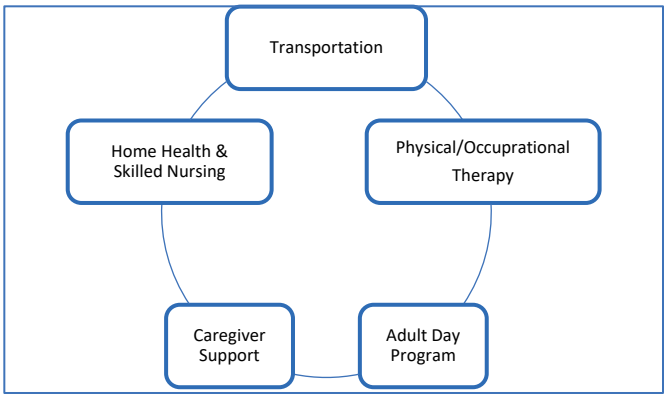
Successful Practices in Accountable Care: San Ysidro Health's PACE Program

Medicare's Program of All-Inclusive Care for the Elderly ("PACE")

PACE is a program that allows seniors who need nursing home care to continue living in their homes as long as possible. Categorized as a Medicare Advantage Plan, most PACE participants are low-income and dually eligible for Medicare and Medicaid. Eligible patients are 55 years or older, require the level of care required under the State Medicaid plan for coverage of nursing facility services, reside in the service area of the PACE organization, and must be able to live in a community setting without jeopardizing their health or safety *(42 CFR 460.150(b)(c)).*

PACE organizations serve as both the health plan and the provider of services, receiving a capitated Medicare and Medicaid rate to provide all services the patient – or *participan*t in the PACE world – needs (see graphic). A multi-disciplinary team including physicians, nurses, therapists, social workers, nutritionists, transportation aids, and caregivers meet to develop an individualized, comprehensive care plan that is monitored and reviewed regularly. PACE promotes independence and the highest levels of functioning while allowing choice and dignity for enrollees and their families. Overall, PACE participants demonstrate better health outcomes than their non-PACE senior counterparts, including but not limited to, lower fall risks.



Issue Brief Objectives:

- Learn the stages of decision-making and planning that goes into developing, managing, and expanding a PACE project at a community health center.
- Identify lessons learned impacting value-based care, care coordination, and other operational aspects of managing a PACE project at a community health center.

Contents

Health Center Profile – 2021

Health Center: San Ysidro Health

Location: Greater San Diego County, San Diego, CA

Number of unique patients served: 109,504 patients; 15,140 senior patients (age 65+); Total PACE Census – 1,853

Racial/Ethnic Diversity: 91,870 identify as a racial and/or ethnic minority (88%); 77,156 identify as Hispanic/Latino (73%)

Number sites: 50 delivery sites; 3 Mobile Units; 4 PACE Centers

Services offered: Integrated Primary Care including:

- Medical (primary and specialty care)
- Dental (primary care and specialty care)
- Behavioral Health (including Certified Community Behavioral Health Clinic)
- Acupuncture and Chiropractic
- HIV & LGBTQ+ services
- Substance Use Disorder Treatment
- Women, Infant, and Children (WIC) Nutrition and Senior Nutrition Program
- Social Services
- Case Management and Care Coordination
- *All of Us* Research Program

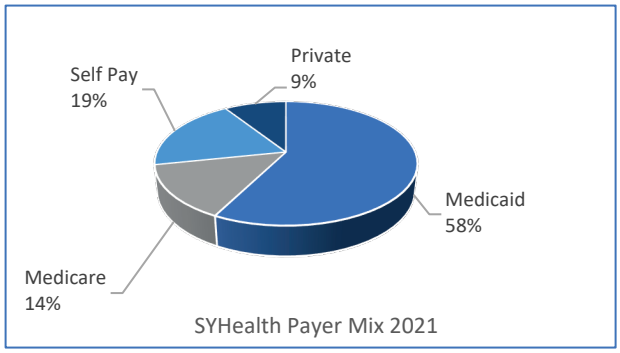
Workforce Development including:

- ACGME Accredited Internal Medicine (operated by San Ysidro Health)
- Family Practice Continuity Site (in partnership with Scripps Family Medicine Residency Program)
- Pediatric Dentistry Rotation Site (in partnership with NYU Langone Pediatric Dental Residency Program)
- Osteopathic Medicine Training Site (in partnership with AT Still University – School of Osteopathic Medicine in AZ)

