Keeping up the PACE:
Educating Nurses about Programs of All-inclusive Care for the Elderly

What is PACE?

- **The Program of All-inclusive Care for the Elderly**:
  - Designed to provide the entire continuum of care and services to frail seniors, helping them to maintain their independence in their home and community for as long as possible
  - PACE is a permanent Medicare/Medicaid benefit that a senior may opt into in lieu of a traditional Medicare plan

PACE Origins

- **1970s**—On Lok Demonstration Project
  - Designed to meet needs of aging San Francisco Bay area residents
  - *On Lok* is Cantonese for "peaceful, happy abode."
- **1990s**—Expansion and replication of model earns PACE name and permanent designation as Medicare/Medicaid benefit
  - 1994 11 PACE Organizations (PO’s)
  - 1996 21 PO’s
  - 2007 42 PO’s
  - 2010 75 PO’s
  - 2014 104 PO’s

In some States PACE Organizations are known by the term “LIFE”
- Living Independently For Elders
2016 - 116 PACE Programs Operating in 32 States

Serving more than 34,000 older adults and expanding...

Trinity Health Operates PACE Plans in Eight States

Trinity Health PACE Organizations

Working with NICHE to pilot in the PACE Environment

Payment Model
Who Pays?

- Payment features are unique compared to other health payment models
- Integrated Capitated Payment System (per member per month)
  - Determined by Frailty and Healthcare Risk scores
  - Fully at risk
- Combines funding from multiple sources to meet all participant needs
  - Medicare Part A & B
  - Medicare Part D
  - Medicaid or Private Pay

Who Pays?

- Medicare Part D
- Medicare
- Medicaid
- Private Pay

PACE: Key Points

Traditional Model: Fragmentation

- Care
  - Multiple providers
  - Discontinuity across sites

- Financing
  - Multiple payors
  - Institutional bias
  - Restrictions
  - Fee for Service drives $$$

PACE Model: Integration

- Care
  - Outpatient care
  - Acute care
  - Long-term care

- Financing
  - All-inclusive
  - Full risk
  - No restrictions

All-Inclusive Care = All-Inclusive Payment

Participant and Family

PACE Interdisciplinary Team

- Prescriptions
- OTC Meds
- PCPs
- Transportation
- Home Care Services
- Outpatient Services
- Inpatient Hospitalization
- Specialty Physician
- ADHC
- Hospice
- Assistive Living
- Nursing Home

Prescriptions
OTC Meds
PCPs
Transportation
Home Care Services
Outpatient Services
Inpatient Hospitalization
Specialty Physician
ADHC
Hospice
Assisted Living
Nursing Home
PACE Eligibility Criteria

- 55 years of age or older
- Live in a PACE service area
- Be certified as eligible to receive nursing home level of care (as determined by the State)
- Be able to live safely in the community at point of enrollment

2015 PACE Innovation Act will allow CMS to develop pilot projects for the PACE model to be used as a platform for innovation to serve more seniors as well as younger individuals in need of integrated care and services.

Saint Francis LIFE, Wilmington, DE

- Opened: February 2013
- Current census: 173 Participants
- Marty Cunningham
  - Health Center Manager

Background
Research

- Research in 2015
  - Literature Review
    - One scholarly peer reviewed article regarding nurses/nursing in PACE
  - Needs assessment/pretest
    - Result
    - Post presentation improvement in knowledge
  - Personal Experience
    - Parent organization
    - Students at LIFE for clinical experience

Why should nurses know about PACE programs and if they exist in their area?!?

- Nurses are patient advocates
- Nurses are essential in discharge planning
- Nurses know who is safe (or not)
- Nurses know their “frequent flyers”
- Nurses are famous for saying “they need to just put him in a nursing home”
  - What if he had PACE support??
So, what does PACE do for seniors.....exactly?

- PACE services
  - Primary Care
  - Episodic Care, Specialist Care
  - Social Services
  - Adult Day
  - Recreation
  - PT/OT
  - In home services
  - Dietary services (dietician assessment/recommendations, hot meals in center, supplements)
  - Transportation

Services, cont.

- When one joins a PACE program they agree to use the program's PCP and also utilize in-network specialists contracted with the program (PACE plan also = managed care organization)
- All medical, social, rehab, and in-home care is provided and coordinated by the program
- All needs are met via the PACE plan including DME and all medications (part D benefit)

Who really benefits from PACE programs?

