
McGregor
PACE

The Program Of All-inclusive Care for the Elderly (PACE):

Improving the Care of Older Adults at Risk for Nursing Home Placement

Tangi McCoy, Chief Executive Officer, MPA, LNHA
Kim Henderson, Chief Financial Officer, CPA, MBA
Peter DeGolia, Medical Director, MD, CMD

Case Western Reserve University School of Medicine
University Hospitals Cleveland Medical Center

Disclosures

- We have no financial or ethical conflicts of interest to disclose.
- Tangi McCoy is the CEO of McGregor PACE
- Kim Henderson is the CFO of the McGregor Organization to include, PACE, 2 Nursing Homes, Assisted Living Facilities, Independent Apartments
- Dr. DeGolia is the McGregor PACE Medical Director and one of 3 PACE primary care physicians. He is a Professor of Family Medicine at the Case Western Reserve University School of Medicine in Cleveland, Ohio. He is Board Certified in Family Medicine, Geriatric Medicine, and Hospice/Palliative Medicine.

Agenda

What is PACE?
- History
- Participant Eligibility
- Services

The PACE Revenue Model
- Current statistics
- Census

Why PACE
- The Problem
- What makes PACE unique
- Case Studies

What is PACE?

- Program for All-Inclusive Care For the Elderly
- Coordinates and provides ***all*** preventive, primary, acute and long term care services
- Primary care delivered through (2) PACE Centers and (1) alternative location
- Interdisciplinary care management team meets daily, disciplines include: Provider, RN, OT, PT, MSW, RD, Transportation, Activities, Day Center Manager, Center Assistant, HomeCare Coordinator
- Regulated by Centers for Medicare and Medicaid Services (CMS) and Ohio Dept. of Aging (ODA)
- More than 40 affiliated service providers/partnership in our network