Accreditations/Certifications: ACGME, CCBHC, PCMH III

Unique Feature: Fastest Growing PACE program in the US

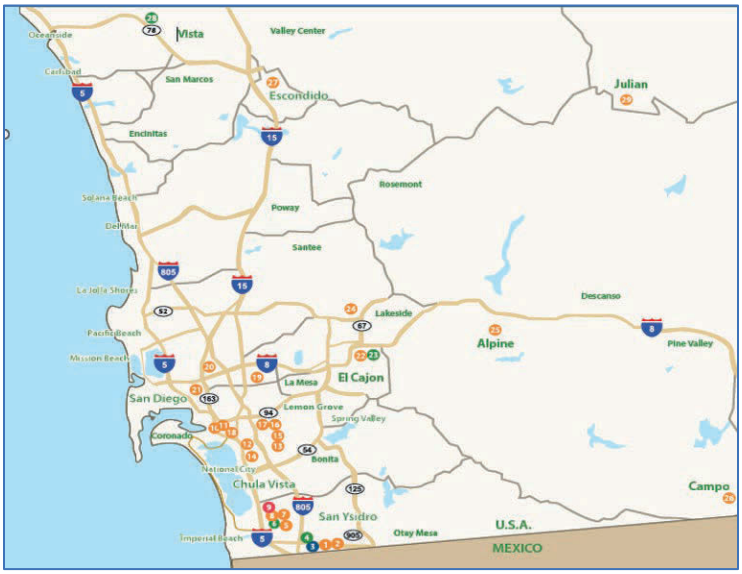
Payer Mix: 57% Medicaid, 14% Medicare, 19% Self-Pay, 9% Private



SYHealth Payer Mix 2021

Sources: Uniform Data System Aggregate Report 2021; HRSA Form 5(2022); Todd, V. (July, 2022) Interview

San Ysidro Health - Centro de Salud de la Communidad San Ysidro, Inc., doing business as San Ysidro Health (SYHealth), is a 53-year-old Federally Qualified Health Center (FQHC) with the mission of "*improving the health and well-being of the communities we serve with access for all*." The work of its "founding mothers" – seven determined women seeking care for their children and families along the border community of San Ysidro – has expanded throughout the entire San Diego County with more than 40 clinic and program sites, four PACE Centers, one residency program (along with partnerships with two residency programs), and a Medical School Affiliation. SYHealth provides care to nearly 110,000 unique patients annually and currently over 2,000 PACE participants.



