

# Asia Forum on Ageing 2009

## THE DEVELOPMENT OF PROGRAMS FOR ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) IN THE UNITED STATES

13 January 2009

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# Client Vision

Set goal to provide seniors the **RIGHT**:

- **SERVICES** (maximize my independence)
- **PLACE** (my own home)
- **TIME** (before I lose function)
- **PRICE** (what I can afford)



# Organization Vision

Be the leading innovator in developing and operating comprehensive services for older adults regardless of economic or functional status



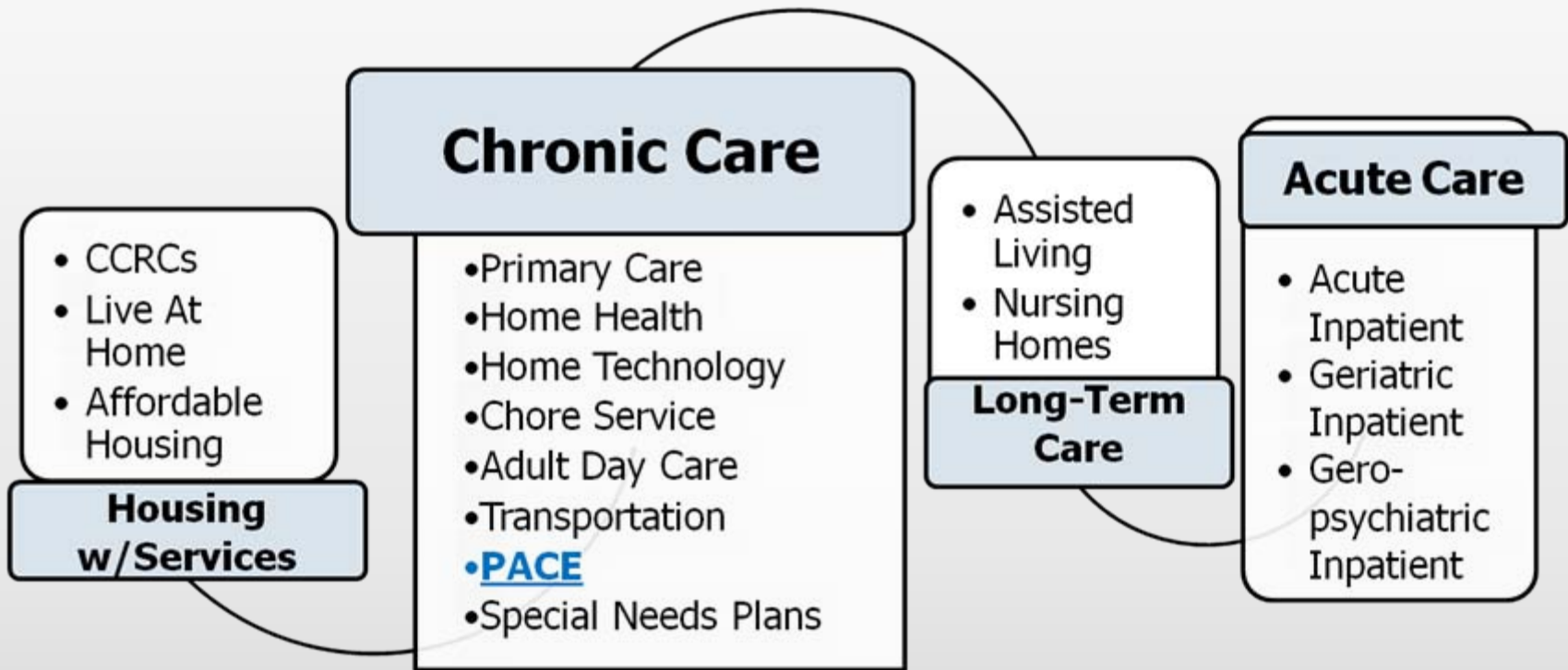
# Definition—Economic Status

- **Impoverished**—Eligible for government support
- **Inadequate Income**—Will spend down to need government support
- **Adequate Income**—ability to privately pay for care for three to five years