Historical Origins

1971

On Lok in San Francisco, California

Formed in response to community concern for the older adults in Chinatown

1986 – 1994

Successful CMS Demonstration Project

2000

RWJ and Hartford Foundations Fund PACE Expansion Initiative

Federal / State / Local Partnership with specific rules and regulations

McGregor PACE History

1998

McGregor PACE's predecessor, Concordia Care founded

2010

McGregor assumes Concordia Care sponsorship, caring for 167 Participants

2011

McGregor PACE is able to actively enroll participants

239 PACE Centers in 32 states

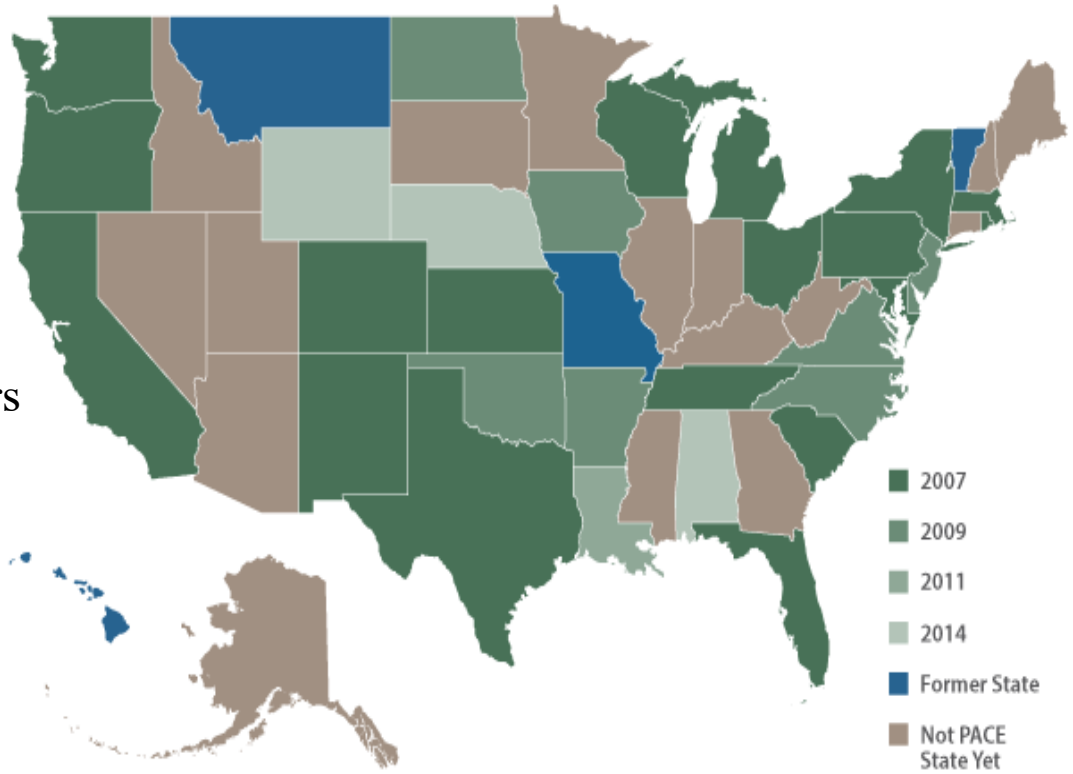
2018

McGregor PACE has almost 600 seniors in Cuyahoga county

2019

PACE is a *PARTNERSHIP* between the Federal Government, (ODA) the State Government, (CMS) and a local Sponsor (McGregor PACE)

- Center for Medicare and Medicaid Services (CMS)
- 32 State partners
- 122 Sponsoring Organizations
- 239 PACE Centers



- 50,000+ participants
- 100% need nursing home level of care
- 95% live in the community
- 5% live in a nursing home

Program Essentials

4 Basic enrollment criteria

- Must meet nursing home level of care
- 55 years or older
- Live in Cuyahoga County
- Living safely in the community at the time of enrollment
  - Cannot live in an institutional setting (i.e. hospital, nursing home)

State-based nursing home level of care criteria – (Ohio)

- Requires 24 hour supervision,
- OR 2) dependent in IADLs plus assistance in 1 ADL plus medication management,
- OR 3) dependent in IADLs plus assistance in 2 or more ADLs

Program Essentials

IADL

(Instrumental activities of daily living)

- Preparing meals
- Shopping
- Housekeeping
- Laundry
- Med Administration
- Transportation

ADL

(Activities of Daily Living)

- Eating
- Bathing
- Dressing
- Toileting
- Mobility
- Grooming

McGregor PACE Services

- Adult day care
- Primary and specialist physician services
- Case management and social work
- Physical, Occupational and Speech Therapy
- Inpatient hospitalization
- Pharmacy (Medicare part D plan)
- Home support - homecare nursing; safety
- Emergency room coverage
- Cover all Medicare & Medicaid services
- Transportation

McGregor PACE Care Sites

Senior Health & Wellness Center	Emery Road

12,079 square ft
220 participants

22,212 square ft
220 participants

Transportation

Basic Revenue Model

Three main revenue streams:

- Medicare - Risk-adjusted, per member per month *capitated* payment from Medicare ~$2,700 PMPM
- Medicaid – fixed monthly payment regardless of living in community or nursing facility ~ $2,900 PMPM
- Medicare Part D - pharmacy benefits included in PMPM payment ~ $900 PMPM

Managed Care Model: surplus from healthier participants offsets deficit from those more needy

