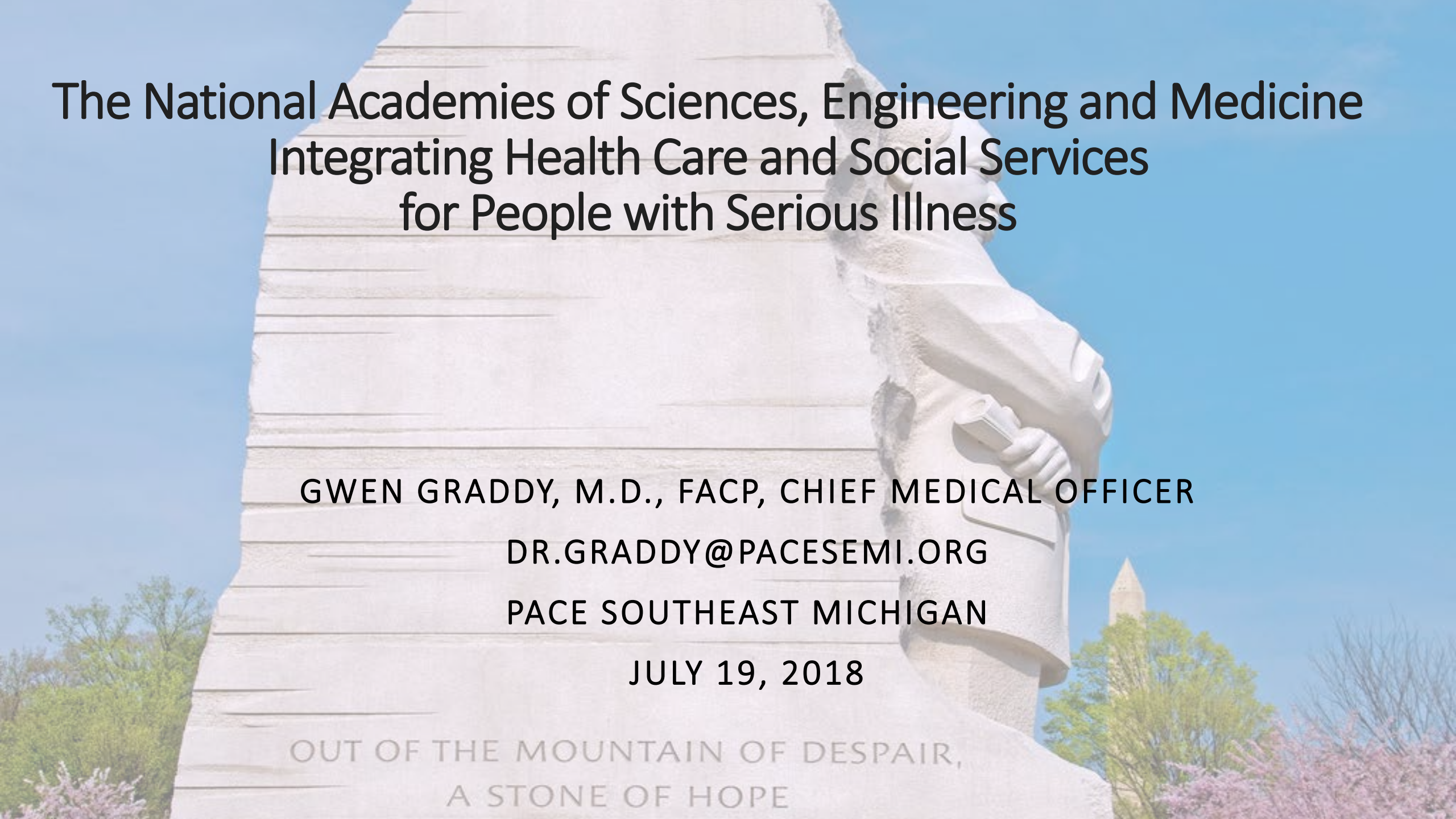




The National Academies of Sciences, Engineering and Medicine Integrating Health Care and Social Services for People with Serious Illness

