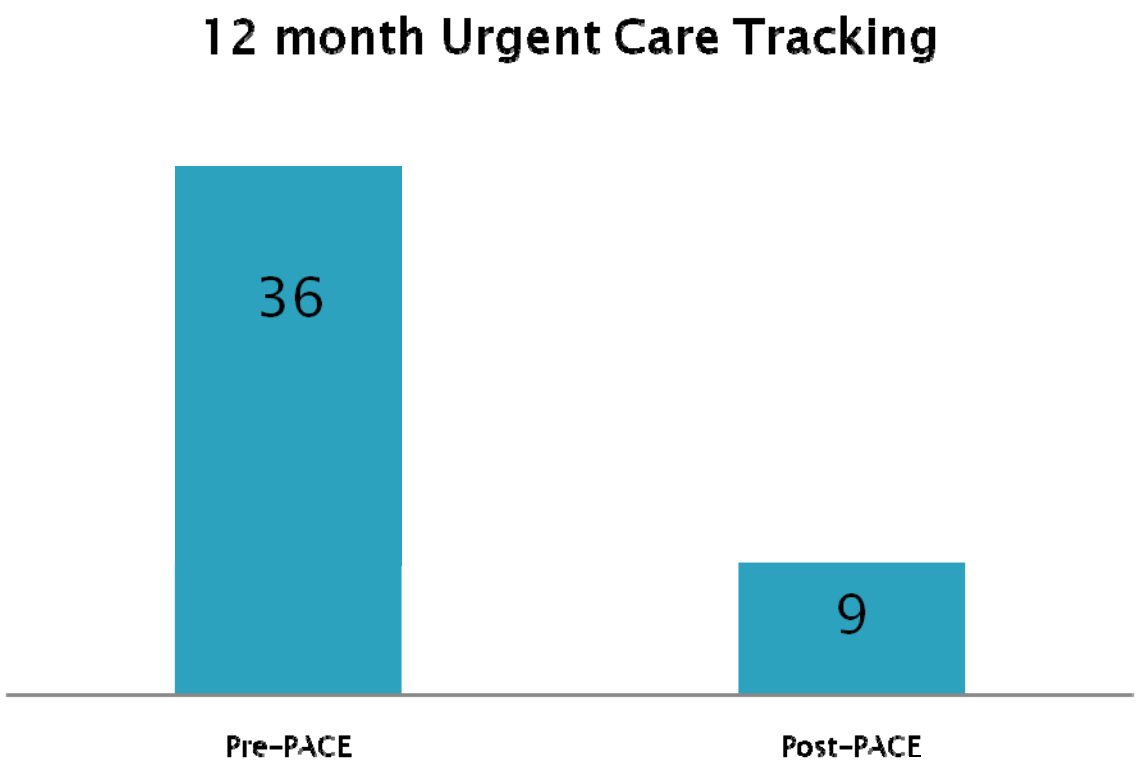
- Center visit days
- Regular physical and occupational therapy
- Weekly home care needs
- Personal hygiene needs
- Specialists (dialysis; psych; eye care; hearing)
- Nutrition
- Medications and management
- Support services (payee)
- DME
- Goals