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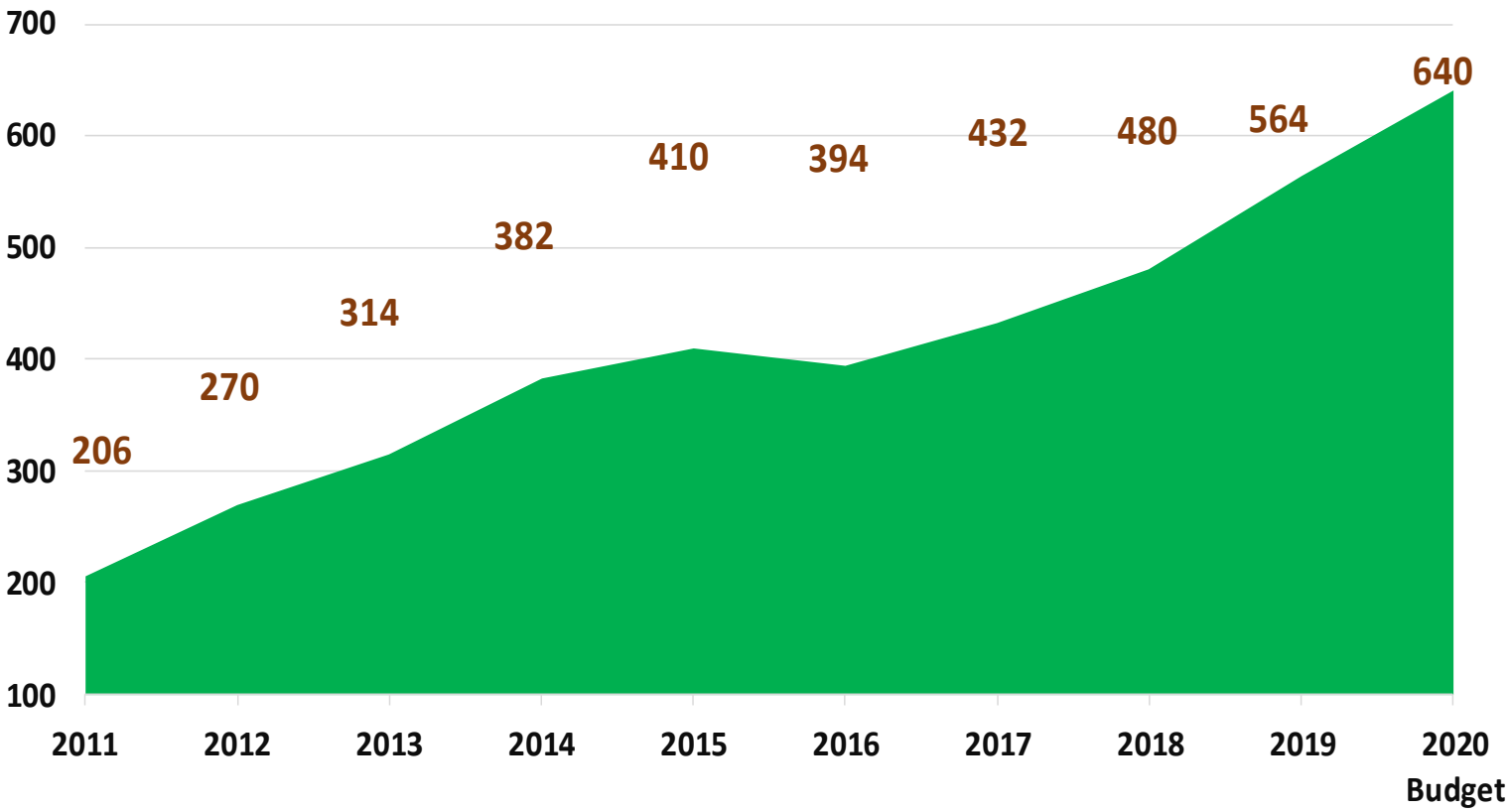
Historical Average Census Growth



