PACE

Program of ***A***ll-inclusive ***C***are for the ***E***lderly

Our Company is

Our Mission Statement: Christ-centered service to seniors, each other & the Community

- **Founded in 1887 by Pastor E.A. Fogelstrom and five Deaconesses**

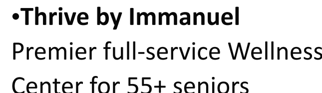
These are the first Immanuel deaconesses. From left, standing, Sister Kristin Monson and Sister Bothilda Svenson; seated, Sister Fredina Peterson, Sister Hanna Erikson and Sister Hanna Swenson.

WELCOME! You are HERE!

Immanuel communities

- **Immanuel Village** (IL, AL)
  Omaha
- **Immanuel Courtyard** (AL, AH)
  Omaha
- **Immanuel Fontenelle (AL, MS)**
  Omaha
- **The Arboretum (IL)**
  Omaha
- **Lakeside Village** (IL, AL, MS)
  Omaha
- **The Light House (MS,AL)**
  Omaha
- **Pacific Springs Village** (IL)
  Omaha
- **Trinity Village & Courtyard** (IL, AL, AH)
  Papillion
- **The Landing at Williamsburg Village** (IL, AL, MS)
  Lincoln
- **Clark Jeary** (IL, AL, MS)
  Lincoln
- **The Shores**(IL, AL, MS)
  Pleasant Hill

- **Immanuel Pathways Southwest Iowa in Council Bluffs, IA**
- **Immanuel Pathways NE in Omaha, NE**
- **Immanuel Pathways Central Iowa in Windsor Heights, Iowa (Des Moines)**



- **Thrive by Immanuel**
  Premier full-service Wellness Center for 55+ seniors

- IL = Independent Living
- AL = Assisted Living
- MS = Memory Support
- AH = Affordable Housing for Low income Seniors

Immanuel and PACE

- **Immanuel Pathways in Council Bluffs, Iowa**
  - Opened January 2, 2012
  - Our 1st PACE program serving the counties of Harrison, Pottawattamie and Mills
- **Immanuel Pathways in Omaha, Nebraska**
  - Opened May 1, 2013
  - Serves all of Douglas and Sarpy counties, and certain zip codes of Cass, Dodge, Saunders, and Washington
- **Immanuel Pathways in Des Moines, Iowa**
  - Opened October 1, 2015
  - Serves Boone, Dallas, Jasper, Madison, Marion, Marshall, Polk, Story, and Warren counties

What is PACE?

- The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive, fully-integrated, provider-based plan for seniors who require a nursing home level of care.

The PACE philosophy is centered on the belief that it is better for frail individuals to be served in their home and community whenever possible.

Who does PACE serve?

- 55 years of age or older
- Living in a PACE service area
- Assessed to meet nursing facility level of care criteria
- Able to live safely in the community with the services of the PACE organization at the time of enrollment

As of 2023, there are 153 PACE organizations in 32 states & the District of Columbia*

**Statistics from the National Pace Association (NPA)*

In the PACE Model

- Participants receive all of their health and social services through the PACE organization
- 24 hour a day, 365 days a year
- An interdisciplinary team, including physicians, provides and coordinates all services for the participant

Integrated Team, Coordinated Care

Immanuel Pathways
Interdisciplinary Team (IDT)

- In Home Services Supervisor
- Clinic Practice Manager or Clinic Nurse Supervisor
- Executive Director
- Primary Care Physician or Nurse Practitioner
- Participant Center Supervisor or Participant Center Aide (PCA)
- Occupational Therapist
- Physical Therapist
- Recreational Therapist
- Registered Dietitian
- Transportation Supervisor or Driver
- (MSW) Masters of Social Work

Other providers may attend if invited

The Interdisciplinary Team (IDT)

IDT Morning Meeting-

The IDT coordinates all PACE services. They meet to discuss topics such as participant updates, change of conditions, coordination of day's activities, and possible new enrollments.

Care Planning Sessions-

The IDT meets to determine the coordination of daily services for the participants, their changing needs, medical conditions, goals, and interventions.

What makes the PACE model unique?

1. **PACE Participants are served by a team of professionals:**
   - Upon enrollment in PACE, participants and their caregivers meet with a interdisciplinary team (IDT).
   - Each participant's needs are assessed, and care plan is developed to respond to all his/her needs.

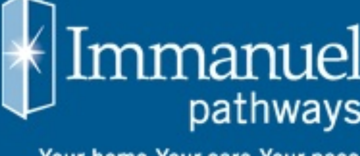
2. PACE Participants receive regular, “high-touch” care and supportive services:

- **At the PACE Center**, they receive primary care, therapy, meals, recreation, socialization, and personal care.
- **In the home**, PACE offers skilled care, personal care supportive services, and supports such as ramps, grab-bars, and other tools that facilitate participant safety.
- **In the community**, PACE offers access to medical specialists and other providers.

