REQUEST FOR INFORMATION:
IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Program of All-Inclusive Care for the Elderly (PACE)

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Identifying Beneficiaries with Social Risk Factors

Program of All-Inclusive Care for the Elderly (PACE) organizations are unique health plans and care providers, committed to keeping older adults with challenging healthcare conditions in their home, by caring for their medical, physical, and social needs. In order to be eligible for PACE, individuals must be 55 years old or older, live in a PACE service area, meet a nursing facility level of care, and be able to live safely in the community with support from PACE. Approximately 90 percent of PACE participants are dually eligible for Medicare and Medicaid, representing a population with lower socioeconomic status, inequitable access to good health care, and overall greater disease burden than the average Medicare beneficiary.

PACE organizations design and utilize best-practice assessment and intervention methods to address the interrelationship between the complex health conditions and associated social risk factors affecting the overall well-being of participants. Possibly the most important aspect of the PACE approach to identifying and addressing social risk factors is the design and function of the interdisciplinary team (IDT). The IDT includes experts from eleven disciplines who work together to treat not just a symptom, but the entire person. Disciplines include a Day Health Center Manager, Primary Care, Nursing, Physical Therapy, Occupational Therapy, Social Work, Recreational Therapy, Dietary Services, Transportation, Personal Care Services, and Home Care Services.

The assessment process for PACE participants begins prior to enrollment. PACE participants are assessed during the intake process by a nurse and/or social work intake coordinator using a semi-structured interview and various screening measures not only to determine eligibility for PACE, but also to gather robust information to assist in beginning to build a person-centered plan of care. Once eligibility requirements are determined, the participant candidate is transported to the center to be evaluated by the primary care team and other disciplines, depending on the most pertinent presenting issues. This assessment allows the IDT to continue gathering information to add to the plan of care, which is immediately implemented upon enrollment. Once enrolled, new participants are assessed by all disciplines within the first month (initial), then on an ongoing basis every six months (semi- and annual), and also as needed any time there is a change in the participant's status. Each discipline, based on their area of expertise, uses structured and semi-structured best-practice assessment methods to obtain, synthesize, and interpret information that contributes to the building and ongoing review and updating of the individualized, person-centered plans of care.

Pre-enrollment intake assessments are intended to give an overarching summary of a participant's history and current presentation including not only medical issues, but a thorough biopsychosocial review of one's socioeconomic position; race, ethnicity, and community context; gender; social relationships; residential and community context; legal issues (including advanced care planning and health care proxy). Once enrolled, all participants are assigned a social worker. Upon enrollment, at every six month assessment, and as needed, social workers are reviewing these social risk factors and recommending interventions based on identified changes in status and needs. Additionally, social workers assess for and intervene and/or recommend interventions to address caregiver burden. As PACE is not a 24-hour facility, caregivers are looked at as instrumental 'partners' in caring for participants and keeping them independent in their own homes. All other members of the IDT are sensitive to and cognizant of the interrelationship between medical conditions and social risk factors, which includes utilizing assessment tools containing items that address social determinants of health and a multi-disciplined approach to care planning and problem solving (the IDT meets every day).

Individual PACE organizations are always seeking to expand upon the minimum requirements of the traditional PACE model in order to enhance the care delivered to participants. PACE Southeast Michigan (PACE SEMI), Huron Valley PACE, Senior Care Partners PACE, Genesys – PACE of Genesee County, and the other PACE organizations in the state of Michigan have developed and implemented several innovative initiatives and approaches to both identify and address the social risk factors of their participants.

With regard to improving the identification of social risk factors and the impact they have on the overall well-being of participants, PACE SEMI developed and implemented an acuity measure, which seeks to identify participants who are at greater risk for utilization of avoidable ED visits, 30-day hospital readmissions, and nursing home placements. The tool identifies and synthesizes scores based on multiple variables including, 'Disease', 'Behavioral', 'Social', 'Utilization Risk' (history), and 'Care Management Risk' (history). Implemented in early 2018, the tool has already demonstrated promise in identifying and care planning for risk factors that affect overall utilization, including social risk factors. In conjunction with the use of the acuity measure, PACE SEMI has implemented Utilization Management workgroups at each of its centers. The purpose of the groups is to review utilization data and trends in order to enhance the plans of care for participants and subsequently improve the organization's utilization numbers overall. Similarly, Huron Valley PACE has developed and implemented a comprehensive Utilization Management Plan. The utilization management focuses on maintaining high-quality, medically necessary and cost-efficient treatment for all participants. The Utilization Management Plan ensures that participants receive medically necessary and appropriate care at the appropriate time and in the appropriate setting. Huron Valley PACE and Senior Care Partners PACE have both implemented a 5 Star Risk Care Model. This model focuses on participants that are recently discharged from hospitals or skilled nursing homes. Huron Valley PACE's IDT members identify participants for 5 Star list based on their professional oversight and comprehensive assessments. More intensive monitoring and support is provided to those identified participants. Interventions are developed and implemented to minimize or eliminate the risk. When the goal(s) is met, the participant is removed from the 5 Star list.