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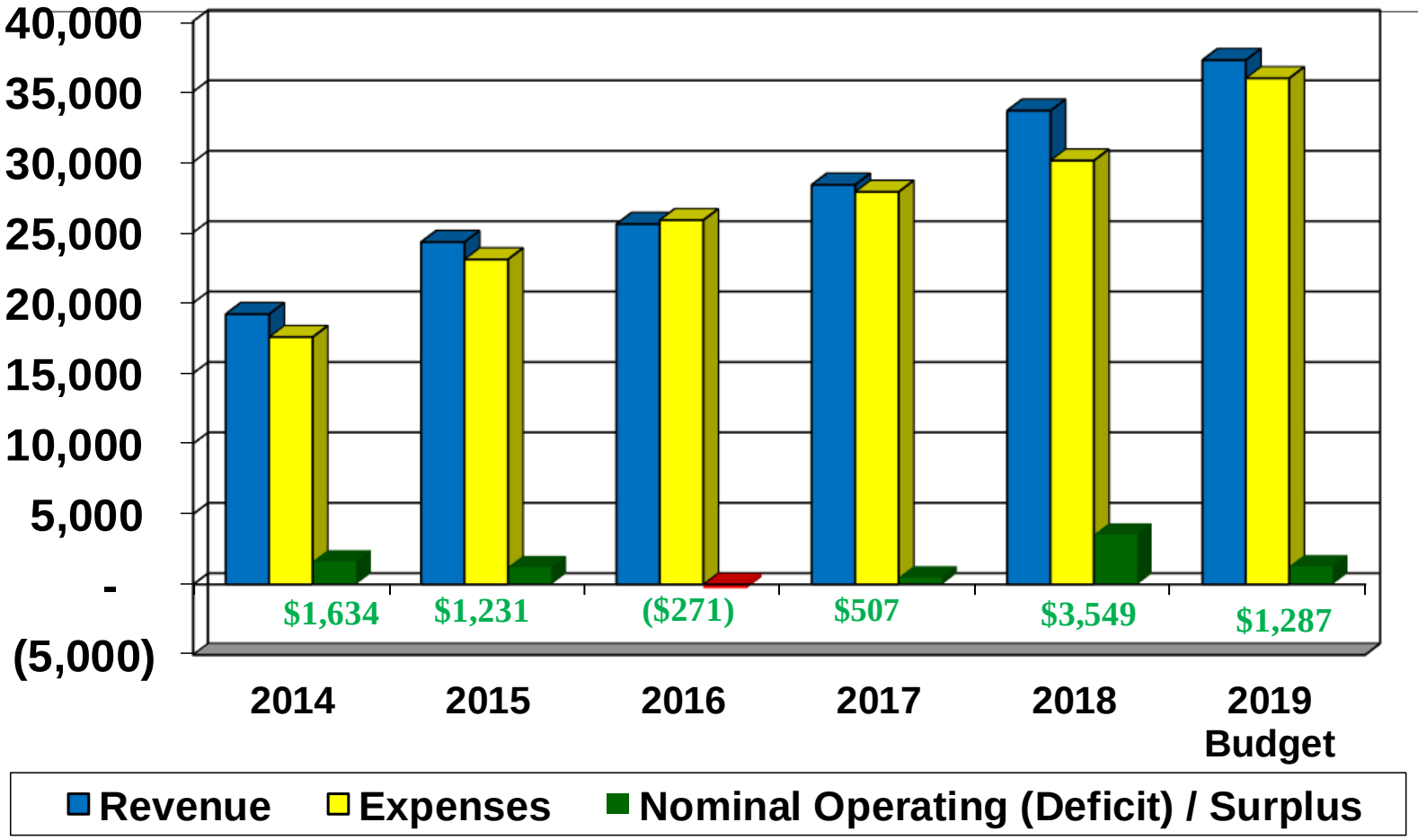
Historical Nominal Operating Margin (EBIDA)



Successful Program Attributes

- Physician commitment to business model
- Sufficient local need to maximize census
- Interdisciplinary team management
- Community recognition and support
- Service delivery model – location, timing, need
- Healthcare community engagement
- Reserve management

Strategic Advantages

1. Aligns with McGregor's Mission
   - ***Supporting Seniors in Need and those who serve them***
2. Strong demand for PACE services – Not reliant on a bed or a room
3. Broadens opportunities for McGregor colleagues

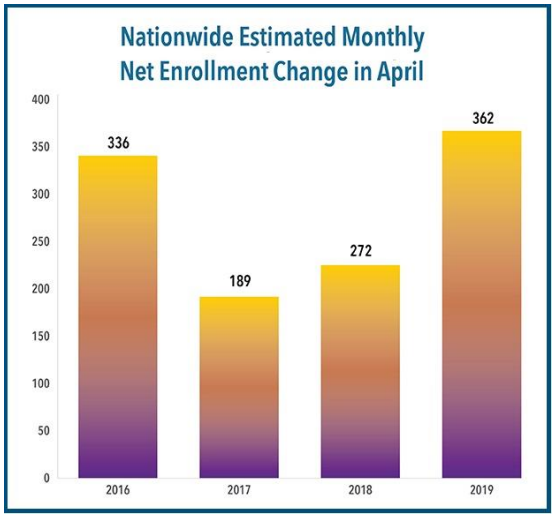
PACE by the Numbers

- PACE serves seniors
- 95% live in the community
- Average age is 76 years
  - 70% are women, 30% are men

