ATTACHMENT 7
From NC Division of Medical Assistance
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PACE – General Overview:

The Program of All-inclusive Care for the Elderly (PACE) model is centered around the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.

PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area. Although all PACE participants must be certified to need nursing home care to enroll in PACE, only about seven percent of PACE participants nationally reside in a nursing home. If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care.

Services: Delivering all needed medical and supportive services, the program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. Care and services include:

- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
- Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant
- Home health care and personal care
- All necessary prescription drugs
- Social services
- Medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
- Respite care
- Hospital and nursing home care when necessary

History:

The PACE model of care can be traced to the early 1970s, when the Chinatown-North Beach community of San Francisco saw the pressing needs of families whose elders had immigrated from Italy, China, and the Philippines for long term care services. Dr. William L. Gee, a public health dentist, headed the committee that hired Marie-Louise Ansak in 1971 to investigate solutions. They, along with other community leaders, formed a nonprofit corporation, *On Lok Senior Health Services*, to create a community based system of care. *On Lok* is Cantonese for "peaceful, happy abode."

1971	William Gee, DDS, and two others execute articles of incorporation for the nonprofit Chinatown-North Beach Health Care Planning and Development Corporation (later renamed *On Lok Senior Health Services*) and retain Marie-Louise Ansak to study the feasibility of building a nursing home in the community. She finds a nursing home would be both infeasible financially and culturally inappropriate. Instead she obtains funding to train health care workers, in cooperation with University of California San Francisco. She also outlines a comprehensive system of care combining housing and all necessary medical and social services, based on the British day hospital model.
1973	*On Lok* opens one of the nation's first adult day centers in San Francisco.
1974	*On Lok* begins receiving Medicaid reimbursement for adult day health services.
1975	*On Lok* adds a social day care center and includes in-home care, home-delivered meals and housing assistance in its program.
1978	*On Lok*'s model of care expands to include complete medical care and social support of nursing home-eligible older individuals.
1979	*On Lok* receives a four-year Department of Health and Human Services grant to develop a consolidated model of delivering care to persons with long term care needs.
1983	*On Lok* is allowed to test a new financing system that pays the program a fixed amount each month for each person in the program.
1986	Federal legislation extends *On Lok*'s new financing system and allows 10 additional organizations to replicate *On Lok*'s service delivery and funding model in other parts of the country.

1987	The Robert Wood Johnson Foundation, the John A. Hartford Foundation and the Retirement Research Foundation provide funding to *On Lok* and the first replication sites to support their efforts.
1990	The first Programs of All-inclusive Care for the Elderly (PACE) receive Medicare and Medicaid waivers to operate the program.
1994	With support of *On Lok*, the National PACE Association is formed. 11 PACE organizations are operational in 9 states.
1996	21 PACE programs are operational in 15 states.
1997	The Balanced Budget Act of 1997 establishes the PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs.
1999	Interim Regulation published in November. 30 PACE programs are operational in 19 states.
2000	The Robert Wood Johnson Foundation and the John A. Hartford Foundation fund the PACE Expansion Initiative to assist the National PACE Association in expanding the benefits of the PACE model of care to more families in need.
2001	Alexian Brothers Community Services in St. Louis becomes the first PACE provider to become a full, permanently recognized part of the Medicare and Medicaid programs.
2006	Final Regulation published in November. Congress awards grants of $500,000 to 15 organizations for rural PACE expansion.
2008	43 PACE programs are operational in 23 states.

Why PACE?

Programs of All-inclusive Care for the Elderly (PACE) serve seniors with chronic care needs by providing access to the full continuum of preventive, primary, acute, and long term care services. PACE programs take many familiar elements of our traditional health care system and reorganize them in a way that makes sense to families, health care providers, and the government programs and others that pay for care.

For consumers, PACE provides:

- Caregivers who listen to and can respond to their individualized care needs
- The option to continue living in the community as long as possible
- One-stop shopping for all health care services

For health care providers, PACE provides:

- Capitated funding arrangement that rewards providers that are flexible and creative in providing the best care possible
- Ability to coordinate care for the individuals across settings and medical disciplines
- Ability to meet increasing consumer demands for individualized care and supportive services arrangements

For those who pay for care, PACE provides:

- Cost savings and predictable expenditures
- Comprehensive service package emphasizing preventive care that is usually less expensive and more effective than acute care
- A model of choice for older individuals focused on keeping them at home and out of institutional settings

FAQ's - Questions that families frequently ask about PACE

How do people qualify for PACE?

In order to be eligible for PACE a person must be aged 55 or older, certified by the state to need nursing home care, and live in an area served by a PACE program.

Are prescription drugs covered?

Yes. All prescription and non-prescription drugs deemed necessary by the PACE interdisciplinary care team are paid for by the PACE program.

How do people get to the day health center?

PACE programs provide transportation to the day health center. Transportation is a key part of the PACE benefit. Transportation is not only provided between the home and the day health center, but also to appointments with specialists and other activities.

Do PACE participants attend the day health center every day?

No. On average, PACE participants attend the day center three times a week. Day center attendance is based on individual needs and can range from once a week, or every month, to several days a week, as needed.

What happens if a PACE participant needs nursing home care?

The goal of PACE is to keep participants out of a nursing home as long as possible. If at some point it is in the best interest of the participant to receive care in a nursing home, PACE will pay for the care and the supervision of the interdisciplinary team will continue.

What happens if a person wants to leave PACE?

A PACE participant is free to disenroll from PACE and resume their benefits in the traditional Medicare and Medicaid programs at any time.

Why Consider PACE for the Future

- PACE provides a full range of preventive, primary, acute and long term care services that enable frail older individuals to live in the community as independently as possible.
- PACE provides care and services consistent with emerging consumer demands for individual choices in health care and services.
- PACE combines adult day settings, home care, interdisciplinary teams, transportation systems and capitated payment systems so providers can respond to the unique needs of each frail elderly individual served.
- Providers across the United States have successfully replicated the PACE model, demonstrating the value of high quality, individualized care PACE provides for its participants.

Who Does PACE Serve?

The typical PACE participant is very similar to the average nursing home resident. On average, she is 80 years old, has 7.9 medical conditions and is limited in approximately three activities of daily living. Forty-nine percent of PACE participants have been diagnosed with dementia. Despite a high level of care needs, more than 90% of PACE participants are able to continue to live in the community.