Approaches to Address the Needs of Beneficiaries with Social Risk Factors

PACE organizations regularly provide 'all-inclusive' care that is designed to address the needs of participants with social risk factors. Services are truly comprehensive and fully integrated and address from top to bottom, all the needs a frail, nursing home eligible older adult requires to live independently in the community. Primary care and nursing providers focus on complex medical needs while social workers actively address all social risk factors that are interwoven and further add to the complexities of participants. Additionally, mobility, strength, and adaptive functioning, which are essential for independent living, are a few of the various focuses of physical and occupational therapy. Dietary services play an important function in addressing not only the nutritional health of participants, but also social factors, as PACE dietary services assist with food insecurity issues through its frozen meals program. Home care, personal care, and transportation ensure that participants have what they need to live safely in a well-kept environment, appropriately manage activities of daily living, and travel safely to and from all appointments, respectively. Recreational therapy works to increase participant socialization and engages participants in meaningful activities inside and outside of the day health center to enhance their overall quality of life. The IDT as a whole, often through information obtained from the social work assessment, addresses caregiver-related issues including burden and burnout. Caregivers are viewed as important partners and services are designed to help them maintain their ability to function in the role (e.g., respite services; caregiver support groups).

PACE SEMI has developed and implemented various strategies to expand upon the traditional PACE model and to better address the social risk factors of its participants. A few of these include: (1) The expansion of 24-hour care coverage; (2) The addition of ancillary services; (3) The integration of Clinical Pharmacy Services with Primary Care; (4) The integration of Behavioral Health Services with Primary Care; (5) The development of a new care model – Participant Care Team (PCT); (6) The addition of Spiritual Care Services; (7) The implementation of End of Life Care; (8) Enhancing assistance with Medicaid redeterminations; (9) The development of a Philanthropic Community Giving Assistance program; and (10) the expansion of community-based partnerships. Taken together, all contribute to furthering the philosophy of providing 'all-inclusive care'.

1. **24-hour Care**: PACE SEMI has developed a process through which its primary care and medical coverage could be expanded and provided more thoroughly through the implementation of a 24-hour/365 day on-call answering and paramedic service. Huron Valley PACE, Senior Care Partners PACE, and other PACE organizations have also begun to utilize contracted community paramedic services.

2. **Ancillary Services**: In addition to traditional primary care, PACE SEMI understands, values, and provides for the needs of older adults, which include services such as dental, vision, audiology, and podiatry.

3. **Clinical Pharmacy Services**: Works closely with primary care to provide additional expertise around the appropriate prescribing, management, and oversight of medication utilization.

4. **Behavioral Health Services**: Works closely with primary care and the rest of the IDT to address the cognitive, behavioral, and emotional well-being of participants. Also addresses issues stemming from the growing number of participants presenting with serious mental illness and substance use disorder diagnoses.

5. **Participant Care Team (PCT)**: A participant-focused, proactive care-management model with a focus on Quality, Collaboration and Streamlined Communication, Assessment and Care Planning, Service Delivery, Prevention, and Optimal Health and Social Outcomes. Each participant is assigned to a core team of 'experts' including a Registered Nurse Case Manager, a Social Worker, a Nurse Practitioner, and a Licensed Practical Nurse.

6. **Spiritual Care Services**: Non-denominational services to address the spiritual, emotional, and relational well-being of participants. Other PACE organizations, including Genesys – PACE of Genesee County, have identified the need and demonstrated the benefits of including spiritual care services through the use of Chaplains and other types of spiritual care providers.

7. **End of Life Care**: Services to ensure quality of care, quality of life, and continuity of care for PACE SEMI participants, as well as, support to family and significant others, during end-of-life phases. The program is made available to participants with limited life expectancy, whose disease is not responsive to curative treatment, those who decline cure related treatment options, as well as, those who though currently stable, have advanced disease and would benefit from the program.

8. **Medicaid Redeterminations**: PACE SEMI recently added full time eligibility specialists to assist in unburdening participants through educating, guiding, and helping to obtain and process required documents during the annual Medicaid redetermination process.