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PACE SOUTHEAST MICHIGAN

JULY 19, 2018

OUT OF THE MOUNTAIN OF DESPAIR,
A STONE OF HOPE

OVERVIEW OF PACE

Population

- High Need, High Cost (HNHC)
- Frail, older adults, multi-morbidity, complex psychosocial needs, disabled, vulnerable, poor
- Fragmented care
- High risk

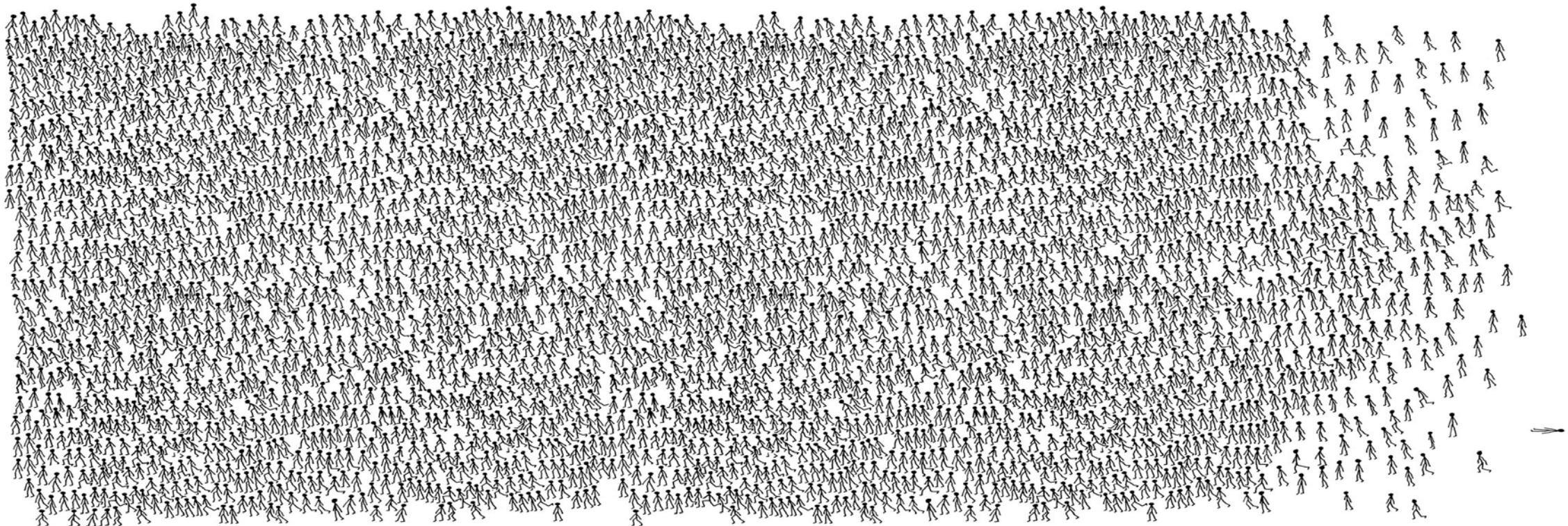


WHY INTEGRATED CARE?

Remembering What Beneficiaries Want from their Health Plan

“ People want health not healthcare, those who require the most healthcare and get the least health---high need, high-cost patients with multiple or severe medical , feels this most acutely.”

-Dr. Dhruv Khullar, September 2017





Integrated Care Model

- Healthcare delivery and financing
- Acute and long-term care
- Behavioral Health and Primary Care
- Interdisciplinary Care
- Medical and Social



WHY PACE ?

QUALITY OF LIFE:

