Bloom S et al, 2021 Expanding Access to PACE (Program for All Inclusive Care for the Elderly) in a post-COVID Environment – Evolution and Growth of a Fully Integrated Model of Care
International Journal of Integrated Care 22(S1) A1, pp. 1-8, DOI: doi.org/10.5334/ijic.ICIC21162

WORKSHOP ABSTRACT

Expanding Access to PACE (Program for All Inclusive Care for the Elderly) in a post-COVID Environment – Evolution and Growth of a Fully Integrated Model of Care

21st International Conference on Integrated Care, Virtual Conference – May 2021

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Introduction

PACE organizations (POs) uniquely integrate all Medicare, Medicaid and medically necessary services and are considered the gold standard of person-centered, team-based care model. POs aim to optimize clinical and functional outcomes for the frail dually eligible older adult participants they serve resulting in fewer ER visits, hospitalizations and adverse outcomes . Recent surveys indicate that 97% of participants and their caregivers are highly satisfied with their care, 94% of whom live in non-institutional community-based. The National PACE Association (NPA) is undertaking efforts to expand access to PACE through its PACE 2.0 initiative. In this workshop, we will

- Provide an overview of PACE and discussion of its integrated operating and financial elements
- Describe PACE guiding principles, outcomes and benefits for high-cost and high-need older adults
- Discuss the evolution of PACE, and strategies for expanding access to a proven model of care

Background

PACE was created by On-Lok in the Chinatown neighborhood of San Francisco in 1971 as a community-based model of care for frail older adults. On-Lok received authorization for a federal demonstration in 1979, after which Congress approved a replication demonstration to ascertain the viability of the PACE. After a successful evaluation, the Balanced Budget Act of 1997 established PACE as a permanent Medicare benefit and a Medicaid state plan option. Today, there are 134 PACE sponsoring organizations, operating 272 PACE Centers that serve 54,000 culturally diverse frail older adults.

With the support of the John A. Hartford, the Gary and Mary West and the Weinberg Foundations, the NPA launched the PACE 2.0 growth initiative to increase both the number of participants served by PACE. The goal of PACE 2.0 is to increase the number of people served by PACE organizations from 100,000 in 2021 to 200,000 by 2028.

Aims and Objectives

- To inform audience of the organization, operations and benefits of PACE
- Outline how PACE addresses social determinants of care of PACE participants
- Encourage and support the adoption of integrated care strategies for high-cost and high-need older adults
- Describe strategies to expand access to PACE

Target audience

- Policy-makers, academia, developers, insurers and health care providers

Learnings/Take away

- Understand the PACE model of care
- Gain familiarity of how PACE generate positive health outcomes
- Identify opportunities for building strategic partnership to support value-driven population health management
- Learn how PACE is being expanded and evolving into the future

Format (timing, speakers, discussion, group work, etc.)

- Overview of PACE – (Shawn Bloom – 15 minutes)
- PACE Essential Elements and Role of Primary Care (Peter Degolia – 10 minutes)
- Economics and Expansion of PACE (Shawn Bloom - 15 minutes)
- Strategic Partnership to Support Integrated Population Health Management using PACE Model of Care - Case Study – (Ye Fan W. Glavin-; Peter DeGolia - 20 minutes)
- Discussion, Q&A (30 Minutes)