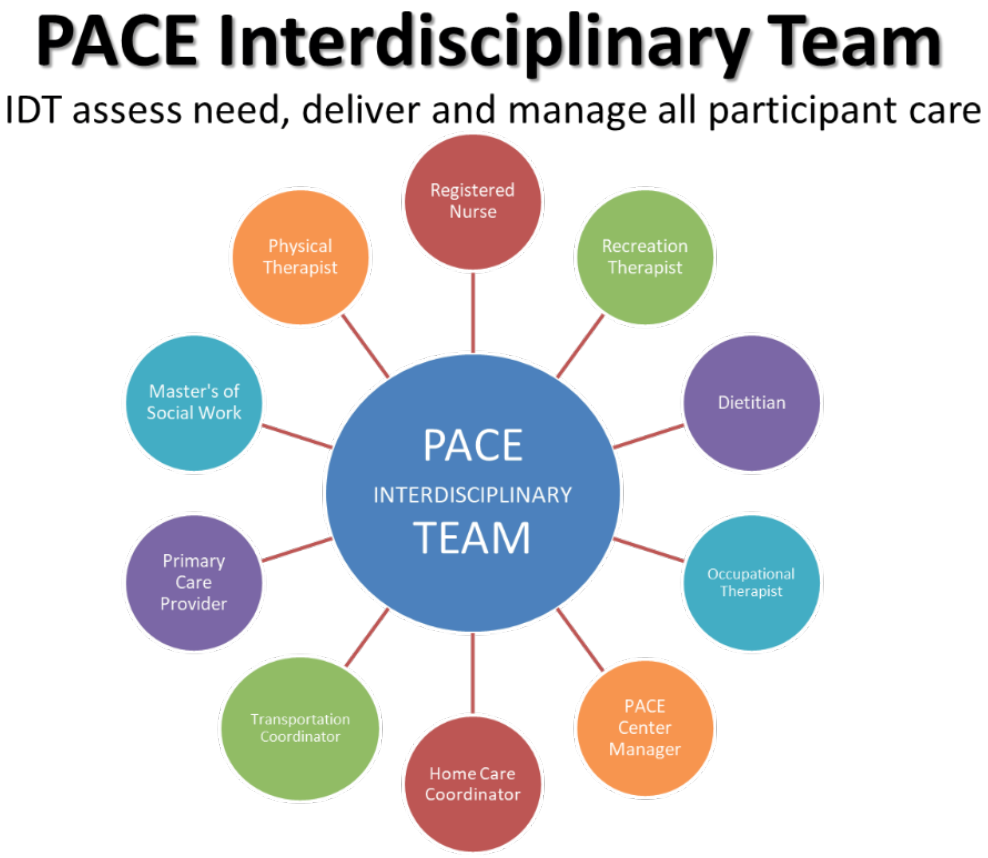
The PACE Journey for SYHealth - The journey to PACE was a circuitous one for San Ysidro Health. Responding to the unmet needs for adult day services for aging seniors, SYHealth opened an Adult Day Health Center (ADHC) in 2010. Just two years later, state budget cuts severely gutted the ADHC program[1] as a transition to what is now commonly known as Community Based Adult Services (CBAS), resulting in a 40% cut in reimbursements for SYHealth. Years of planning to increase access to culturally competent care for aging seniors seemed to be slipping away but the patient-majority Board of Directors was committed to this endeavor and requested that the CEO identify other ways to serve this population. Given the growth of the senior population in San Diego County and SYHealth's goal to expand culturally competent senior services, leadership kept the ADHC/CBAS open, despite operating at a deficit, while they searched for other alternatives. San Diego PACE was born after discovering PACE as a financially viable option for long-term sustainability. Months of work – including service area assessment, work plan development, and submission of PACE application to Centers for Medicare and Medicaid Services (CMS) – came to fruition when SYHealth opened its first San Diego PACE site almost three years later in April 2015. With best practices, openness to innovation, and ongoing leadership commitment, SYHealth steadily grew its PACE network in San Diego County within a short period of time: *San Diego PACE – San Ysidro (2015), San Diego PACE – Chula Vista (2019), San Diego PACE – El Cajon (2020), and San Diego PACE – Vista (2022*). Construction for a fifth PACE center, San Diego PACE – National City (~2023), is currently underway. One of four PACE organizations in the county, SYHealth's San Diego PACE catchment area has expanded to serve 114 zip codes in San Diego and has a current census of 2,119 participants, spurring recognition as one of the fastest growing PACE programs in the country for the past two years[2]. As the first FQHC to become a PACE organization in San Diego County, SYHealth has illuminated the way

[1] https://www.nytimes.com/2011/10/28/us/plan-to-close-california-adult-day-health-care-centers-sets-off-protests.html

[2] https://www.npaonline.org/member-resources/strategic-initiatives/pace2-0

for other local FQHCs to follow suit, establishing best practices on how to successfully operate complex PACE requirements in an equally prescriptive FQHC organizational framework. Two additional San Diego FQHCs now operate PACE Programs (Neighborhood Healthcare and Family Health Centers of San Diego).

SYHealth tried something innovative with the opening of its *San Diego PACE – Vista* Center. Typically, seniors transfer their primary care to a PACE physician after enrollment into the PACE. In partnership with three sister FQHCs within the county, San Diego PACE implemented a *Community Based Provider* program which allows participants to retain primary care relationships with their community health center while gaining all the benefits of the comprehensive wraparound services PACE can provide (e.g., adult day center services, durable medical equipment, home care/personal care, nursing care, prescription medications, nutritional counseling and meals, physical and occupational therapy, social services, etc.). A significant barrier to participation in the PACE program is the threat of patients losing their long-term provider relationships. Under SYHealth's *Community Based Provider* program, partner FQHCs retain their patients by assigning dedicated PACE providers who can fully participate in the **interdisciplinary model** (below) that makes PACE successful. Patients face less disruption when they can still receive care in familiar surroundings, even as they gain new experiences like access to the PACE Activity Center, Occupational Therapy & Physical Therapy services and more.