# Definition—Functional Status

- **Frail**—nursing home eligible
- **Needs Assistance**—impaired in at least one Activity of Daily Living (ADL) (instrumental/functional)
- **Independent**—able to function without assistance

# Continuum of Care

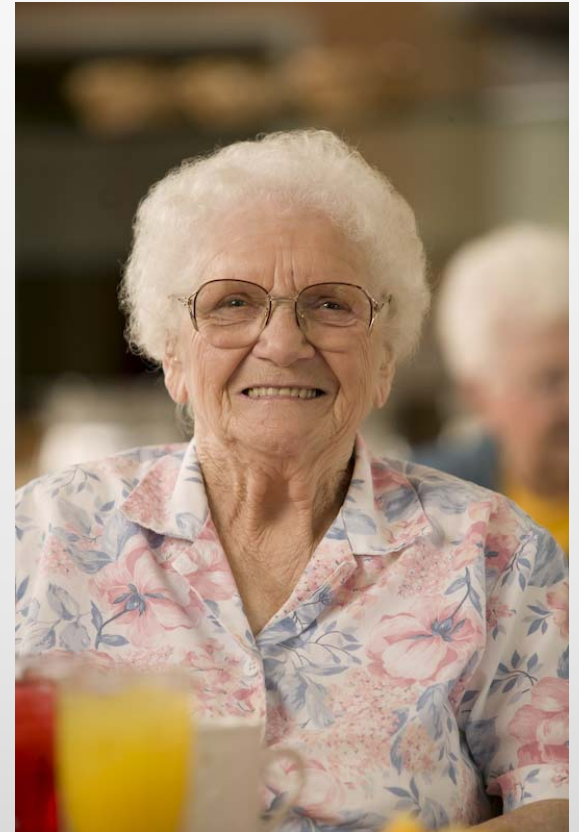


# Continuum of Care

Economic Status		
Adequate	Inadequate	Impoverished
Functional Status		
Independent		
Retirement Communities Live at Home	Rental Retirement Communities, Middle and low income Tax-credit financed housing	Affordable Housing
Needs Assistance		
Home Care Adult Day Care Assisted Living	Home Care Adult Day Care Assisted Living	Home Care Adult Day Care
Frail		
Private Pay PACE Home Care Nursing Home	Spend Down in to PACE Home Care Nursing Home-Spend Down	PACE Home Care Nursing Home

# What is PACE?

“... a unique capitated managed care benefit for the frail elderly...”



# What is PACE?

- ▶ Community-based
- ▶ Comprehensive (medical and social services)
- ▶ Capitated (managed care)
- ▶ Coordinated



# Why PACE?

- ▶ **Honors the desires of the frail elderly**
  - ▶ To stay in familiar surroundings
  - ▶ To maintain autonomy
  - ▶ To maintain a maximum level of physical, social and cognitive function



# The Current System

- ▶ **Fragmented**
  - ▶ Primary Care
  - ▶ Acute Care
  - ▶ Institutional Care
  - ▶ Home Care



# The Current System

- ▶ Acute-care focused
- ▶ Expensive
- ▶ Inefficient



# The Current System

Next generation of residents will expect organizations to have **integrated care management** across a continuum of care



# Focus on the Frail

- ▶ 55 years of age or older
- ▶ Living in PACE service area
- ▶ Certified as needing nursing home level of care
- ▶ Can be safely cared for in the community

# Serves Triple Eligibles

- ▶ Poor—Medicaid
- ▶ Old—Medicare
- ▶ Frail—nursing home eligible

# Comprehensive Services

- ▶ Integrates preventive, acute- and long-term care services
- ▶ All Medicare/Medicaid services **PLUS** community long-term care service
- ▶ **NO** benefit limitations, co-payments, or deductibles

