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

% Requiring Assistance

Meal Preparation: 91%
Shopping: 96%
Housekeeping: 96%
Laundry: 94%
Finances: 83%
Medication: 85%
Transportation: 97%
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.
12 month Urgent Care Tracking

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

% of population with hospitalizations over a 12 month period

- Medicare: 20%
- Medicare 3+ ADL: 43%
- PACE: 16%
Length of stay: hospitalized

Medicare: 6.6
PACE: 4.1
Place of Death in PACE

- Hospital: 15%
- Home: 53%
- Nursing Home: 32%

Legend:
- Hospital
- Home
- Nursing Home
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
Capitation

- 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.
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