Results

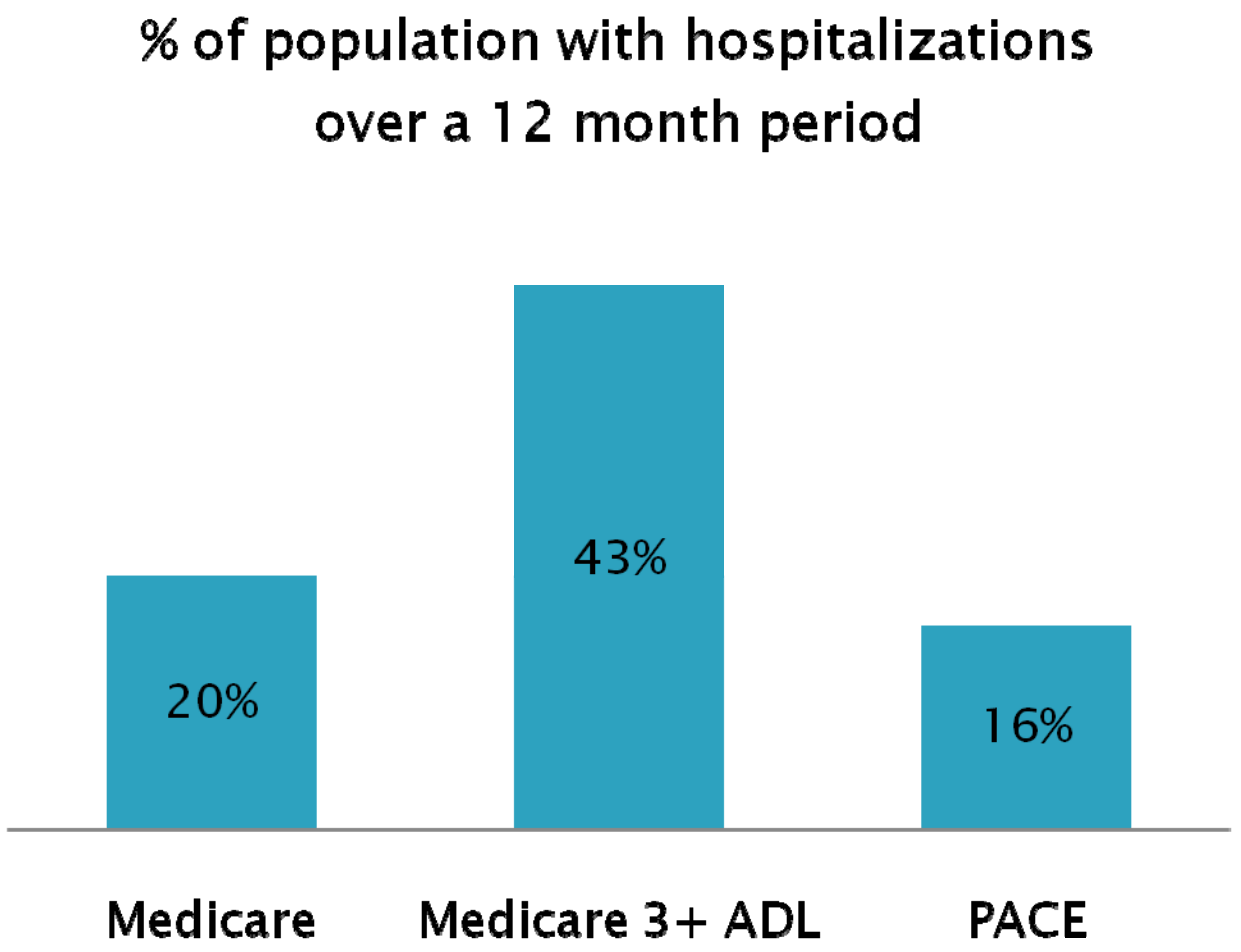


Source: Vermont PACE site study of hospitalizations using a sample of 37 seniors.