# Five Service Elements

- ❑ Intensive primary care
- ❑ Integrated Team management
- ❑ Use of adult day health center
- ❑ Home care
- ❑ Transportation

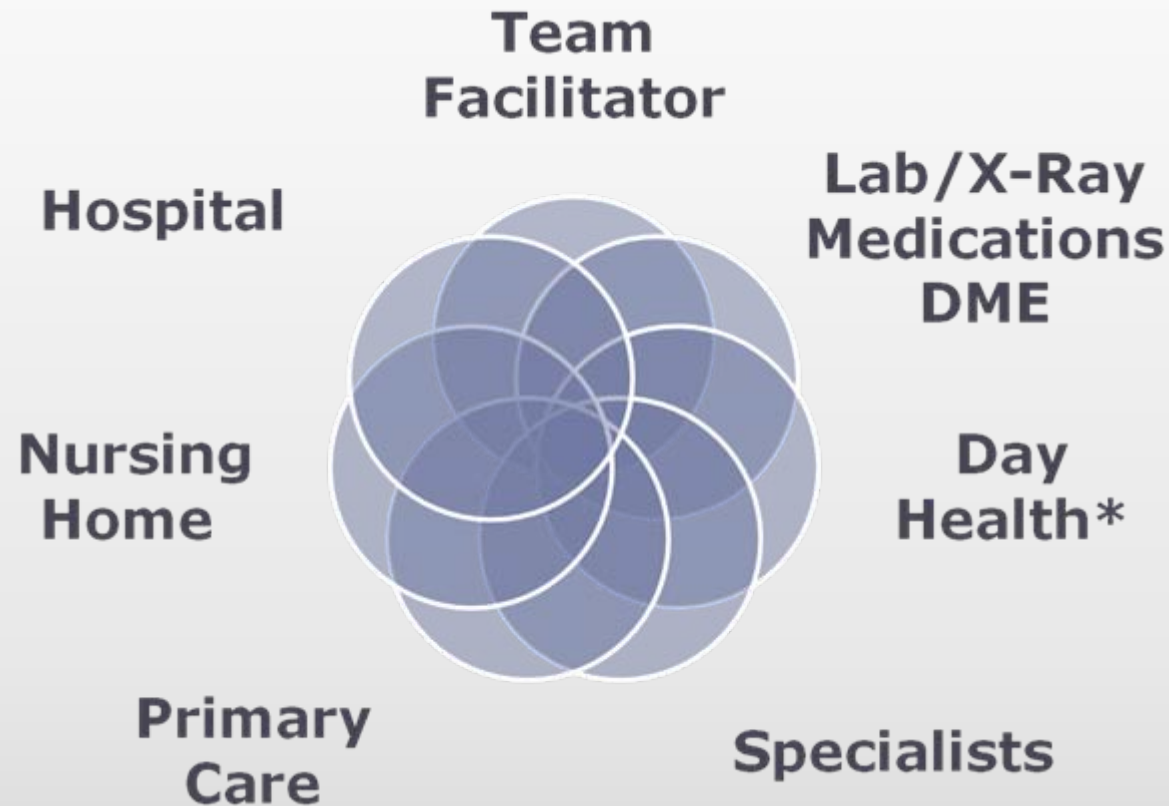
# Primary Care

- ▶ Salaried full-time physician and nurse practitioner for 125 participants
- ▶ Physician follows participants through all settings, including acute care
- ▶ Part-time Medical Director
  - ▶ Oversees quality insurance
  - ▶ Communicates with the physician community
  - ▶ Assists physician in managing specialists

# Team Managed Care

- ▶ An interdisciplinary Team
- ▶ Team managed care versus individual case manager
- ▶ Continuous process of assessment, treatment planning, service provision and monitoring
- ▶ Focus on prevention