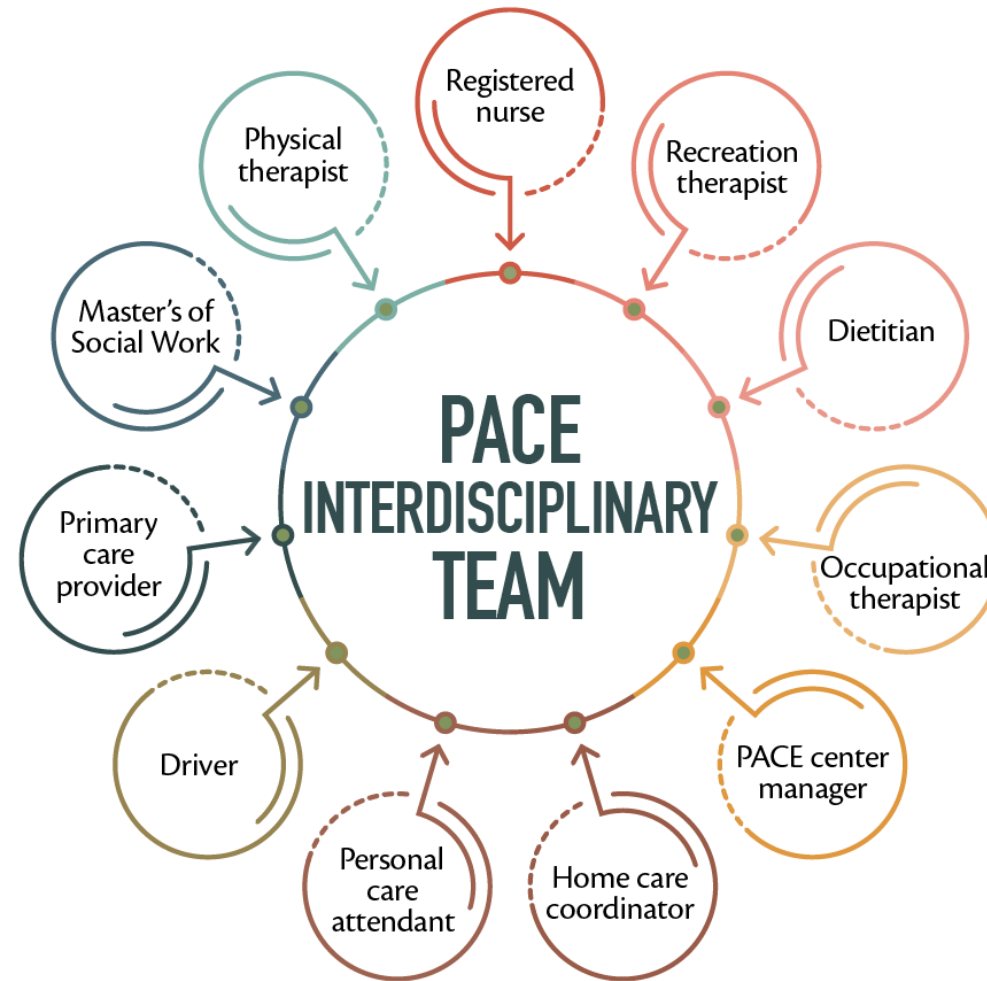
- Higher self health report
- Reduction on nursing home placement
- Reduction in hospitalization
- Reduction in fragmentation of care
- Impact on health disparities for AA older adults
- Caregiver support
- Lower cost