- Pt. 85 female, lives with daughter, has dementia, daughter has full time job, but does not want to place mom
  - 5 days of day center attendance, bridge services in AM and PM when needed
  - Transportation to and from center
  - Bi-annual physical, all medications
  - Social services, care coordination
  - Respite care if needed
  - Other services as needed (approved by IDT)
PACE benefits, cont.
- 55 year old female, multiple comorbidities
- NH eligible for community programs by state due to comorbid conditions
- Utilized emergency services 1-3 times/month prior to enrollment (functioned as primary care)
- Reduction in utilization and increase in self report quality of life

Nursing Home Level of Care
- Set by individual states
- Eligibility for PACE is same as for other Community Based Services (i.e. NH eligible for community programs)
- Varies widely—usually based on deficiencies in Activity of Daily Living (ADL)

Example of state requirements for PACE:
- DE = 1 ADL deficiency
- NJ = 3 ADL deficiency
- Participants can look very different from state to state

PACE Enrollees Snapshot

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age</td>
<td>77.5</td>
</tr>
<tr>
<td>Gender</td>
<td>73% women</td>
</tr>
<tr>
<td>Average Number of Basic ADL Deficits</td>
<td>3.5</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>63%</td>
</tr>
<tr>
<td>Average Life Expectancy</td>
<td>2.2 years</td>
</tr>
<tr>
<td>Dually Eligible</td>
<td>90%</td>
</tr>
</tbody>
</table>
The PACE Interdisciplinary Team (IDT)

- The IDT is a CMS mandated hallmark of PACE programs
- Includes:
  - RN*
  - MD/NP*
  - HCC*
  - Social Worker*
  - PT*
  - OT*
  - RT*
  - Dietician*
  - Day Center Manager
  - Transportation
  - Center Director

* VOTING MEMBERS OF IDT
Source: CMS 2011

The PACE IDT, cont.

- All care for participants is decided by the IDT
  - No member makes unilateral decision
  - The IDT meets daily to discuss pertinent participant issues
  - All interventions are included in an Interdisciplinary Plan of Care
  - IDT updates the plan of care at minimum every 6 months
  - When the IDT is split in opinion there is a vote to decide the direction of care
  - All actions of the IDT are based on participant assessment and overarching goals set by the care plan

Interdisciplinary Team

A LIFE Plan of Care

- The Interdisciplinary Team (IDT), with the participant and caregiver, develop an individualized plan of care (POC) based on data from the IDT assessment and participant and family goals
- The POC is updated at six months and on an as needed basis
- Most care plans include care at the PACE Center and in the home
- Most participants attend the PACE Center 2 – 3 times each week
- Participants must agree to receive all services and medications through the PACE provider network (exceptions for emergency and urgent care)
- Some PACE Organizations allow continued visits with prior PCP
### PACE Care Plan

**Excerpt from Sample PACE Participant Care plan**

<table>
<thead>
<tr>
<th>Participant has unstageable pressure sore on right heel causing difficulty in ambulating</th>
<th>Goal (10/21/15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unstageable pressure sore on right heel causing difficulty in ambulating</td>
<td>HCC, RN (10/21/15)</td>
</tr>
<tr>
<td>Participant will demonstrate wound healing</td>
<td>Goal (10/21/15)</td>
</tr>
<tr>
<td>Wound care as prescribed</td>
<td>HHRN, PCP (10/21/15)</td>
</tr>
<tr>
<td>Participant will demonstrate functional transfers without bearing weight on residual limb</td>
<td>Goal (10/21/15)</td>
</tr>
<tr>
<td>OT to provide education and training</td>
<td>Goal (10/21/15)</td>
</tr>
</tbody>
</table>

**Nurses in PACE**

- Nurses can hold many roles within a PACE organization
  - Director of Nursing
  - Health Center/Clinic roles
  - Home Health roles
  - Case Management roles
  - Quality/Risk Management RN
  - Infection Control Nurses
  - WOCN
  - APNs (Nurse Practitioners)
  - Unlimited opportunities based on program need and size
Nurses in PACE, cont.