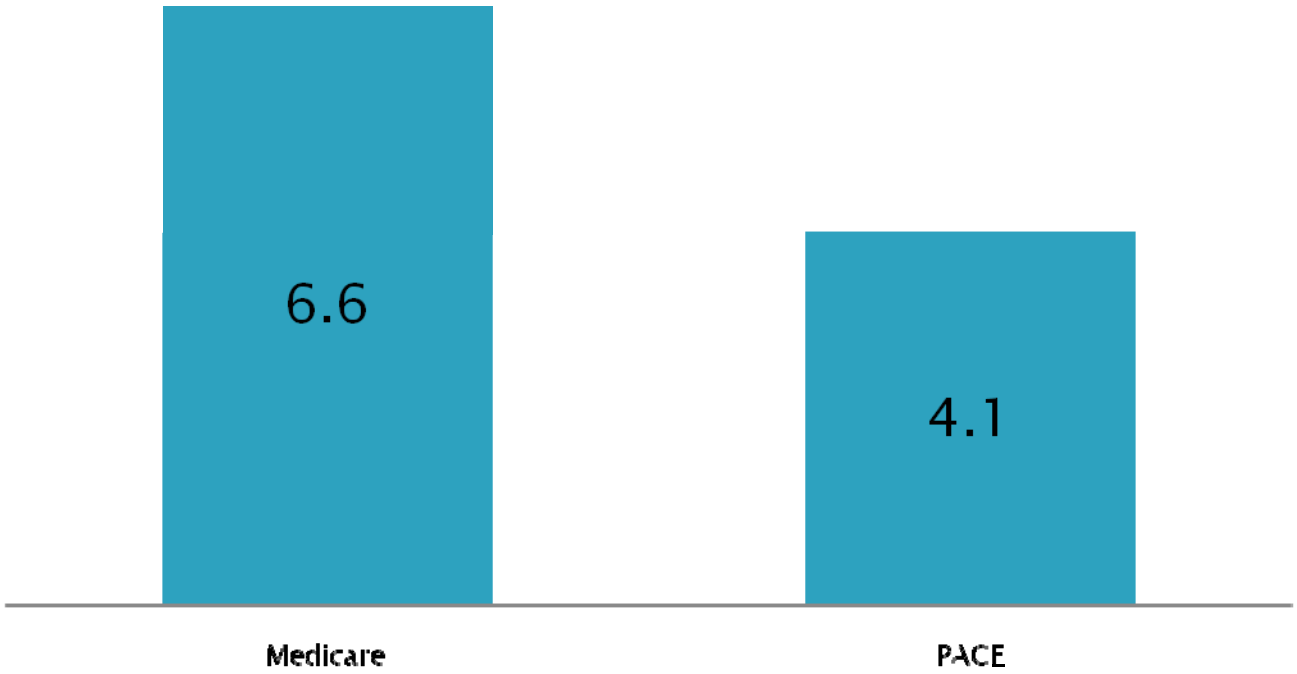


Source: Vermont PACE site study of Urgent Care visits using a sample of 37 seniors.

