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# PACE: Program of All-inclusive Care for the Elderly

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age in action

Virginia Center on Aging
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## Case Study

# PACE -Program of All-inclusive Care for the Elderly

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### Educational Objectives

1. Describe the Program of All-inclusive Care for the Elderly model of care for frail seniors with chronic health care needs.
2. Demonstrate how PACE benefits providers in the delivery of services.
3. Explain how the PACE concept complements Virginia's Long Term Care Reform, as well as initiatives to develop further the PACE program in Virginia.

### Background

The Program of All-inclusive Care for the Elderly (PACE) model is grounded in the belief that the community is the best setting to maintain the well-being of older adults with chronic care needs and their families. The PACE model organizes a range of services, from health care to social to support, and blends funding streams to pay for them. The focal point for delivering these services is an adult day care center.

The PACE model of care can trace its lineage to the early 1970s, when the Chinatown-North Beach community of San Francisco witnessed pressing needs for long term care services among families whose elders had migrated from Italy, China, and the Philippines. Marie-Louise Ansak, a community member, was instrumental in the creation of On Lok (Cantonese for "peaceful, happy abode") Senior Health Services, a community-based system of care. On Lok quickly became a model for innovative, non-institutional care that preserved family relationships and community connections. In 1983, a new payment system was tested at On Lok, a single capitated fee per month per participant which drew upon and "blended" two customarily separate funding streams, Medicare (based on age) and Medicaid (based on need). Due to the success of this experiment, Congress passed legislation to allow ten additional organizations to replicate On Lok. PACE follows in this heritage.

The National PACE Association (NPA) formed in 1994 to advance the efforts of PACE programs by educating and promoting a reimbursement and regulatory environment which promotes the PACE philosophy, educational opportunities for programs, and benchmarking data for cross-site comparisons. The NPA offers numerous resources and tools for a provider to understand the PACE model, appraise its own organizational commitment and capacity, assess the community's needs, and move forward with development or expansion of a PACE program.

The Balanced Budget Act of 1997 firmly established the PACE model as a permanent provider under Medicare and Medicaid services, allowing PACE financing based on the combination of monthly capitated payments from both Medicare and Medicaid. Currently, there are more than 40 PACE and pre-PACE programs in 22 states.

### PACE in Practice

Participants. To qualify for enroll-

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ment into PACE, individuals must be ages 55 or older, with significant impairment levels, having been pre-screened to meet nursing facility criteria, using the Virginia Uniform Assessment Instrument (UAI). Individuals must reside in the PACE program service area, be able to live in a community setting without jeopardizing his/her health or safety at the time of enrollment, and agree to the terms of participation of the program. Although all PACE participants must meet nursing facility level of care, only about 7% of PACE participants nationally reside in a nursing facility.

Providers. Each PACE program has an interdisciplinary team (IDT) composed of key professional personnel, i.e., primary care physician, nurse, physical and occupational therapists, dietitian, recreational therapist, pharmacist, Master level social worker, home health and transportation coordinator. This team is responsible for both authorizing and providing services. By coordinating and delivering all needed medical and supportive services, the PACE program is able to provide the entire continuum of care and services to elderly persons with chronic care needs, ensure the coordination of these services, and at the same time, help to maintain the participants' relative independence in their own homes. The majority of individuals enrolled in PACE receive their services in a community-based adult day care center.

Services. PACE covered services include:

- Primary care, including physician and nursing services
- Social work services
- Restorative therapies, including physical therapy, occupational therapy and speech-language pathology services,
- Personal care, home health and durable medical equipment
- Prescription medications
- Respite care
- Nutritional counseling
- Recreational therapy
- Transportation
- Meals and specialty services

The primary services include physician and nursing services, day health care, physical therapy, social services, home health and personal care, transportation, meals, and all medications.

Payment. Under PACE, the providers receive a set amount of money for each person enrolled, called a capitated payment, that allows flexibility and creativity to provide the best care possible to participants. PACE providers have the ability to coordinate care for participants across settings, which means PACE participants are able to receive services at the PACE center, in skilled facilities, the hospital and in their home.