3. The services *follow* the participant across all care settings including the home, assisted living, hospital, nursing home and back home again

The focal point is a multi-purpose PACE center providing medical services along with:

- Transportation
- Therapies
- Home care
- Social services
- Meals and Nutritional counseling
- Prescription drugs



4. PACE is both a Health Provider and a Health Plan:

IDT delivers much of the care directly to monitor participants' health and respond rapidly with necessary changes.

The PACE team is responsible for managing and paying for services delivered by contract providers such as hospitals, nursing homes, and specialists.

No benefit limitations, co-pays or deductibles for services **within the PACE network.** PACE Participants may choose services outside the "network" but would be personally liable for those costs.

How is PACE financed?

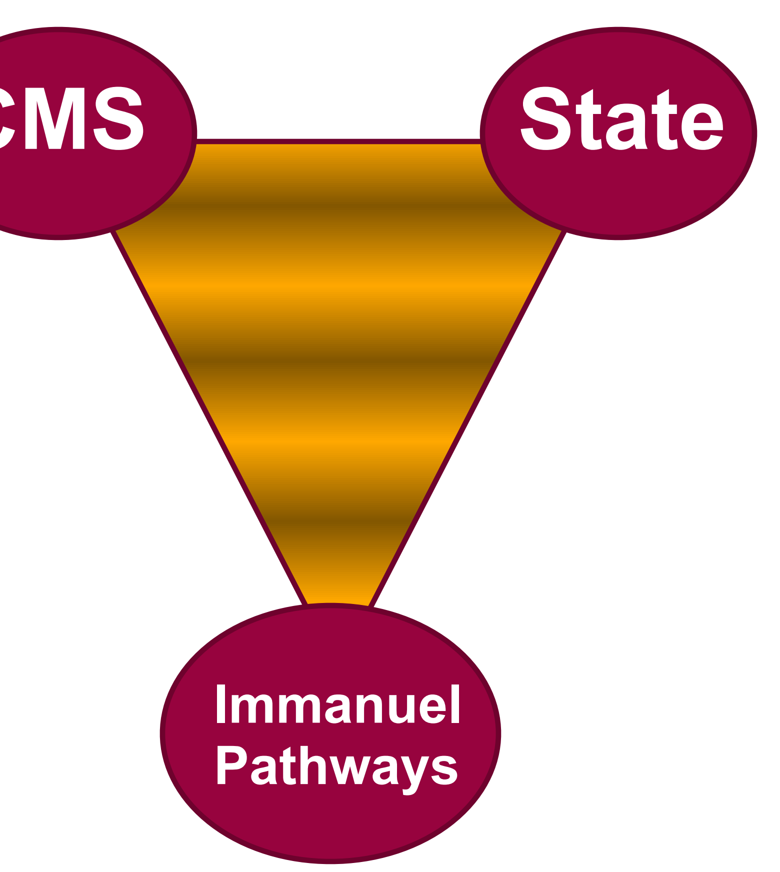
PACE organizations receive fixed monthly payments from Medicare, Medicaid and private-payers (for program participants who are not dually-eligible). These funds are pooled and care is provided following a comprehensive assessment of all participants' needs.

This bundled payment provides a strong incentive to avoid unnecessary services and encourages the use of appropriate alternatives to hospital and nursing home care.

How is PACE authorized and regulated?

Congress authorized PACE as a Medicare provider and Medicaid state option in the Balanced Budget Act of 1997. Operationally, the PACE program is implemented through a three-way program agreement between the **PACE organization**, the **Centers for Medicare and Medicaid Services** (CMS), and the **State**.

Both CMS and the State are responsible for monitoring PACE programs.



Department
Overview

Immanuel
pathways
Your home. Your care. Your pace.

The Enrollment & Marketing Team

- Responsible for marketing the Immanuel Pathways PACE program to key referral sources, potential participants and community agencies.
- Obtain initial information from potential participants for enrollment.
- They create the “pipeline” for eligible participants to the PACE program.
- Provide information and referrals to community agencies.
- They relate the initial information to IDT to determine if PACE meets the needs of the potential participant.

The Enrollment service areas for Immanuel Pathways:

Nebraska Counties:

All of Douglas and Sarpy,

And certain zip codes of

Cass, Dodge, Saunders, and Washington

The Healthcare Clinic Team

The Healthcare Clinic provides medical and nursing care to PACE participants.