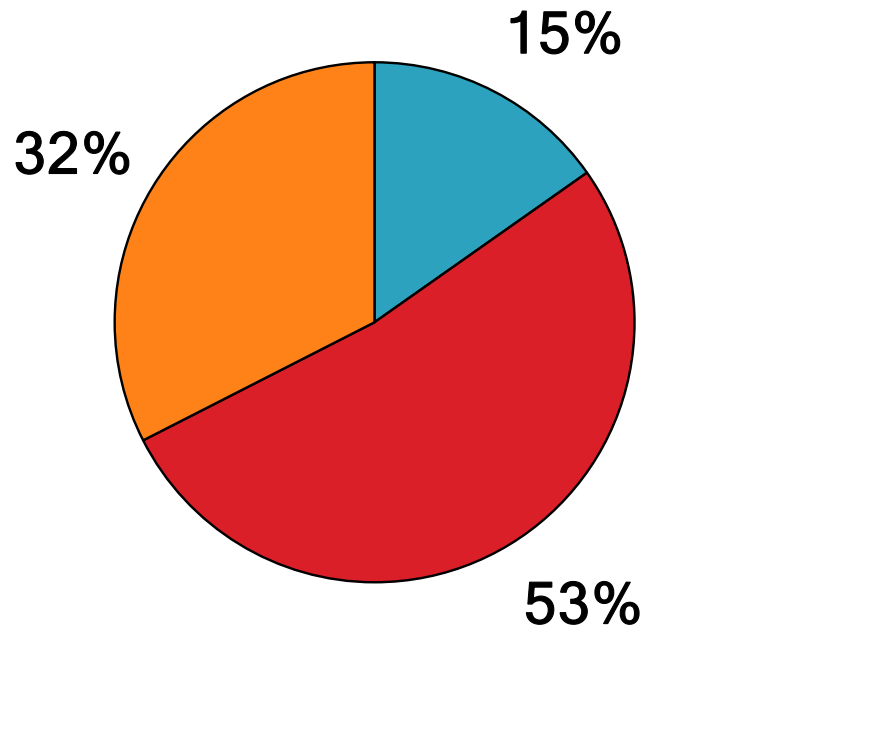
Hospitalization Rates



Length of stay: hospitalized



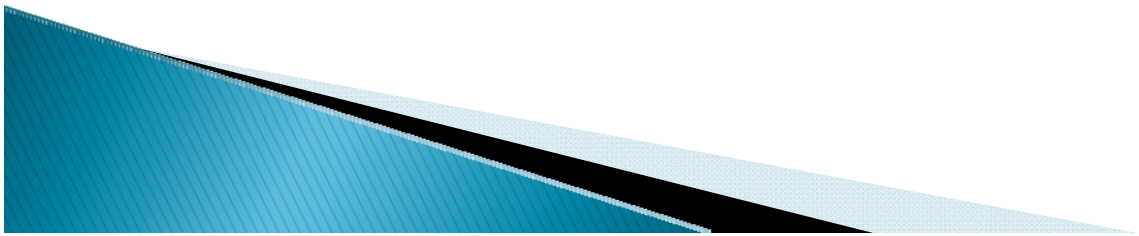
Place of Death in PACE



Challenges/Barriers

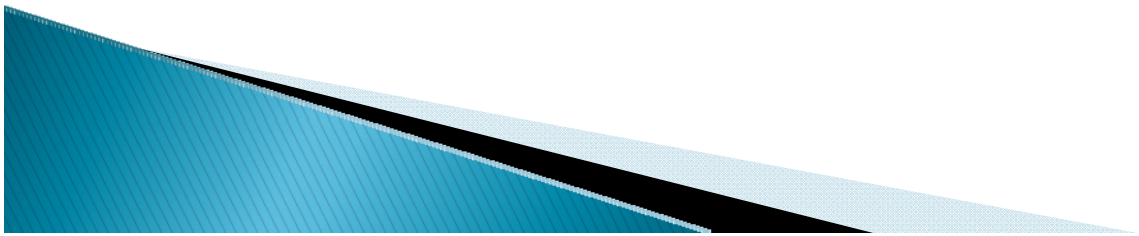
Integration

- ER/Hospital/SNF Case Management
  - Communication
  - On Call service
  - Protocols (calls, visits, chart review)



PACE

- Medical Necessity vs. regulated guidelines
- No 3 day hospital stay
- Therapy services
- Hospice vs PACE Comfort Care

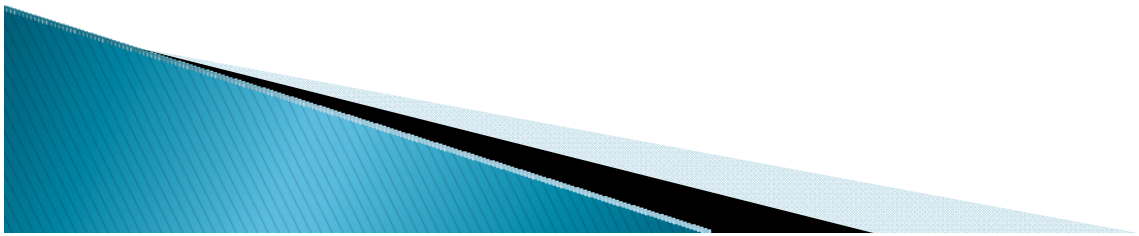


Mental Health

- Regular visits: group and individual
- Staff training
- Paradise Valley Hospital

Program Expenses

- Hospitalizations
- SNF
- Specialists
- Transportation
- Medication
- Bed Bugs – a great example



Cost Savings

- Fingerstick INR
- Wound Care in-house
- EKG
- In-house specialists save $:
  - Dentist
  - Podiatrist
  - Optometrist
  - Psychologist/Psychiatrist
  - Mobile X-Ray
  - Labs

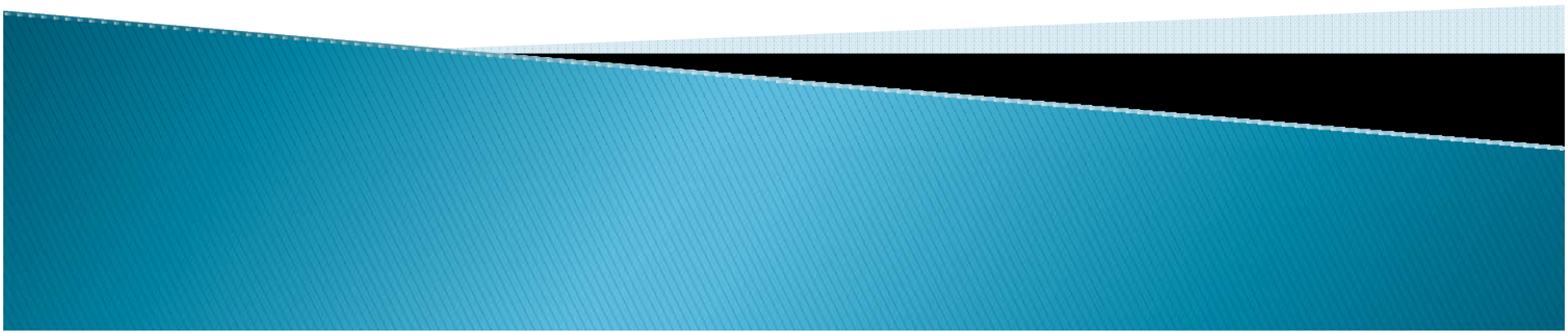
Capitiation

- Medi-Cal and Medicare = Capitated rate per participant
- Higher level of frailty = increased capitation
- This parallels with their higher level of care

