The right PACE for ALCs and beyond

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD a,b,c,*, Dan Haimowitz, MD, CMD, FACP d,e,f

a Health Policy & Public Health, University of the Sciences in Philadelphia, PA, USA
b The Access Group, USA
c Mercy LIFE, Philadelphia, PA, USA
d Private Practice, Levittown, PA, USA
e Arden Courts of Yardley, PA, USA
f Brunswick at Aulteboro, Langhorne, PA, USA

“If you always do what you always did, you will always get what you always got.” When Albert Einstein said that, he probably wasn’t thinking about the creation of assisted living communities (ALCs). ALCs were a new idea aimed at creating new outcomes for older adults in need of assistance. Traditionally, frail seniors in need of assistance were forced into a skilled nursing facility (SNF), an institutional setting that costs more than $250 per day. Someone realized the SNF model had to be changed to provide a different outcome, and the ALC was born.

ALCs today provide a less medicalized, more home-like setting at almost one-third the cost of traditional SNFs. Similarly, the Program of All-inclusive Care for the Elderly (PACE) was introduced as a more home-friendly cost-saving approach to long-term care for older adults.

An estimated 25% of Americans aged 18 years and older lived with multiple chronic conditions (MCC) in 2009 (Machlin and Soni, 2013).1 The same study estimated that around 67% of people aged 65 years and older were treated for 2 or more chronic conditions and 24.6% were treated for 4 or more conditions. As complications from untreated MCC increase, so too do the costs of associated health care. The health care system has struggled to successfully manage individuals with MCC, and although there are high expectations for disease management programs and other initiatives, there is no conclusive evidence that they will be able to reduce costs or improve quality.

On the other hand, comprehensive care models (CCMs) have consistently demonstrated an improvement in quality of services (Boult et al, 2009).2 CCMs grew from the need for public health efforts, policies, and programs to promote healthy aging and independence.

PACE is one such initiative, and has proven to effectively manage older adults with MCC. PACE is a comprehensive, best-practice model that combines exemplary interdisciplinary team care and caregiver engagement to allow older adults the opportunity to successfully age in place in their community—ideally, in their own homes. PACE has been demonstrated to decrease hospitalization rates and prevent or postpone long-term nursing home placements. Since its inception in the 1970s, the PACE model of care has been centered on the belief that comprehensive community treatment is better for the well-being of chronically ill older adults and their families. PACE serves individuals who are aged 55 years and older, are certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and who live in a PACE service area. Although all PACE participants must be certified to need nursing home care to enroll in the program, only about 7% of PACE participants nationally reside in a nursing home.

Maintaining older adults in the community can be a difficult task; with PACE, this effort is orchestrated by an interdisciplinary team (IDT) composed of physicians, nurses, social workers, physical and occupational therapists, dietitians, and recreational therapists, among others. The IDT is responsible for a wide range of functions, including care coordination, caregiver support, and end-of-life planning, based on social and behavioral strategies. The belief is
that these best practices from PACE can be successfully replicated in the community to benefit non-PACE enrollees, as well.

The PACE model

PACE is a very rare mixture of health insurance and health care provider. It is a very logical approach to health care, offering all Medicare and Medicaid services through a single point of delivery targeted to frail elderly with a host of chronic care needs (Hirth et al., 2009). PACE started with the On Lok Center in San Francisco, which offered adult day care with comprehensive medical services, rehabilitation services, respite, and social services as a way to serve the community’s immigrant elders with long-term care needs. This model of adult day care quickly became successful because of the model’s flexibility to meet the needs of a wide variety of older adults (Hirth et al., 2009). The PACE model, in some ways, is similar to a staff-model health maintenance organization, in that physicians are employed by the organization and the organization accepts financial risk.

