PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Integrated care at Midland Care Connection, Inc.

The Program of All-inclusive Care for the Elderly (PACE) began more than forty years ago as a small adult day center in the heart of San Francisco and grew into a program with a national footprint. Funded and administered by the Centers for Medicare and Medicaid Services, PACE is currently operating in 90 locations across the United States, deploying innovative means to provide integrated care for the frail elderly.

One such thriving PACE is housed at Midland Care Connection, Inc., under the leadership of Midland Care’s CEO Karren Weichert and the primary PACE medical director, AAHPM member David Wensel, DO FAAHPM. In the six years since its inception, Midland Care’s PACE has grown from 21 participants to nearly 130. Covering Topeka, KS, and its seven surrounding counties, the program helps older adults and individuals over 55 living with disabilities remain independent in their own home. Midland Care’s PACE participants have an average of 12 diagnoses, so it uses an Interdisciplinary Team to provide each with an assessment, a care plan, and the full range of services they require. These services are offered primarily in the program’s Adult Day Centers, at which participants can receive medical care, meals, socialization, assistance with medications, therapy services, necessary specialist visits, or home support when needed.

AAHPM caught up with Wensel to discuss how PACE has been ahead of the curve in integrating and coordinating services for decades.

**What’s innovative about your program?**

**DW:** PACE is actually well-established, but it has elements that are common in newer approaches to care coordination. It was chosen as an alternative to the three managed care programs under KANCARE, Kansas’ Medicaid Managed Care program launched this year. That shows, I think, that PACE and its underlying strengths have a role in the changing healthcare landscape.

Participants get a comprehensive array of services from a team of professionals including physicians, nurses, social workers, home health aides, dieticians, physical and occupational therapists and others. So, what they’re actually receiving is good palliative care and good hospice care over a longer period, since we are not restricted to a prognosis of six months or less. In that way, PACE is a model based on how interdisciplinary care can be used to make primary care better.

**What was the motivation behind the program’s creation?**

**DW:** PACE focuses on keeping frail elderly patients living safer and longer in the community through better-coordinated care and the help of their families. The model works medically and financially toward those ends.
How was institutional/financial support for the program generated and maintained?

DW: Midland Care Connection has a track record of serving this patient population that goes back three decades. It’s operated a hospice program since the days when having a hospice program was an innovation in-and-of-itself. It opened a Hospice House in 2000 and licensed a residential facility in 2004. Because of this experience, the Board of Directors and organizational leadership was fully supportive when they were approached by the National PACE Association to develop a program.

Our PACE program doesn’t have a specific budget since it is funded through a monthly per diem based on the patient’s diagnosis, the county Medicare frailty index, and self-reported functional status. It’s funded by Medicare and Medicaid only, so the program was sparked and has been moved forward by Midland Care’s commitment to supporting the frail elderly in the communities that it serves.

What metrics are you using to evaluate the program? What has the data shown?

We monitor hospitalizations, visits to the emergency department, clinic visits, Adult Daycare attendance, pharmacy utilization, and use of specialist. We also use the Kansas TPOPP (Transportable Physician Orders for Patient Preferences) to document advanced directives and align the direction of a patient’s medical care based on their goals of care.

The National PACE Association has published all the data that has been collected up to now, and the data show that patients in PACE – compared to patients in usual medical care living in nursing facilities – spend less time in the hospital, live longer, and are less costly. They all report that the quality of care they are provided is better.

What lessons have you learned as you’ve engaged in this work? Any advice to colleagues in the field who may wish to promote a similar initiative?

DW: I’ve been the primary medical director for PACE for 3 years now, and the outcomes have far exceeded my expectations. We provide better-coordinated care for people who would most likely be living in nursing facilities without our help.

Along the way, I learned that some focus has to go toward controlling the cost so that the program is able to continue. It takes time, but it is also something that has to be pushed forward. Had I known this going in, we would have become financially viable sooner and I would have taken the program to the next level faster.

For more information on this project, contact Midland Care Connection, Inc. at (785) 232-2044, and for more information about PACE, go to www.npaonline.org. If you would like to contact David Wensel directly, he can be reached at dwensel@midlandcc.org.