Silver or Grey Tsunami[3] **-** Today, seniors 65 and over represent 16% of the United States population with estimates projecting that number will increase to nearly 23% by 2050. According to 2021 UDS statistics, the senior population in FQHCs has seen the most significant growth – rising 2% in the last five years (an increase of more than one million patients). The implication for healthcare providers is clear. More services will be needed. In addition to primary care, this aging population will need more specialty care, medications, long-term care, social support, and in-home care. Fighting chronic conditions such as diabetes, heart disease, hypertension, arthritis, depression, along with memory or mobility issues, seniors require intentional and coordinated care to successfully age in place. While the PACE program is ideal for seniors who need nursing home care to continue living in their homes as long as possible, health centers would be wise to begin implementing age-specific populations health strategies, including those that address social needs, with all their aging patients. Building those connections and relationships are critical to retaining patients as they age and can help mitigate some of the challenges faced by seniors. Beginning this early is the key; and organizations like SYHealth have been researching how to begin this engagement as early as age 50. Activities can range from social opportunities to group visits to chronic disease cohorts. The important part is to start the engagement process!

Growing the PACE Program - According to the National PACE Association (NPA), "At least 7.6 million Medicare beneficiaries and 2.2 million dually eligible (both Medicare and Medicaid) individuals live with complex care needs."[4] These are the exact folks who could most benefit from having access to a PACE Program. From mobility to memory issues, the effects of aging are impacting not only the lives of frail seniors, but also the lives of their families and caregivers too. Yet, PACE currently serves only about 68,000 beneficiaries nationwide, through 151 PACE organizations in just over 30 states – well short of the total eligibility numbers quoted by NPA. Compare this to the Community Health Center movement which reported a milestone 30 million patients served in 2021, through 1,400 grantees and 14,000 program sites. While it is not realistic to believe that the PACE program would or should match the numbers served by community health centers, it is tenable to see community health centers as a perfect vehicle to spur access to PACE for low-income seniors. In 2021, community health centers served 3.2 million seniors (65+ years old) and a total 7 million adults aged 55 years and above. Even if a conservative one percent of those patients gained access to PACE, the program could double nearly overnight! The National PACE Association seeks to reach 200,000 PACE participants by 2030 and a partnership with the nation's FQHCs could help do just that.

Establishing <u>New</u> PACE Organizations **-** Clearly, the need to establish new PACE organizations in new locations is paramount as the program is not equally available to seniors nationwide as identified in the map pictured on the right. Though some states have multiple PACE organizations, many states have zero, so the movement to grow access

[3] https://en.wikipedia.org/wiki/The_Silver_Tsunami
[4] https://www.npaonline.org/sites/default/files/PDFs/PACE2.0InitiativeFactSheet.pdf

for seniors must focus on advocating, developing, and establishing new PACE organizations. This is a prime opportunity for well-established FQHCs with strong clinical care protocols and a solid balance sheet to become a part of care delivery.

The model of FQHC-led PACE programs is not farfetched. In fact, it's been proven successful in multiple case studies throughout the country. FQHCs' collective missions require access to high quality care for all members of the family. Why does that stop for seniors? Haven't community health centers been focusing on population health strategies to improve health outcomes? Haven't FQHCs realized the importance of social determinants in reaching those outcomes? PACE is where those concepts come together.

Partnerships **-** In other instances, growth of PACE will not only come from establishing new PACE organizations, but rather from establishing partnerships with existing PACE programs. While the benefits of the PACE are easy to see, establishing the needed PACE infrastructures is an intense process with multiple regulatory hoops and requirements. For those contemplating such an endeavor, responsibilities are significant as both the health plan and the provider for senior participants. In areas where PACE organizations already exist, the ideal way to spur growth is not in developing new competing PACE organizations but in partnerships. Since PACE is a health plan, health centers can consider contracting as Community Based Providers for a segment of their senior population. It does not have to be thousands of patients to be beneficial. In fact, most PACE organizations enroll fewer than 20 participants per month on average. It is very possible and realistic to have a strong PACE partnership with 150 seniors. Remember, because the model of care is comprehensive, the panels are smaller to allow for necessary attention. For most health centers, elderly patients' complex healthcare needs require longer clinic visits and/or more intensive attention, thereby impacting overall productivity, causing appointment schedules to fall behind, and/or leading to need for patients to return for multiple appointments to address their needs. Many of those patients can be ideal referrals for PACE. Allowing them to retain care with their trusted provider while creating access to additional services is a win for patients, their families, and the health center. Who doesn't like a win-win?