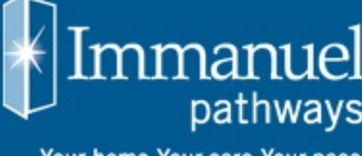
Therapy Services

- **Occupational Therapy:**
  - Help people participate in everyday activities.
  - Assess the participant's safety in the home, including their ability to perform activities of daily living, such as dressing, bathing, toileting, and meal preparation.
  - They educate the participant to keep them safe in their home.
- **Physical Therapy:**
  - Maintain, restore, and improve movement and activity.
  - Assess participant fall risk, including ability to walk, balance and overall strength.
  - Provide training on proper transfer techniques such as use of gait belt and assistive devices
- **Speech Therapy:**
  - Act as primary consultant on swallowing issues and respective diet needs
  - Integrate a speech therapy treatment plan of care.

Recreational Therapy

- Assess the needs, interests and capabilities of participants and develops individualized therapeutic recreation plans.

- Organize, direct and participate in the therapeutic recreation programs tailored to the general and individualized needs of the participants.



In-Home Services

- The In-Home Services Nurses perform participant assessments in the participant's home.
- Coordinate plan of care with community resources and Interdisciplinary Team (IDT) which include clinical, chore and home maker services.
- Provide treatments and health education in the participant's home.
- Maintain the participant's medical record and communicate participant's changes and progress to IDT.

Social Services

- Assist in assessments, teaching and counseling participants, caregivers or other appropriate representatives.
- Coordinate participant and family education; provide community resources and ongoing case management
- Advocate to ensure participant and caregiver needs are met and addressed; and initiate disenrollment procedures when needed
- Liaison between the IDT, caregiver representatives, and community agencies.

Transportation Services

- Responsible for the transportation, including transport of participants, meals, durable medical equipment, pharmacy, and any other transportation as deemed necessary.
- Oversees procurement of vehicle and repairs and preventative maintenance of vehicles.
- Drivers follow a "door through door" service

Dining & Nutrition Services

- Registered Dietitian (RD) provide
  - Nutrition Education
  - Weight Management Counseling
  - Monitors Weights

- **Meal Service**
  - Monday-Friday
  - Hot Noon Meal, AM & PM snacks

Dining & Nutrition Services

- Refer to Registered Dietitian if participant is experiencing:
  - Loss or gain in weight (observed or reported)
  - Swallowing or chewing difficulties (observed or reported)
  - Not eating meals
  - Any other diet or nutrition related concerns

Case Study

What PACE can do for a participant to keep them safe in their home

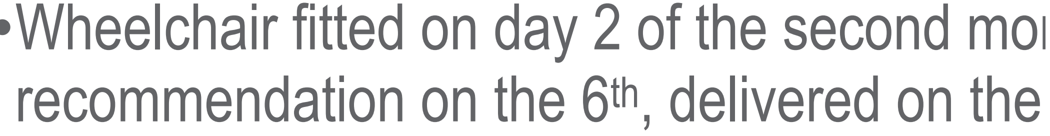
Participant Demographics

Health History

- UTI w/o hematuria
- R hip pain
- Bacteremia
- Allergic rhinitis
- Candida intertrigo
- Nausea
- Weakness
- Chronic Pain Syndrome
- Ambulatory Dysfunction
- HTN
- Slow Transit constipation
- Intractable pain
- Fibromyalgia
- Morbid Obesity
- Osteoarthritis
- Sacroilitis
- Spinal stenosis
- B knee replacement
- Left shoulder surgery

Months 1-2 of Enrollment

- Team performed initial assessments, developed care plan
- In home scheduled 2 hours, 1x/week
- OT & PTA began co treatments
- OT provided new DME: patient lift, full electrical hospital bed
- Ultra light customized wheelchair provided



- Wheelchair fitted on day 2 of the second mo
  recommendation on the 6th, delivered on the
- Took 12 days to obtain customized manual wheelchair

Care Plan Example

▼	voices dissatisfaction with her independent leisure, which can impact her quality of life.		IDT
▼	will voice an increase in her leisure satisfaction over the next six months –		
	RT to complete weekly touch points for increased socialization and provide leisure education.	8/28/2023 – Intervention not complete yet, but continues to be appropriate – Activities Coordinator	RecTher
	RT to provide leisure supplies upon request		RecTher
▼	has fibromyalgia and is dependent for transfers as well as all activities of daily living (ADL) and instrumental activities of daily living (IADL).		IDT
▼	will have no unmet ADL/IADL over the next 6 months. –		
	In home nurse to set up med planner monthly. Nurse to monitor for compliance with visits up to 4 times a month. Report concerns to PCP.		Nursing
	In home PT up to 2xw for 6months for strengthening, functional transfer training to decrease burden of care. Report concerns to IDT.	9/8/2023 – Intervention Appropriate--Continue Intervention – Physical Therapist Asst	Physical Therapy
	In home OT up to 2x/wk for6 months for strengthening, ADL retraining, and functional transfer training. Report concerns to IDT.	8/29/2023 – Intervention Appropriate--Continue Intervention – Occupational Therapist	Occ Therapy
	In home aide 1x/week for up to 2 hours per visit for bathing, lt. housekeeping, laundry, and meal prep. Report concerns to IDT.		Nursing- IHS
▼	will have her needs met while at outside medical appointments over the next 6mo. –		
	Escort Needs	Escort Needs: Need escort to all contracted service appointments	