9. **Philanthropic Community Giving Assistance Program**: Aims to raise and donate funds from community donors to keep participants with financial hardships safe and independent in the community by providing for basic and emergency needs when other avenues of assistance have been exhausted.

10. **Community-Based Partnerships**: PACE SEMI continually seeks ways to expand services by contracting with other community-based organizations. Since ensuring the safety of the living environment is critical for the well-being of older adults, PACE SEMI contracts with living facilities with different levels of care and other property management and home health care organizations that provide 24-hour per day staffing and medication management protocols.

Huron Valley PACE has also developed new initiatives and strategies outside of the traditional PACE model to address social risk factors including: (1) Communication "Aphasia" Group; (2) Men's Group; (3) Healthy Aging Group, (4) Wellness Group (focuses on healthy eating); (5) Food Pantry (partnership with local food pantry); (6) Holiday Meal Program (staff financed and supported); (7) Volunteer Program; (8) Intergenerational Program; (9) Positive Approach™ to Care (PAC) (education provided internally and to the community that offers practical and structured approaches for caring for individuals with dementia); and (10) Dance with Me (exercise group for individuals with dementia).

Senior Care Partners PACE expands upon the traditional model of care through (1) the creation of 'Intervention Toolboxes' targeted to meet specific care needs; (2) partnerships with local mental health agencies; (3) including both the participant and their family at care planning sessions as well as ongoing family meetings throughout the care process; (4) a thorough transition of care protocol to allow for seamless transitions throughout the healthcare continuum when needed; and (5) a robust triage process in which homecare and day center staff identify acute needs (clinic and homecare nurses are available for response to immediate needs).

Impact of Approaches on Quality

PACE organizations are required to regularly measure, monitor, and report various quality metrics, some of which include:

- Number of days in the community
- 30-day hospital readmissions
- Emergency department visits
- Falls
- Nursing home placements
- Per member per month cost

Various studies have demonstrated that despite the complex needs of its participants, the PACE care model contributes to the following positive outcomes (Beauchamp, et al., 2008; Eng, et al., 2015; Fretwell, et al., 2015; King et al., 2012; Segelman, et al., 2014):

- Participants stay in the community longer
- Improved access to and continuity of care

- Decreased rates of emergency department visits and hospitalizations
- Better medication adherence
- Significantly decreased isolation/loneliness
- Improved sense of community
- Improved mobility
- Happier, more satisfied participants
- Caregiver support and relief
- Full end-of-life care
- Per member per month cost savings over nursing home placements – this is why Medicare and Medicaid continue to fund the PACE model!

Strategies to Disentangle and Address Social and Medical Risks

As previously stated, members of the IDT have their own unique role in assessing and addressing the needs of participants, while at the same time, all remain sensitive to and cognizant of the interrelationship between social and medical risks. Depending on the discipline, the assessment being completed may dictate a focus that is more on medical risks (e.g., primary care; nursing) or more on social risks (e.g., social work; spiritual care). However, when the disciplines come together as an IDT to care plan for participants, assessment data and recommendations are based on a whole-person approach, as opposed to treating a symptom or single risk factor.

References

Beauchamp, J., Cheh, V., Schmitz, R., Kemper, P., & Hall, J. (2008). The effect of the Program of All-Inclusive Care for the Elderly (PACE) on quality: Final report. *MATHEMATICA Policy Research, Inc.*

Eng, C. E., Pedulla, J., Eleazer, G. P., McCann, R., & Fox, N. (2015). Program of All-inclusive Care for the Elderly (PACE): An innovative model of integrated geriatric care and financing. *J Am Geriatr Soc, 45*(2): 223-232.

Fretwell, M. D., Old, J. S., Zwan, K., & Simhadri, K. (2015). The Elderhaus Program of All-inclusive Care for the Elderly in North Carolina: Improving functional outcomes and reducing cost of care: Preliminary data. *J Am Geriatr Soc, 63*:578–583.

King, J., Yourman, L., Ahalt, C., Eng, C., Knight, S. J., Pe´rez-Stable, E. J., & Smith, A. K. (2012). Quality of life in late-life disability: "I don't feel bitter because I am in a wheelchair". *J Am Geriatr Soc*.

Segelman, M., Szydlowski, J., Kinosian, B., McNabney, M., Raziano, D. B., Eng, C., van Reenen, C., & Temkin–Greener, H. (2014). Hospitalizations in the Program of All-Inclusive Care for the Elderly (PACE). *J Am Geriatr Soc, 62*: 320-324.