PACE by the NUMBERS

PACE is Growing

- As of July, 2019:
  - 129 Sponsoring Organizations
  - 263 PACE Centers
  - Enrollment exceeds 50,000 patients



PACE by the NUMBERS

PACE saves taxpayer dollars

- States pay PACE program 13% less than the cost of other Medicaid services

NPA Analysis of PACE upper payment and capitation rates, March 2017

The Effect of PACE on costs, nursing home admissions and mortality: 2006:2011. Mathematica Policy Research evaluation prepared for US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disablity, Aging and Long Term Care Policy (2014)

The Problem

Fragmented care

The traditional healthcare model – reactive care

Loss of the patient and caregiver voice

Rising costs of healthcare

- Unnecessary services
- Disconnection between service provider and insurer

Case Study #1

Mr. S was an 83 years old man who moved into the WOS ALF in 2012. He used his life savings and spent down into poverty after 2 years at the ALF. The facility wanted to retain Mr. S and contacted McGregor PACE. Approximately 12% of this facility's residents are enrolled in the Ohio Medicaid waiver program. Mr. S had vascular dementia with HTN and end stage renal disease. He chose not to pursue dialysis. Until his death due to CKD stage 5 in 2016, he required only assistance with tub transfers and bathing. He was dependent in medication management. Routine and acute care PACE team visits managed Mr. S's medical care in the facility without hospitalizations or ED visits.

Case Study #2

Mrs. A was a 100 year old woman with mixed dementia who aged in place in her home with the care and support of her family. As time progressed, Mrs. A was dependent in all of her ADLs except eating which she required set-up and encouragement only. As her condition declined and her needs, McGregor PACE increased services and support for Mrs. A and her family until the ability of her family to manage her care became to much for them. Mrs. A was transferred to Nursing Facility for the last 3 months of her life. Routine and acute care by the PACE team prevented ED or hospitalizations during her 6 years in PACE. PACE IDT members continue to work closely with Mrs. A and her family until her peaceful death.

Case Study #3

Mrs. J is a 76-year old woman, private patient of Dr. DeGolia's, who lived in senior housing for 3 years before moving to the an ALF 1 years ago. She has multiple chronic medical problems including HTN with CKD, chronic diastolic heart failure, and DM with complications requiring insulin. The ALF she moved into has nearly 100% Ohio Medicaid waiver residents. Whenever Mrs. J has a change in condition (uncontrolled DM or HF exacerbation are most common), she is sent to the local ED. Since moving to the ALF, she has been hospitalized 3 times - once following a fall without injury (sent out per facility protocol), once for hyperglycemia with confusion, and once for SOB.

Traditional Healthcare Models

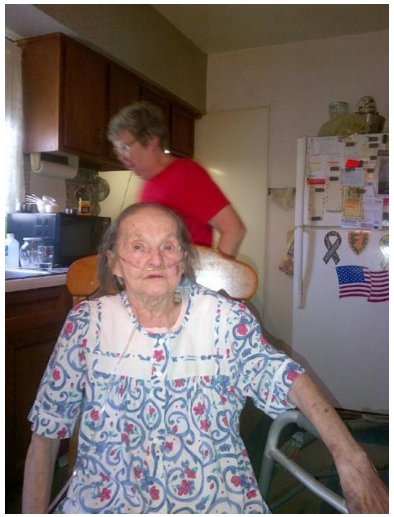
Traditional healthcare is reactive.

- The primary approach is to treat, not prevent
- When ill, then seek care
- Requires the patient to figure out when to get help – they wait too long!
- Very limited opportunities for regular observation and ongoing education
- Poor communication with limited ability to coordinate care among multiple providers and disciplines

The PACE Model of Care

The PACE Model of Care is centered on the belief that it is better for the well-being of older adults with chronic care needs and their families to be served in the community whenever possible.

