

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

If there is one idea that begins to address the multitude of challenges that the elderly population faces, it is PACE—Program for the All Inclusive Care of the Elderly. Build a PACE program that includes housing and you will address transportation, comprehensive health care, socialization, coordinating social services and in-home supportive services, nutrition, livable communities, recreation/socialization, and social isolation.

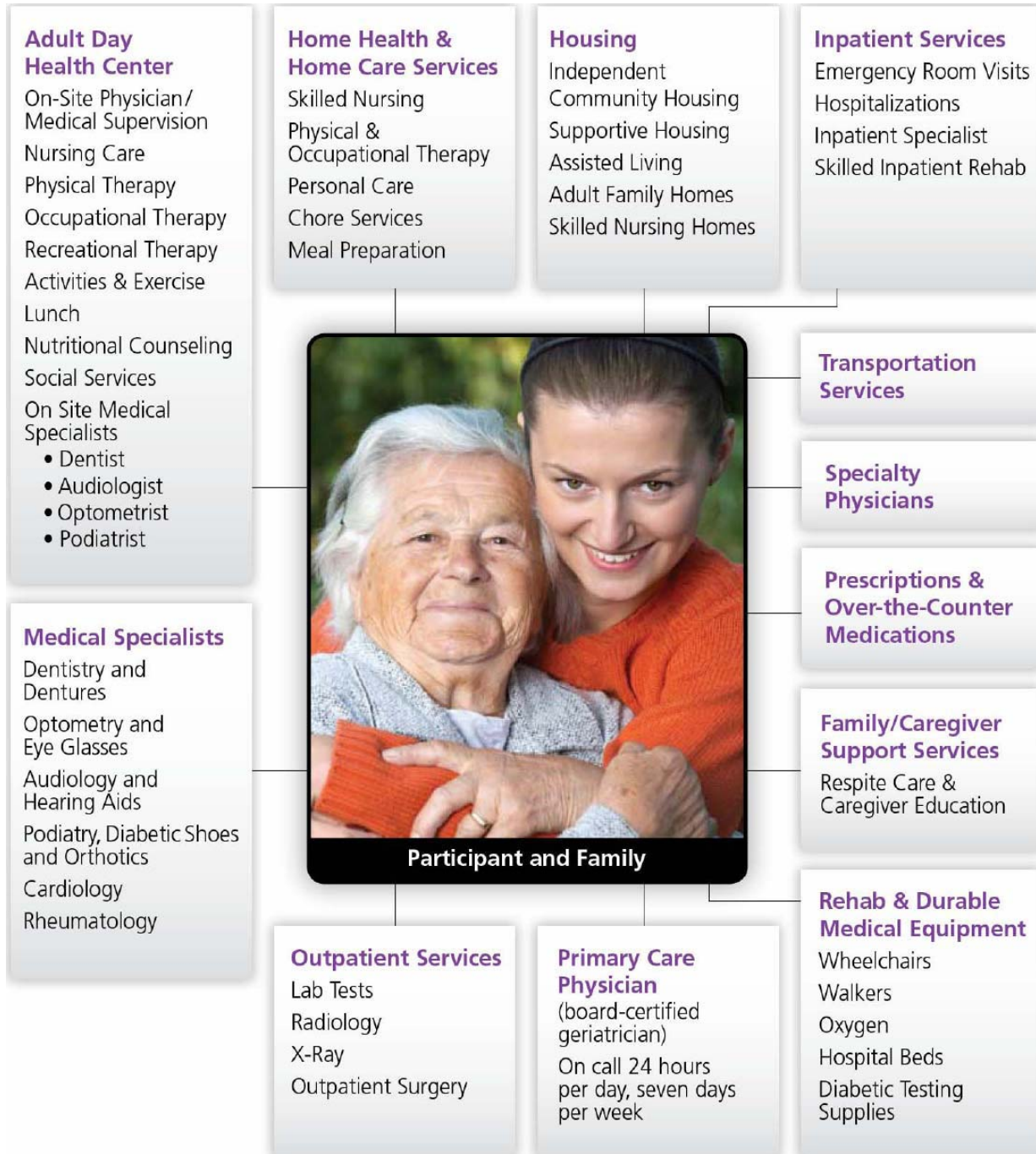
1. We all cross our fingers and hope we will be able to live independently and get decent health care. But here's what is happening now: turn 65 and you are bombarded by HMOs trying to get you to sign up. It's hard to figure out what the best plan is. Once you start using the insurance, you are hit with co-pays and additional fees that may put health care and prescriptions out of your reach. A senior or his family will spend hours, days, weeks, trying to get appointments and coordinate care among a dozen different health care providers. The health care providers don't always communicate with you or with each other, and you wonder and worry about the continuity of care—do you know everything you should, are you getting the best care possible? And then there is the problem of multiple health care appointments, scattered all across town—how does an elderly person who may not drive, may have trouble hearing, and may have trouble with memory, coordinate all these appointments and get transportation to them? Even if the elder has a caregiver, it is still complex, with significant gaps in services.