# Integrated Team



\*Day Health services include nursing, social services, therapies, nutrition, recreation, personal care, pharmacy, transportation

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▶ Slide 20

# PACE Center

- ▶ 12,000 to 15,000 square foot building comprised of a
  - ▶ Clinic
  - ▶ Rehabilitation Center
  - ▶ Traditional Adult Day Care
- ▶ Participants attend an average of three days per week

# Home Care

- ▶ Less than 10% skilled visits
- ▶ Visits primarily assist participants with ADLs and getting ready for the vans and for bed
- ▶ Average visit—one hour
- ▶ Average monthly usage—60 hours

# Transportation

- ▶ A van and full-time driver for every 15 participants
- ▶ Drivers are the eyes and ears of the program because they are the only Team members at every home every week
- ▶ Most common dissatisfaction is with transportation

# Required “Best Practices”

- ▶ Voluntary caregiver support
- ▶ End-of-Life care
- ▶ Management of participant/family member noncompliance

# Caregiver Support

- ▶ 80-85% of PACE participants have voluntary caregiver support
- ▶ Costs substantially increase when caregivers burn out or caregiver's health declines where they cannot assist
- ▶ Effective programs provide measures of caregiver stress and satisfaction with services, along with frequent respite care for participant/family

# End of Life Care

- ▶ Provided through palliative care without transferring to hospice
- ▶ Keys are great consistent communications, value-based decision making and using present and advance directives
- ▶ **RESULT: 50% of PACE participants die in their own homes compared to 14% of all Medicare beneficiaries**

# Managing Non-Compliance

- ▶ **Frequent flying**—calling 911 for non-emergency situations
- ▶ **Dumping and running**—family members overpromising and under delivering support
- ▶ Successful PACE Teams have great communications with participants and families led by social workers

# Funding



- ▶ **Capitated, pooled financing**
  - ▶ Medicare capitation rate adjusted for the frailty of the PACE enrollees
  - ▶ Integration of Medicare, Medicaid and private-pay payments

# Average Capitation Rates

2006 average capitation rate PMPM  
(per member per month)

