Effective health care management for the elderly is becoming increasingly important as the number of frail elderly requiring long-term care continues to grow. How can health care providers best serve the needs of this frail, elderly population? Models of care must incorporate cost effectiveness without compromising the quality of care or quality of life. Frail elders want to stay at home in their own community, but frequently their complex medical conditions and lack of resources make nursing home placement the only option.

BACKGROUND

The Program of All-inclusive Care for the Elderly (PACE) is an innovative long-term care model that allows frail elders to continue living at home. PACE delivers high quality, cost effective care managing their participants’ complex medical, functional, and social needs. PACE is the only program that integrates acute and long-term care service delivery and finance. PACE enables frail older persons who are eligible for nursing home care to continue living in the community with the full spectrum of medical, social, and rehabilitative services (Eng et al., 1997). The PACE model of care was created in the early 1970’s in an effort to help the Chinese-American community in San Francisco care for its elders in community settings as nursing home placement was not a culturally acceptable solution (Greenwood, 2001). Based on the British Day Hospital model, community leaders believed that day health and social services would enable their neighborhood’s frail older adults to delay or even avoid nursing home placement. The model was tested through CMS (then HCFA) demonstration projects that began in the mid-1980s. The Balanced Budget Act (BBA 1997) established the PACE model of care as a permanent entity within the Medicare program and enables states to provide PACE services to Medicaid beneficiaries as a state option. Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care by the appropriate state agency. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees assuming full financial risk for participants’ care without limits on amount, duration, or scope of services.

PRACTICE INNOVATIONS

Interdisciplinary Team Each morning an Interdisciplinary Team (IDT) consisting of physicians, nurse practitioners, physician assistants, nurses, social workers, therapists, van drivers, dieticians and aides meet to manage the changing needs of their PACE participants. Emphasizing creativity and flexibility, this team approach allows much more information to be available at the critical points decisions are being made.

Access to Primary Care All PACE participants have a close and ongoing relationship with their primary care physician (PCP). A usual caseload of 120-150 participants allows
the PCP to perform frequent assessments and treatment interventions for their frail elderly patients. PACE places a priority on the best interest of the individual with an emphasis on continuous assessment and aggressive prevention strategies without the restriction of fee-for-service reimbursement.

**Payment System**  PACE sites receive a monthly capitated reimbursement from Medicare and Medicaid. By optimizing preventive, restorative, and palliative care, inappropriate and expensive hospital and nursing home utilization are avoided.

**Adult Day Health Center (ADHC)**  The ADHC serves as a social center for participants and an efficient setting for the delivery of medical, therapy, and social services. PACE services are not time-limited or tied to an acute event or hospital stay. PACE services are center-based. The ADHC gives care providers greater opportunity to note changes in patient’s health status and implement prompt interventions.

**Transportation**  Van drivers are valuable IDT members providing transportation to the ADHC and specialists appointments, as well as delivering meals, incontinence supplies, and medications. This ability to provide mobility and necessary support services allows frail participants to remain living in the community.

**OUTCOMES**

**Target Population Served**  PACE sites serve a population having risk factors for institutional care with less than 5% being institutionalized. A typical PACE participant is 80 years old, has an average of 7.9 medical conditions and three activities of daily living limitations (Gross et al., 2004).

**Cost Effectiveness**  Medicare compared costs for PACE with the costs for a similar frail elderly population under fee-for-service Medicare finding PACE costs 38% less for the first 6 months of enrollment (Bodenheimer, 1999). PACE also saves money for state Medicaid programs with states paying 85% to 95% of the cost of care for a comparable non-PACE population.

**Utilization of Institutional Care**  Despite their greater morbidity and disability, hospital days for PACE participants are comparable to the general Medicare population (Wieland et al., 2000). While 50% to 70% of severely ill patients are reported to want to die at home, only 20% actually die at home or in hospice (Temkin-Greener and Mukamel, 2002). By comparison, 45% of PACE participants die at home reflecting the PACE goal of honoring individual’s preferences and delivering quality end-of-life care.

**BARRIERS TO GROWTH**

**Development**  Although the BBA cap for PACE sites is currently 180, there are currently only 34 PACE sites in 22 states serving 11,000 participants. Growth of PACE sites has been slow with significant upfront investment required to procure the necessary facilities, set up risk reserves, provide cash flow, and hire staff. Sponsoring organizations
(hospitals, health care systems, long-term care systems) typically subsidize the PACE site for several years with the goal that the PACE site will eventually become self-sustaining.

**Failure to Attract the Middle Income Market** Currently, PACE is primarily a program for people who are eligible for Medicare and Medicaid (95% are dually eligible). The majority of frail elderly are covered by Medicare but not poor enough to receive Medicaid benefits. Medicare-only participants would need to spend a median of $2,841 monthly to enroll in PACE (National PACE, 2003). These high out-of-pocket expenses make it difficult to expand PACE into the middle income market.

**Choice of Primary Care Physician/ Involvement of Community Physicians** Prospective PACE enrollees are often reluctant to give up their primary care physician in order to enter the program. Several PACE sites are piloting programs where participants can keep their primary care physician and still enroll in PACE. Community physicians often see PACE as a competitor and are reluctant to refer their patients. Educating community primary care physicians and specialists on the PACE model is very important to the growth of any individual PACE site.

The PACE model is an integrated health delivery model offering cost effective and high quality care to frail elderly with complex medical, functional, and social needs. Future growth of PACE and other integrated care models will depend on commitment of funding from federal and state legislative bodies to assist healthcare systems with development and start-up costs.

REFERENCES