**PACE in Virginia**

Sentara began to explore the concept of PACE in 1994 when evaluating ways to provide alternative services for frail seniors in the community. Having PACE would add another option for Tidewater consumers, providing innovative care through a closely managed care model. In 1996, the Commonwealth of Virginia opened a pre-PACE program, Sentara Senior Community Care (SSCC) in Virginia Beach. A pre-PACE program integrates primary and long-term care services within Medicaid but does not integrate Medicare financing and services. Pre-PACE also excludes Medicaid funded inpatient and outpatient hospital, lab/x-ray, and ambulatory surgical costs. SSCC provides services to participants who reside in the cities of Chesapeake, Norfolk, Portsmouth and Virginia Beach. Since opening, SSCC has cared for more than 475 frail elderly persons in Hampton Roads. Currently, SSCC has an average enrollment of 125 participants, with approximately 75-80 attending the day health center each day. DMAS has been instrumental in providing technical assistance and oversight to SSCC during their pre-PACE operations.

As a PACE program, Sentara Senior Community Care will lead Virginia in its mission to improve health everyday by providing quality healthcare services to elderly citizens enrolled in PACE. SSCC has completed all PACE provider application requirements with the Centers for Medicare and Medicaid Services (CMS) and the Department of Medical Assistance Services (DMAS) and is awaiting final approval from CMS to operate as Virginia's first PACE program. By becoming a PACE program, SSCC will be able to provide all Medicare and Medicaid covered services to PACE participants and receive a capitated payment for those services.

**Case Study #1**

Mabel M. is an 81-year-old African American who enrolled in the Sentara Senior Community Care

pre-PACE program five years ago. Mabel lived independently until she suffered a stroke in December 2001. Her family described her as very quiet in nature, preferring to spend time alone. Mabel's memory had suffered as well from the stroke. She received rehabilitative services following her stroke, returning to her home with the assistance of her daughter. Both Mabel and her daughter were dubious about the new living arrangements and the challenges they were presented. Mabel utilized a wheelchair for mobility and needed 24-hour supervision.

When she was referred to SSCC in March 2002, she had a history of falls in the home, showed signs of severe depression, was underweight and was dependent on others for all of her activities of daily living. Mabel began attending the SSCC Day Health Center and received personal care services in the home. A certified nursing assistant (CNA) helped her get up in the morning, bathe, get dressed, and have breakfast before the SSCC van came to pick her up each day for the Day Health Center. This schedule allowed her daughter to return to work without worry. She participated in physical and occupational therapy, learning to ambulate and to assist in her daily care needs once again. She received socialization and cognitive stimulation through her participation in the daily recreational activities at SSCC, such as current events, exercise, musical programs, and establishing friendships with peers.

Today, Mabel is a different person. She is a happy, revitalized senior who feels she has a purpose in life each day. She continues to attend the SSCC day health center while her daughter works. She has made lasting friendships with her peers and greets each person she sees with a bright smile participating in all of the center activities. Both her long and short term memory have improved significantly, she is alert and oriented, conversing with peers and staff about current events. She takes great pride in her appearance and her ability to ambulate independently with her walker.

Mable has gained 20 pounds, reaching and maintaining her ideal body weight with the support of counseling by the SSCC Dietician. Her health remains quite stable without significant medical changes; she has not been hospitalized for another stroke in the past five and a half years.

**Case Study #2**

Thomas W. is a 75-year-old African American diagnosed with congestive heart failure, diabetes, and a history of colon and prostate cancers. He had been a resident in a nursing facility for several months when he was first referred to SSCC in September 2005. He used a wheelchair for mobility and had wounds on his feet that were slow to heal. Thomas and his daughter hoped for him to return to the home they shared, but, due to his impaired cognitive status, he was at risk for wandering from the house and required 24- hour supervision for his transfers and all activities of daily living.