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PACE grew from On Lok into a Medicare demonstration project. The model was so successful that 11 organizations were operating in 9 different states by 1994. PACE became a defined Medicare benefit in 1997 and by 2012, 88 PACE programs were operating in 29 different states. The PACE program’s demonstrated ability to 1) improve the quality of life of frail older adults by keeping them in the community rather than in SNFs and 2) decrease hospital utilization rates is accomplished, in part, due to very involved social workers who are responsible for a wide range of functions—including care coordination, caregiver support, and end of life planning—using social and behavioral strategies. These patient and caregiver engagements can provide tremendous opportunities for a large range of older adults, including non-PACE participants, benefiting them with an improved quality of life and independence. The Medicare and Medicaid systems benefit, as well, through more efficient and effective use of limited health care resources.

Although PACE has focused solely on a very specific set of older adults and a single-payment method, its principles have much wider application. Specifically, PACE principles can be applied to older adults in need of assistance in ALCs.

Five care focus areas

The foundation of PACE care delivery revolves around five critical care areas. These areas include 1) Management of Red Flags, 2) Medication Management, 3) Primary Care Provider (PCP) Access, 4) End of Life Management, and 5) Caregiver Support. Attention to these areas can go a long way in improving the health of ALC residents.

Management of red flags involves ensuring that residents and their caregivers, both formal and informal, understand the early signs of a resident’s decline and the need for timely intervention to reverse a downward progression. The typical example given is the resident with congestive heart failure who overindulges and gains a few pounds in fluid. The resident misses the weight gain shown by the scale until his or her condition progresses to the point where he or she ends up in the emergency room, all of this occurring following a recent admission for a similar event. Had the ALC staff spent time educating the various team members, the resident, and the resident’s caregivers on this early sign (the sudden weight gain) and its management, the resident’s downward spiral may have been avoided. Red flags exist for most chronic diseases affecting older adults—the critical issue is identifying them and then, even more importantly, making ALC staff and residents acutely aware of them. One way PACE programs are able to do this effectively is by using one of the key elements of culture change. All members of the PACE team are enabled to identify early warning signs of illness, ranging from the drivers of the transportation van to the receptionist of the adult day care center to the center staff, up to and including the physicians and advanced care practitioners.

Medication management comes in many forms, from the required monthly consultant pharmacists’ drug regimen review for SNF residents to the review required by Medicare Part D plans in the form of medication therapy management. PACE programs pay special attention to medications, with expert geriatric prescribing, continual assessment of possible medication side effects, and evaluation of whether medication usage aligns with a participant’s goals of care. ALC residents who are in transition are at high risk for medication misadventures and, therefore, require at least the same amount of attention that is paid to SNF residents’ and high-risk Medicare Part D members’ medication usage. This process starts with medication reconciliation. All too often, medications are discontinued and switched during a hospital stay for nonclinical reasons, including switches to a hospital’s preferred agent and discontinuation of medications because of lack of attention on the part of the hospital team. This may result in an ALC resident being discharged with a medication list that is very different from what he or she was admitted with. Upon the ALC resident’s transition, an attentive ALC nurse can immediately sit down with the resident and his or her caregiver and review both the hospital discharge medications and those medications the resident was on prior to admission for issues of misalignment. Beyond this medication reconciliation process, medication management includes ensuring that ALC residents adhere to their medications with the use of not only reminders, but also education on the importance of medication adherence. A resident forgetting to take a medication is certainly an issue, but the resident’s belief that a medication is not important makes remembering to take it that much tougher.

PCP access is truly provider access rather than physician, as the provider can come in the form of a geriatrician or a nurse practitioner. PACE has always had a solid foundation of PCP care. Assuring timely access to PCPs is critical to improve health and avoid emergency room services, and can be best accomplished with highly available onsite PCP services. Quick access to PCPs through home visits can also serve an ALC well, although these are typically not as readily available. As we will go into a little later, having a PCP clinic within the ALC that is open to the community as a whole can increase the ability to support such an onsite clinic. Plus, a high level of PCP access can alleviate unnecessary emergency care.

One addition area where PACE has focused is Care Coordination. This involves not only coordination among the interdisciplinary team which in part occurs every morning with a IDT meeting to discuss the highest risk participants as well as high risk occurrences. Care coordination also includes coordination among various providers and interventions as individuals pass through emergency rooms, hospitals, nursing homes and other sites of care as well as various providers. This is critical as it has been well documented that patients are especially at high risk during these transitions for failures in coordination that result in missed opportunities and adverse events. Improving care coordination at these critical times can impact the outcomes for patients.