• Nurses are a regulatory member of the PACE IDT
  • Beyond that, CMS is limited in what it says is the role of the nurse in PACE
  • Literature reveals that the role of nurses in PACE programs is understudied

• Based on experience of presenter, nurses in different roles are integral to function of PACE programs, but nursing in PACE setting nearly absent in the literature

Case Study

• 76 year old male, no formal caregiver, wife’s sister assumed responsibility for him after wife passed
• NH eligible (for community and placement), but is he appropriate?
• Has informal caregiver/home
• Benefits from PACE services and is safe in environment
• 5 day center attendance, medical needs met, sees nurses daily, in home services and respite as needed

Case study, cont.

• Prior to enrollment
  • ED visits/PAH:
    - 2013—7 ER visits/3 admissions
    - 2014—Jan-July 31 (prior to enrollment)—6 ER visits/3 admissions

• After enrollment
  • ED visits/hospitalizations:
    - 2014—Aug-Dec—3 ER with 1 admission (learning period)
    - 2015 to date—2 ER visits with 1 admission (not PAH)
PACE Outcomes and Benefits

Why PACE??

• PACE participants and caregivers report:
  • Improved quality of life
  • Stable or improved functional outcomes
  • Decreased caregiver stress
  • Decreased likelihood of nursing home placement
  • Increased likelihood that end of life wishes are followed


Why PACE?

• Research indicates:
  • Decrease in Medicare dollars spent among peer groups
  • Increase or stabilization of function among PACE enrollees
  • Decrease in hospitalization rates
  • Decrease in nursing home placement rates
  • Increase in not only quality, but quantity of life (PACE participants lived 1.3 years longer than peers)

Cost Comparison

• Several studies validate:
  • Decreased hospitalization rates
  • Decreased utilization of nursing homes
  • Decrease in Medicare spending vs. peer groups

• All of this in the frailest of the elderly who traditionally utilize Medicare dollars $\$$

Hospitalization Rates

Hospital Discharges Per 1000/Year

- Duals - All: 574
- Duals - NH: 719
- Duals - HCBS: 962
- PACE: 538

Source: Temkin-Greener 2011; Walsh 2010

Hospitalization Utilization

Hospital Days Per 1000/Year (DPK)

- Duals - All: 4,076
- Duals - NH: 5,247
- Duals - HCBS: 6,447
- PACE: 3,024

Source: Temkin-Greener 2011; Walsh 2010; National PACE Association Cross-site data CY 2014
PACE Nursing Home Placement

Trinity Health PACE Quality Metrics for FY16

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fall Rate</td>
<td>Number of Falls X 1,000 / Participant Days</td>
</tr>
<tr>
<td>Falls with Major Injury</td>
<td>Falls with Major Injury or Death X 1,000/Participant days</td>
</tr>
<tr>
<td>Pressure Ulcer rate</td>
<td>Total Participants, With Stage III, IV or unstageable PU X 1,000 / Total Participant Days</td>
</tr>
<tr>
<td>UTI Rate</td>
<td>Total UTIs X 1,000/Participant Days</td>
</tr>
<tr>
<td>Pressure Ulcer rate</td>
<td>Total Participants, Transferred (PU) / Total Participants for Month</td>
</tr>
<tr>
<td>Pressure Ulcer rate</td>
<td>Number of Participants Transferred (PU) / Total Participants for Month</td>
</tr>
<tr>
<td>Source Identifiers Rate</td>
<td>Total treatment (OCT) - (1,000) Total Participants</td>
</tr>
<tr>
<td>All Cause Hospital Readmissions Within 30 Days</td>
<td>Percent of hospital discharges with a readmission within 30 days of discharge - all cause, planned or unplanned, in- or out-patient</td>
</tr>
<tr>
<td>MI Rate</td>
<td>Total MI Events X 1,000/Total Participant Days</td>
</tr>
<tr>
<td>Participation Satisfaction - Overall Satisfaction</td>
<td>Percent “satisfied” on “How would you rate your overall satisfaction with this service?”</td>
</tr>
<tr>
<td>Participation Satisfaction - Recommendation to Others</td>
<td>Percent “satisfied” on “What is your recommendation of this service to others?”</td>
</tr>
</tbody>
</table>

Local PO’s also track additional metrics based on their QAPI plan

Summary and Questions

• PACE is a viable alternative for frail elderly who wish to remain living in the community
• PACE programs are successful in reducing unnecessary utilization
• PACE programs offer a unique practice setting for nurses
• PACE programs offer traditional and non-traditional opportunities for nurses

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References