Another PACE/FQHC partnership benefit is ACCESS. Because of SYHealth's status as a 330 grantee during COVID, our PACE participants had access to earlier testing, vaccinations and COVID-19 antibody treatments. While our health centers received reliable, direct shipments from Health Resources and Services Administration (HRSA), neighboring PACE organizations were beholden to supply distribution from the state which was less timely and less available. The community health center movement has credibility in serving low-income families and structures in place that position us as ideal partners to solve the care gap for our elderly.

SYHealth: Lessons Learned

The Road to Value Based Care **-** Most community health centers have been talking about the transition to value-based care for the past decade. Paying for value versus paying for volume has been a key buzz phrase but has yet to see that transition take place. Operating in the PACE setting has been a wonderful learning opportunity about what it will really take to manage risk in FQHC patient populations. While SYHealth still strives to master these concepts, SYHealth has learned three key factors imperative to operating in a risk-based environment: *Landscape, Utilization Management and Care Coordination.*

Landscape **-** SYHealth's experience with PACE has been colored by operating in a state that embraces the program. California has more than 20 PACE organizations and serves almost one third of all PACE participants nationwide. This is because the state has a progressive Medicaid philosophy and counts PACE as a Medicaid benefit. That is not the case universally. Recent legislative changes in California (such as increasing the Medicaid Asset test) may mean more Medicare-only individuals will now be eligible for Medicaid and the PACE program. Without Medicaid, the cost of participating in PACE is often prohibitive for moderate to lower income seniors. Medicare Part D plan alone is significantly higher in PACE – a regulation that all PACE organizations are trying desperately to change.

Utilization Management **-** Managing utilization of services is a priority concern in a risk-based environment. As the PACE organization, responsibilities include hospital care, skilled nursing, rehabilitation, specialty care, and more. If the PACE team is not paying attention, does not have proper care protocols in place, or neglects the participant's care plan – it can result in overutilization of unnecessary services. This hurts the patient and the PACE organization's bottom line. This is where participant and caregiver education are critical. Do they know to call you when something goes wrong or do they just seek care? Helping participants navigate the system creates a better user experience and is just good business! Because it's a 'risk' environment, insurance should be a part of the plan. However, it just cannot be *the only* plan.

Care Coordination **-** Most health centers think they understand care coordination, but it requires an enhanced level of understanding in a risk-based environment, particularly with patients battling multiple chronic diseases, scads of medications, and requiring both medical and social supports. The PACE interdisciplinary team is the beginning of proper care coordination. A well-defined level of care plan will set a proper foundation; but oftentimes the real challenge is making it happen. Coordinating multiple referral appointments, transportation arrangements, caregiver hours, labs, medications and ensuring social activity is a lot of work; doing it for an elderly senior with memory issues or an overworked caregiver can add to the complexity.

Despite health centers' integration of electronic medical records over the past decade, there is still a long way to go in creating smart IT systems that connect with each other to sufficiently follow patients' care outside the walls of the health center. Health centers need systems that prompt care protocols, so they are readily available and able to be carried out by the appropriate staff (case managers, health educators, nurses, social workers, providers, etc.). It is time to brush off the "top of their license" buzz phrase to really make care coordination effective and efficient. Understanding these key factors and building processes around them can allow all health centers to build a solid foundation for operating in value-based reimbursement environments.

Better outcomes + Better patient experience = Better Health System.

Our patients and our seniors deserve nothing less.

San Diego PACE and San Ysidro Health

For more information contact:

- Jason Patnosh, Associate Vice President, Development and Innovation, NACHC (jpatnosh@nachc.org)
- Learn more about PACE through community health center models at the Health Center Resource Clearinghouse (www.healthcenterinfo.org) by searching "PACE and aging".

Special thanks to:

- Kevin L. Mattson, President & Chief Executive Officer, San Ysidro Health (kmattson@syhealth.org)
- Vernita Todd, Vice President & Chief Strategy Officer, San Ysidro Health (vernita.todd@syhealth.org)
- The National PACE Association (www.npaonline.org)