2. So far, the easy answer to all these problems has been to send people to nursing homes. Research indicates that few people wish to go to nursing homes, and we know that even today, on the leading edge of the Baby Boom tsunami, that there are not enough spaces in nursing homes, and many people can't afford nursing homes. Medicaid will pay for long term care, but Medicare will not, leaving out the majority of the population, who have Medicare and modest incomes—with a realistic fear that they will outlive their money.

3. The Program for the All Inclusive Care of the Elderly (PACE) has been around for 25 years, and there are about 40 operating around the United States. On Lok in San Francisco is probably the premier example: a comprehensive health care program, led by a multi-disciplinary team, and built around an adult day health care center that is its own HMO.

4. The HMO receives all the Medicare and Medicaid dollars a person is eligible for and is responsible for providing all the health care and supportive services the person needs out of those dollars, without additional co-pays or fees.
5. PACE programs employ an interdisciplinary team, led by a geriatrician, to assess needs, coordinate and provide care using an adult day health center as the hub. Participants come to the day care center at least twice a week for routine medical management and therapy—when the situation dictates, they come more often. They see all their specialists and ancillary providers at the adult day health center, and all their records reside there.
6. Some PACE programs provide housing for independent living in close proximity to the health center, eliminating or minimizing the need for transportation. This housing is not paid for out of health care dollars, but by Social Security or out of pocket, reserving Medicare and Medicaid dollars just for health care.
7. Here is how I propose to expand PACE programs:
  - a. PACE should be a local program with local partners—not an extension of existing HMOs. Each PACE program would create and manage its own HMO that will manage the Medicare and Medicaid dollars only of the people enrolled in their PACE program—the PACE program would be personally acquainted with everyone their HMO insures and make all their health care decisions based on the assessment of the in-house interdisciplinary team.
  - b. Local nonprofit providers of health care services—particularly agencies with experience operating Adult Day Health Care—should team up with property development companies that build and manage affordable housing for seniors and people with disabilities to live independently—ideally with spouses or family caregivers.
  - c. The health care providers would work with the property development company to design a facility for the PACE program inside the housing complex that would be easily accessible from the apartments without the use of vans.
  - d. All care and services—including in home supportive services—would be delivered from this one-stop shop health care center and managed and coordinated

by its staff: no running all over town, no frustrating efforts to get health care providers to talk to each other or send reports to each other.



**Required Components of a Program for the All-Inclusive Care of the Elderly**

Source: Providence ElderPlace, Seattle, WA,  
<http://depts.washington.edu/geron/images/09conf/kroll.pdf>

- **ADULT DAY HEALTH CARE:** Adult Day Health Care, which is reimbursed by Medicaid in very different ways from state to state, can do so much to manage and minimize the effects of chronic illness, and so much more affordably, than institutional care; yet CMS has been resistant to supporting this model to its full potential. In some communities, a day care program may be more helpful than a senior center, and adult day care should be built into the OAA as a community option, while efforts should be made to ally AoA and CMS in this effort. At the same time CMS, and perhaps AoA, needs to get better regulatory controls to put an end to the fraudulent for-profit ADHCs that are sapping the resources of this program without adding medical value.
- **AGING AND DISABILITY RESOURCE CENTER (ADRC):** Direct OAA IRA funding to the creation of more regional ADRCs. The small amounts of money allowed for IRA, combined with complexity of creating and maintaining a robust IRA system is beyond a single small or mid-sized social services agency; but combining this funding and focusing it on dedicated regional ADRCs not only promises the effective execution of this function, but creates a point in the community around which the aging and disability communities can coalesce as well as a pulse point where trends and immediate needs can be identified.
- **Community-Based Senior Multi-Purpose Centers:** Look at models such as St. Barnabas Senior Services, Hollywood MPC or ONE Generation in Los Angeles as examples of a center that is truly integrated into and accessible to low to moderate income seniors with the full array of OAA services plus some very innovative programs. However, we need to consider how relevant senior centers are to the new seniors and imagine new models.
- **Case Management Private-Public partnerships:** Encourage for-profit and nonprofit senior apartment buildings to house and perhaps reimburse social service coordinators and care coordinators to assist elderly residents. HUD funds some social services coordination for low income senior housing, but the coverage tends to be spotty. In addition, social service coordinators who work for residential managers can be perceived by residents as having a conflict of interest—working with management to evict residents who have problems is a frequent concern expressed by residents—which is detrimental to the helping relationship that a social service coordinator can offer to the benefit both property managers and residents. This idea should be promoted among senior housing facilities for more affluent seniors as well as low income seniors, because the needs are much the same regardless of wealth, and a social services coordinator/care coordinator could be equally valuable to all.