Reimbursement Issues

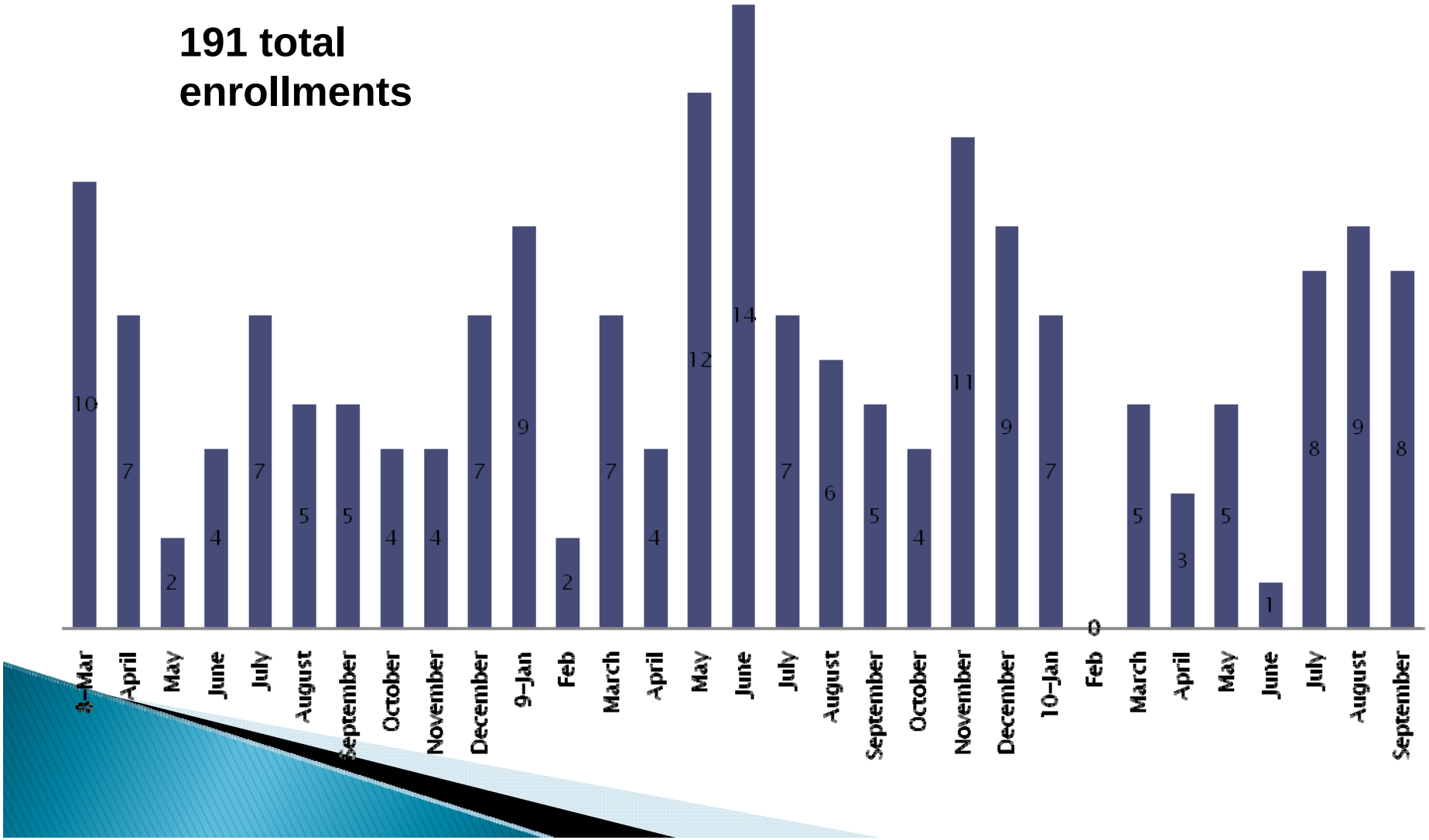
- Cannot generate more income by more activity, BUT can generate savings by more activity
- PCP works at staying on top of chronic illness and preventing complications, reducing institutional care
- Drug cost containment requires knowing evidence
- No procedure coding, credentialing, billing or collection hassles
- ICD-9 diagnosis coding now hugely important