PACE vs Traditional Medicare

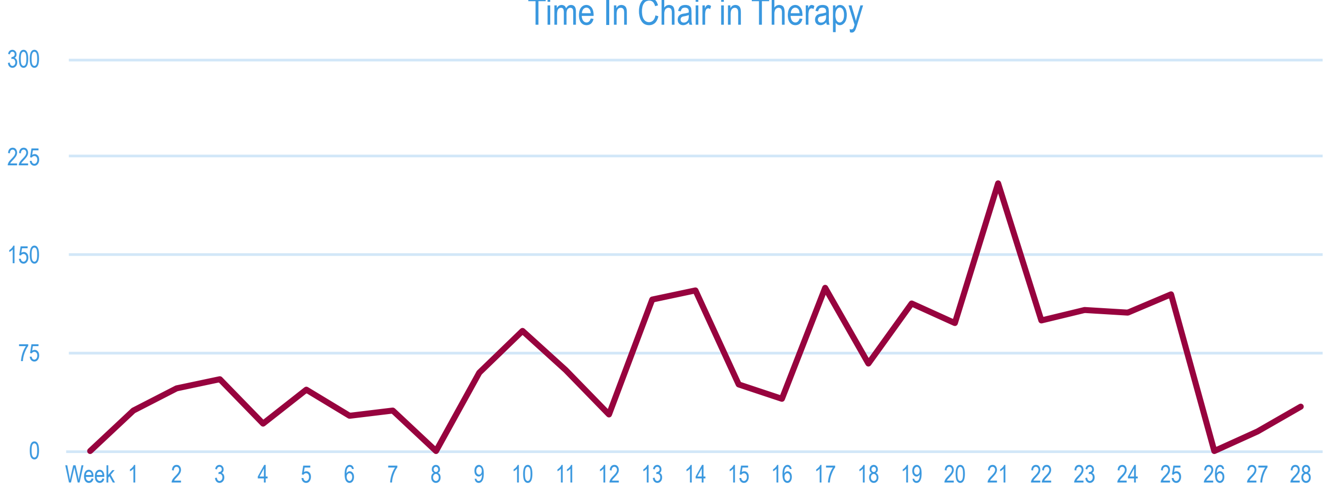
- With Medicare, patient pays 20% after deductible vs. no additional cost being in PACE
- MS-79 was not needed, team was able to vote and approve so it could be ordered right away
- Medicare every 5 years replaces a wheelchair or scooter, PACE can order whenever the team deems necessary

Therapy Plan

- Initially, focus was bed mobility and sitting EOB, static and dynamic seated balance
- Transitioned to building up tolerance out of bed
- Additional day of in home services added
- Staff training for aides and caregiver to be able to transfer out of bed during scheduled in home times
- Lift chair was provided for another option for participant to be out of bed
- Pain Control- provided IFC unit for chronic RLE pain

Therapy Progress

– Goal duration and frequency out of bed (lift chair or wheelchair)
– Once able to tolerate extended times, began focusing on trunk control, coordinated movements, seated balance while up
  - Ex- corn hole, golf putting, balloons, throwing a ball, etc.
– Participant came to the center week 21. First time leaving home in over a year
– Was getting up with aides 30-45 minutes 2x/week as participant tolerate



Months 8-9

- Experienced fall from Hoyer lift during month 8, set back in therapy
- Hospitalized end of month 8 with acute on chronic respiratory failure with hypoxia and hypercapnia
- Palliative care discussion in the hospital- declined use of BiPAP and opted to no longer return to the hospital or wish to pursue outpatient pulmonary work up
- Switched care to symptomatic approach with no escalation of care
- Hospice consult, opted to not pursue
- Added nursing touch point weekly for wellness check and med compliance
- 5 days/week oversight with in home, therapy, and nursing
- **What Matters Most**: Therapy as needed for companion visits or getting participant out of bed & outside

Financial Costs vs LTC

QUESTIONS?

Thank You for attending!

Immanuel
pathways
Your home. Your care. Your pace.