Finally, the reality is that most ALC residents will pass away within a few years of entry into the ALC, necessitating end-of-life management. A different way of thinking about this is that ALCs, similar to PACE programs, can be considered palliative care programs. Despite this fact, most residents enter the ALC without an Advanced Directive or even have a discussion about one. This presents not only the opportunity, but also the need, for ALC nurses to initiate these end-of-life discussions. Such discussions are best
when they include the ALC resident’s caregivers to obtain their support and buy in so that the caregivers can assist in the follow-through of a resident’s wishes at this most critical transition. This planning also goes a long way to ensuring that complex or extraordinary use of resources is not used against a resident’s wishes.

As mentioned in the previous four areas of focus, the caregiver is critical. In fact, all four areas have a component that requires caregiver support. From the early identification of red flags to the reinforcement of medication importance, to facilitating PCP access, to the end-of-life discussion, caregivers are at the heart of each of these critical areas. For this reason, ALC nurses would be well served to reach out to resident caregivers to assure they understand their important role and are armed with the tools to be successful in it. One way to accomplish this is to host monthly resident and caregiver educational sessions dealing with each of these topics. Besides the caregiver focus, the ALC is keenly focused on participant engagement—in fact ‘patients’ in PACE are referred to as participants as a means to empower their active role in their health; rather than the victimization and dependence that often is forced upon ‘patients,’ a situation that can negatively impact health.

**Assisted living to the community**

Although the application of PACE in an ALC helps obtain better results through a different approach as Einstein proposed, there are similar great results that can be achieved by pushing other innovative approaches—what about the application of assisted living outside of the ALC? Think about the ALC team, led by geriatric nurses serving community-based older adults from their ALC base. For example, inviting the community’s frail older adults and their caregivers into the ALC for care provides an introduction to the ALC so that when the time comes, an easier transition from one’s home into the ALC can occur. Not only does this improve the marketing of the ALC, but offering these services also increases the utilization of the ALC team so that the ALC can support more significant staffing and diagnostic resources.

This dedicated ALC care team using PACE care delivery can be ideally positioned to accept the increasing clinical and financial responsibilities of accountable care organizations (ACOs). ACOs and similar organizations are increasing in prevalence and importance as a means to better manage care. As such, developing the foundation to support these systems by the ALC care team seems both advantageous and necessary for ongoing success of the ALC.

**Conditions to focus on**

Although the PACE principles can provide the “how to” for improving care delivery, even greater focus has been provided by the Office of the Inspector General (OIG). In February 2014, the OIG released a report titled *Adverse Effects in Skilled Nursing Facilities—National Incidence Among Medicare Beneficiaries*. This report found that one-third of older adults in SNFs experienced an adverse event or temporary harm, and well over half of these were preventable. Although this report focused on SNFs, it can be used to identify issues plaguing any group of frail older adults. These identified areas would benefit from those PACE principles addressed and aiming them at the areas of:

- Delirium, especially with regard to falls
- Anticoagulation with regard to deep venous thrombosis, pulmonary embolism, and bleeding
- Bathroom issues such as constipation, urinary tract infections (UTI), and *Clostridium difficile*
- Dehydration
- Infectious disease management, especially with regard to UTIs and *C. difficile*, as well as respiratory and surgical site infections

By applying the PACE principles to these five areas, ALC providers can improve the lives of the older adults they care for in their community. This effort could have tremendous results for the ALC and beyond.

**Starting a new beginning**

The goal of improving quality of, access to and cost of care for older adults cannot be accomplished with the same systems we have worked with for years. Albert Einstein said, “We cannot solve a problem by using the same kind of thinking we used when we created them,” although at times it seems like we sure think we can. Perhaps now is the time for ALCs to apply some of the learnings from PACE and not only apply them to their residents, but also consider opening up services to the entire community they serve and focusing on those issues identified by the OIG. It may be that ALCs will be best served by thinking outside of the ALC box and using new care focus areas, such as those developed by PACE, and applying them through ACOs outside of the ALC and in the community.

**References**

4. [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html).