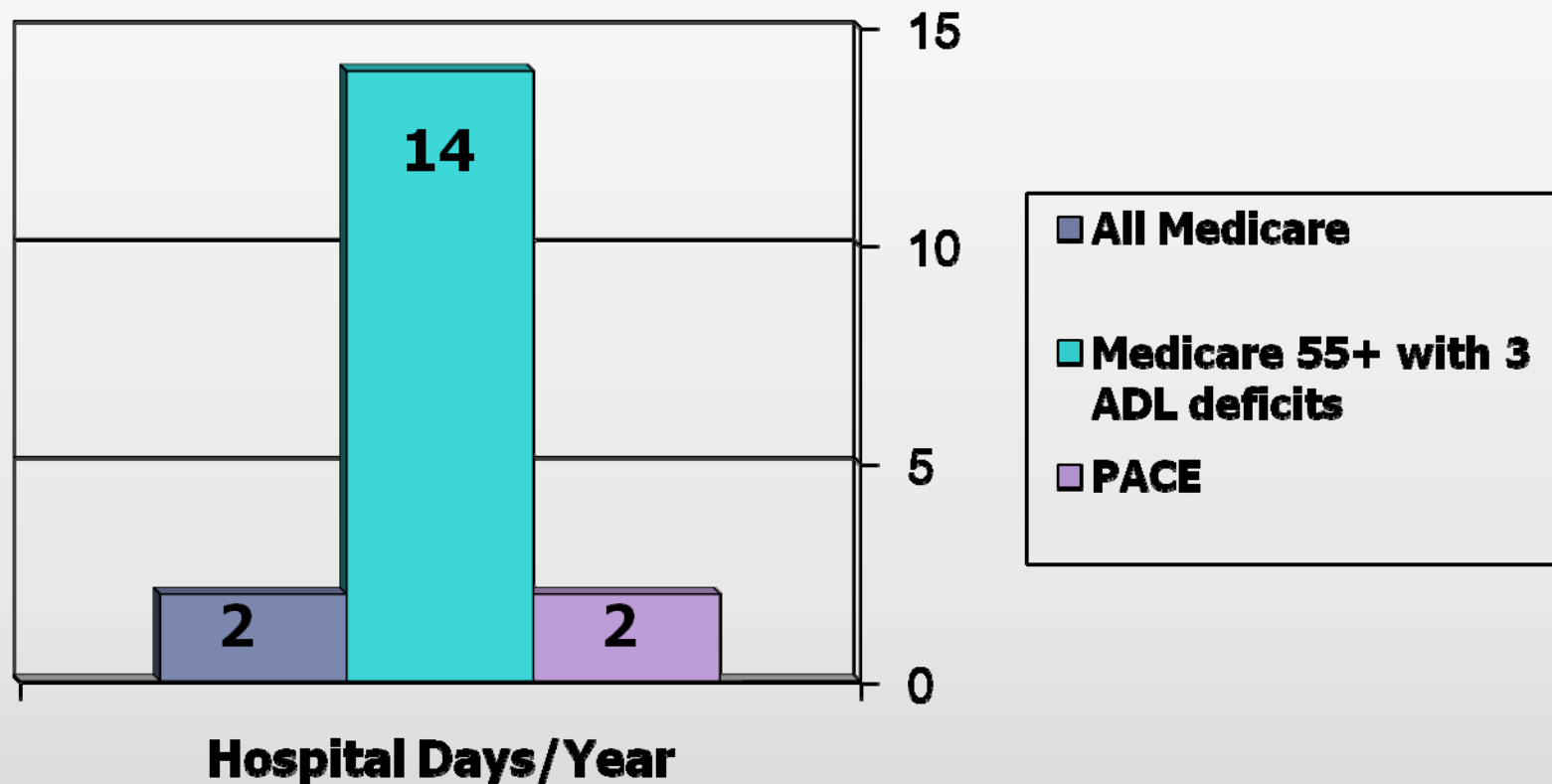
Medicare	\$1,980
Medicaid	<u>\$2,970</u>
Total	\$4,950

# Typical PACE Participant

<b>AGE</b>	<b>DIAGNOSIS</b>	<b>ADLs</b>	<b>INSTRUMENTAL ACTIVITIES</b>
<b>80</b>	<b>7.9</b>	<b>3.6</b>	<b>7.2</b>

SOURCE: Program Characteristics and Enrollees' Outcomes in the Program for All-Inclusive Care for the Elderly, Mukamel, Dana, University of California, Irvine Center for Health Policy Research