- Ongoing observation and communication
- Coordinated and all-inclusive care
- Rapid access to health services
- Team-based care



Critical clinical components to a PACE organization's success

Proactive team-based care

Communication among team members and

patient/family members

Knowing a participant's baseline health status

- Actively managing chronic diseases

Early recognition of a change in a participant's condition

Early access to care

Care coordination and care navigation

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Benefits of Proactive Care for Participants and Families

Improve the quality of life for participants and families

Slow the decline of chronic diseases and stabilize a participant's health

Decrease exacerbations of chronic disease symptoms and acute episodes requiring ED / hospitalization

Improve daily well being with better symptom management

Benefits of Proactive Care for the Providers of Care

Decrease cost of healthcare for frailest population

- **Pay for less costly care (wellness) to save on more costly care (acute exacerbations)**
- **Coordinate care to manage utilization of services and avoid unnecessary care**
- **Pay for nontraditional approaches that are more cost effective and with the same or better outcomes**

Professional satisfaction

Personal satisfaction

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McGregor PACE Census

As of 10/1/2019:

Participants: Currently 585

2 PACE Centers and 1 Alternative Site

Soon to open a 3rd PACE Center

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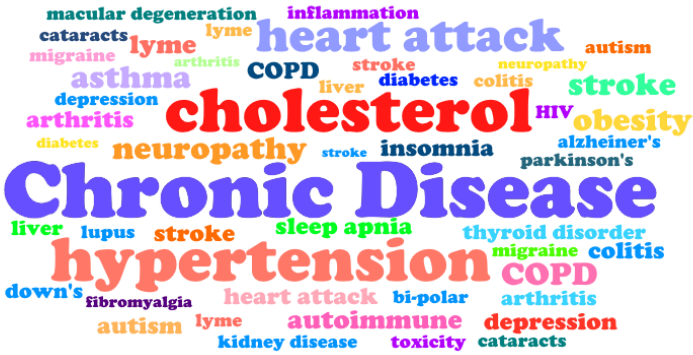
PACE by the NUMBERS

PACE serves impoverished older adults with chronic disease and disabilities

- ADL impairment
  - 26% with 1-2; 25% with 3-4; 35% with 5-6
- 5.8 Chronic conditions per patient
  - 46% have dementia
- 90% are dual-eligible
  - 9% are Medicaid only
  - 1% are private pay



PACE by the NUMBERS

PACE provides high quality outcomes

- Reduced ED visits
  - On average, less than 1 ED visit per participant per year
- Reduced hospital admissions
  - 24% lower hospitalization rate than dually-eligible beneficiaries who receive Medicaid nursing home services
- Decreased Re-Hospitalizations
  - 16% less than the national rehospitalization rate of 22.9% for dually-eligible beneficiaries age 65 and over

Segelman, M; Szydlowski, J, Kinosian, B et al (2014), Hospitalizations in PACE. JAGS 62: 320-24.

PACE by the NUMBERS

PACE Provides High Quality of Life

- The Institute of Medicine report titled "Retooling for an Aging America" recognizes PACE as a Model of Care with the capacity to bring geriatric expertise and care coordination to the needs of older adults.
- High Caregiver Satisfaction
  - 97.5% of family caregivers would recommend PACE to someone in a similar situation

NPA (2018) PACE reduces Burden of Family Caregivers. 8/30/2018.

Summary

McGregor PACE is one of 129 PACE programs in 31 states

PACE programs are growing rapidly in Pennsylvania, Michigan, and Indiana

McGregor PACE is serving older adults with complex chronic diseases who are at risk for nursing home placement

PACE is effective at managing chronic diseases, improving patient and caregiver quality of life, and reducing the overall cost of care to Medicare and the State of Ohio because

- Team-based coordinated care
- All-inclusive
- Fully capitated
- PACE Centers promote socialization and offer rapid access to care

THANK YOU!

Questions?

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