Since Thomas' enrollment in SSCC two years ago, he has become independent in his mobility, his lower extremity wounds have healed, and his diabetes is reasonably well controlled with assistance from the SSCC clinic staff. The nursing staff changed the dressings on his feet daily and closely watched his glucose and dietary intake to promote the wound healing. The physical and occupational therapists worked extensively with him to help him to regain his ability to bathe, dress, transfer, and use a walker instead of a wheelchair. The social worker provided support to him and his daughter, encouraging him to do as much for himself as possible without depending on others. He has had one short acute care stay in the past two years. SSCC transports him to the adult day health center during the week and ensures he is seen regularly by the podiatrist. He is no longer as risk for wandering; he has a personal safety monitoring device (Health Watch) at home, so his daughter is able to leave him alone for short periods of time, knowing assistance is close at hand.

Thomas says, "This program has helped me walk and not have to use a wheelchair. I feel quite good these days for a young man like myself."

**PACE and Virginia's Long Term Care Reform**

The Virginia Department of Medical Assistance Services (DMAS) in partnership with the Centers for Medicare and Medicaid (CMS) and PACE provider organizations offer seniors and caregivers a choice to remain appropriately in the community for as long as possible. The implementation of the *Blueprint for Inte-*

*gration of Acute and Long Term Care Services* initiated in 2006 by Governor Kaine involved DMAS in the development of alternative ways to provide care to Virginia's most vulnerable citizens, namely, low income seniors and individuals with disabilities.

In Virginia, most Medicaid older adults and individuals with disabilities receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care is provided in a fee for service environment with no chronic care management. Long-term care is provided in a nursing facility or by a variety of home and community-based care providers with no overall care coordination or case management.

In 2006, Governor Kaine allocated $1.5 million for start up grants to develop PACE programs in Virginia. DMAS published a Request for Application (RFA) in July 2006, inviting all organizations interested in establishing a PACE program in Virginia to submit an application. DMAS awarded start-up grants of $250,000 each to three health systems and two Area Agencies on Aging (AAAs); in addition, these two AAAs, located in far Southwest Virginia, received grants totaling $500,000 each from CMS to develop PACE. PACE programs are being developed in the following areas:

- PACE Sentara, Virginia Beach
- PACE Riverside Peninsula, Hampton, and PACE Riverside Richmond, Richmond City
- PACE Centra Health, Lynchburg
- PACE AllCare for Seniors, Cedar Bluff
- PACE Mountain Empire, Big Stone Gap

These grants are allowing PACE provider organizations the opportunity to take great strides in offering PACE as a viable option for service delivery.

A seventh PACE program is earmarked for Northern Virginia in 2009. A Request for Application was published July 23, 2007 to solicit applications from organizations interested in developing a PACE program in undeserved areas of Northern Virginia. Five agencies, specializing in a diverse mixture of human services, submitted a letter of intent indicating their interest in working together to develop a PACE in Northern Virginia. The due date for receipt of their application is April 30, 2008.

**Conclusion**

The PACE model of care takes many familiar elements of our traditional health care system and reorganizes them in a way that makes sense to individuals, families and health care providers. For hundreds of elderly citizens across the Commonwealth of Virginia, PACE will offer them a one-stop shop for all healthcare services, by helping them to access needed services in a setting that is licensed and operated by a professional team who will help them live safely and appropriately in the home and community.

For families and caregivers, PACE will provide additional support that will enable them to manage their lives and their loved ones better. For PACE organizations, PACE will give them the ability to deliver quality care to elderly persons keeping them at home and out of an institutional setting.

**Study Questions**

1. What is the PACE philosophy?
2. List significant advantages of the PACE model for individuals, families and healthcare provider organizations.
3. How does PACE differ from other care options for frail seniors?

**About the Author**

Laura R. Gadsby has been the Site Manager for the past two years of Sentara Senior Community Care (SSCC), Virginia's first pre-PACE program. Prior to her current position, she was the Director of Enrollment & Marketing for SSCC for six years. She was educated at Virginia Weslyan College and is a member of the Portsmouth & Virginia Beach Task Forces on Aging, and the Sentara Healthcare Ethics Advisory Council.

**Related Sources**

*Blueprint for the Integration of Acute and Long-Term Care Services.* Richmond: Virginia Department of Medical Assistance Services, December 15, 2006. Available at www.dmas.virginia.gov/altc-home.htm

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