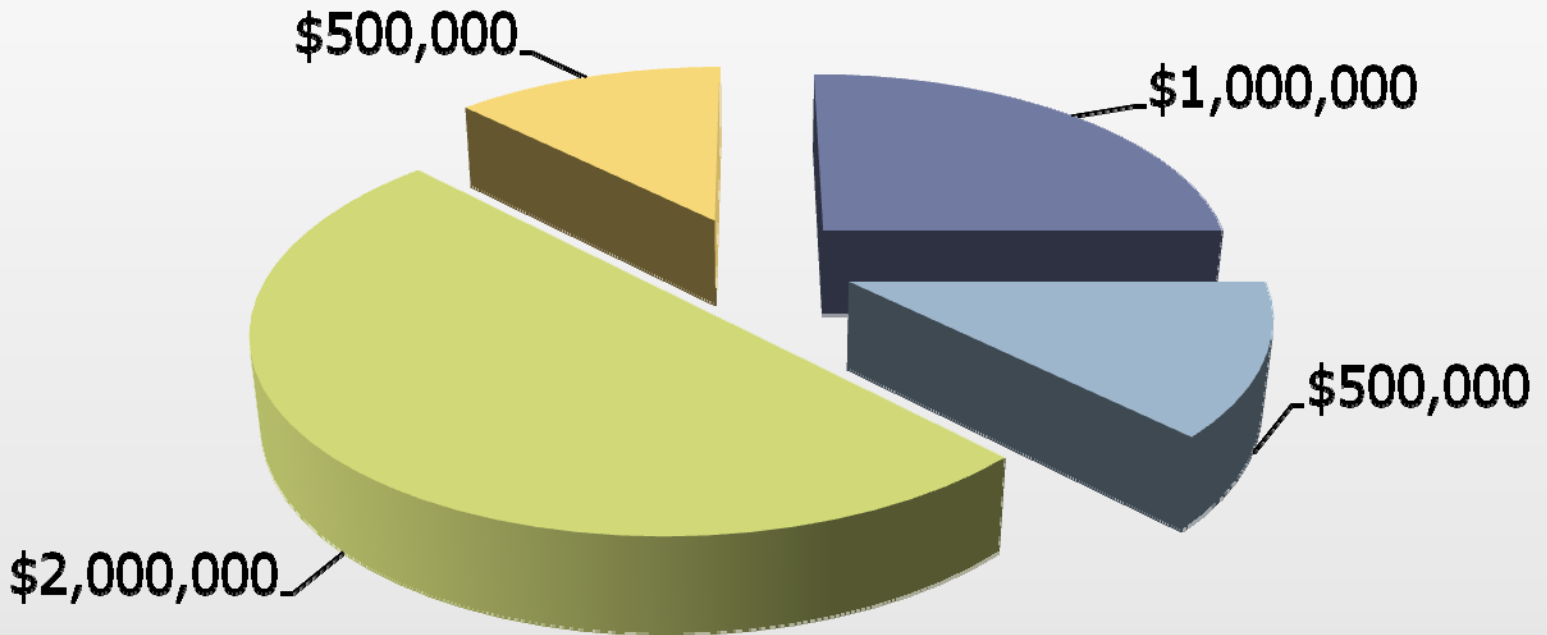
# Hospitalization Rates



Wieland, JAGS 2000; 48:1373-1380

# Start-up Costs

(approximately \$4M)



- Leasehold Improvements
- FFE (w/Vans)
- Cash for Operations
- Cash Reserves



# Financial Performance

Indicator	CDS Target
Breakeven	16 <sup>th</sup> Month
Operating Margin	10%
Return on Revenue – 5 Years (a)	8%
Return on Investment – 5 Years	10%

(a) Includes start-up

**Pays back \$4M LOC by Year 5**

# PACE In Asia

- ▶ The PACE model originated in the Chinese American community of San Francisco (On-Lok)
- ▶ There was an initial concern that PACE would not work in United States outside the Chinese culture

# The Filial Obligation

- ▶ PACE supports the family in caring for the elderly through day care, education, home care and respite care
- ▶ Many US states require participants to pay a share of costs, based on income, to be in the program

# Senior Hospitalization

- ▶ High hospital costs for older adults across the region is the best opportunity for PACE to be funded
- ▶ Average hospital stay for Singaporean seniors is 11 days—US PACE participants average approximately 3 days because of proactive management of chronic care needs

# Nursing Home Use

- ▶ All US PACE participants are nursing home eligible—only 10% are in the nursing home
- ▶ Intensive services and care management provided by PACE could reduce nursing home utilization in Asia

# Challenges for PACE in Asia

- ▶ PACE has been most effective serving seniors in urban areas—the rural model is relatively new and untested
  - ▶ 14 new rural programs are currently serving participants
- ▶ Support services and primary care available to seniors in rural areas are very limited

# Challenges for PACE in Asia

- ▶ Many Asian communities are experiencing a decline in the willingness of children to be the parental caregiver
- ▶ Because PACE provides services to support these caregivers and the unmet need is so great, the demand could increase overall costs for the government

# Questions



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