Continued Growth

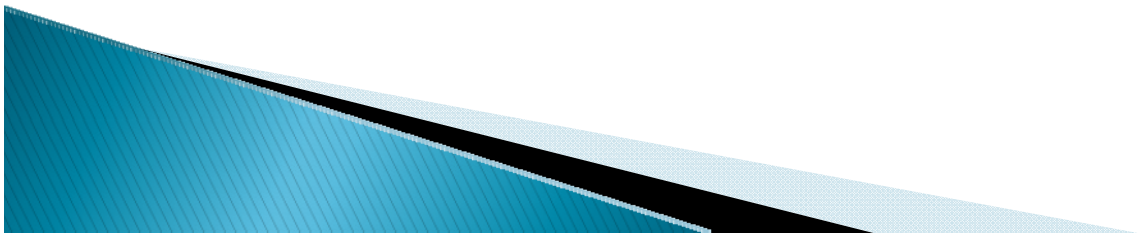


St. Paul's PACE
monthly enrollments

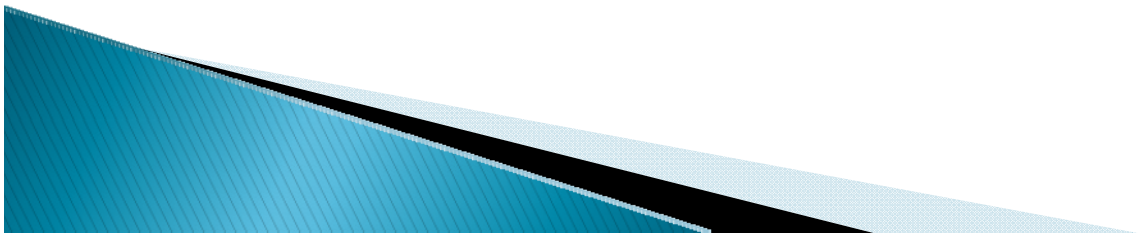
191 total enrollments



- Have cared for 191 frail SD seniors
- Now at 118 active participants
- Can take up to 175 at this site
- Our initial business plan focuses on opening in south and east county next followed by north areas
- Ultimately covering all of SD County and beyond



Case Studies



Leroy

Pre-PACE:

- Depression
- Isolation
- High number of medical issues
- Regular hospitalizations

Post-PACE:

- Medication Management
- PT & OT addressed fall prevention, lower extremity care, pain management
- Speech Therapy 2xwk has helped with dysarthria
- Socially: arranged food stamps, Medi-cal
- Provided DME so he could bath at home, provided housekeeping, laundry and shopping assistance
- Dietary: educated on how to manage cholesterol
- Recreation: now plays both piano and guitar for participants
- No hospitalizations

Evelyn

Pre-PACE:

- Wheelchair dependent
- Could not transfer to commode or bed
- Could not bath in bathroom as not wheelchair accessible
- Could not stand
- Declining in function
- High fall risk
- Regular hospitalizations

Post-PACE:

- Can now take 3 safe steps and sit on commode without assistance at home
- Has set a goal to transfer from wheelchair to commode without assistance
- Can get clothing over feet and hip and zip pants with minimal assistance
- Can now ambulate 200ft with stand by assistance.
- Bathing is now done here at PACE.
- No hospitalizations in 10 months and continues to live at home with her son.

Dan

Pre-PACE:

- Live in an assisted living
- Depression
- 4WW at home and in day center with no independent activity in the community

Post-PACE:

- Now capable of going up and day stairs with handrails
- Is ambulating at PACE with no AD and walking up to 6 blocks in the community with without his 4ww.
- Is now going to movies, dinner and theatres.
- Has set a goal to attend a local gym and pool.
- Set a goal to loose weight and is working with our dietitian
- Sees PT 3 x week to improve function and endurance and balance