Benefits

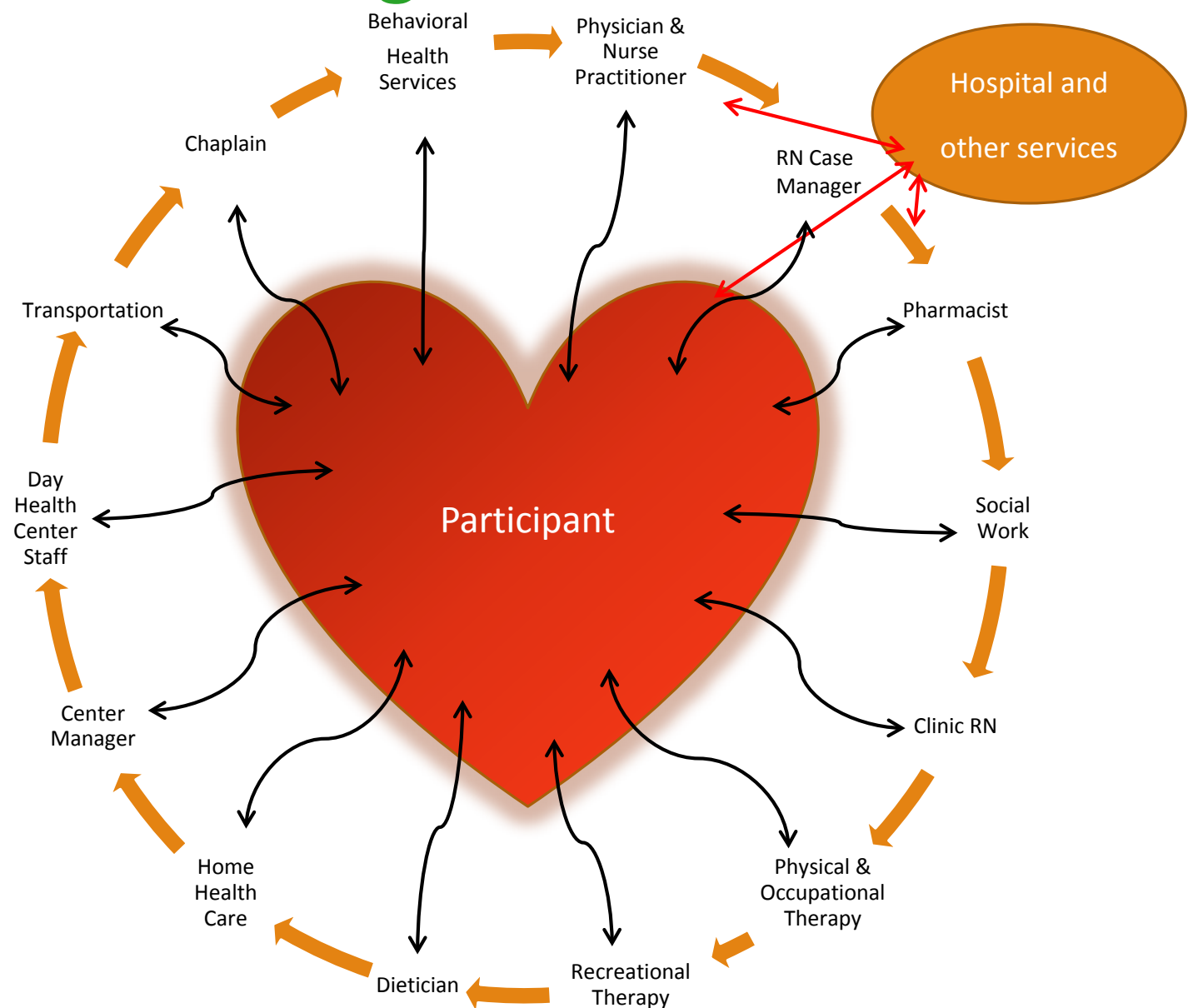
Integrated care	The best of each discipline to provide the best care
Wrap-around care	Interdependent
Education	Participant focused (case study)
Best practice	Hospitalization/ED
Quality: Federal regulations	Value Based
Cost	IDT
Insurance and Healthcare provider	Creative use of dollars-IDT

Integrated Service Delivery and Team Managed Care





PACE Integrated Care Model



Barriers

Understanding PACE and its Benefits	Competition
Competition	Wanting to stay with PCP
Lack of visibility	Medicaid income eligibility
Start up cost	Spend-down
Lack of appropriate referrals	Creative innovation of other populations
Medicaid dollars and capitation	Lack of community liaisons who know how to connect with community
Spend-down	Lack of census goals to work toward
Limitations on the type of people served	Provider skill-set
Health Care providers – concerns re: risk	



WHERE DO WE GO FROM HERE?



2016-2021 NPA Strategic Plan



Champion the value of PACE and support growth

- PACE pilot programs
- New population expansion
- New payer arrangements
- Regulatory support for growth
- Local, grassroots advocacy
- Benefits of population health management strategies
- Benchmarking tools capabilities
- Vendor support for data analytics

Advocate for effective regulatory and payment policies

- Strong relationships with regulators
- Operational flexibility in regulatory policies
- Appropriate payment
- Interested stakeholder collaboration
- Population health management advocacy

Support PACE operational quality through education and data

- Training and education programs readily available
- Industry and PACE-specific model practices
- Educational partnerships
- Investment in data
- Value of data for benchmarking and analytics
- Onboarding programs for new members
- Membership tiers

Distinguish and promote the PACE brand

- Positive awareness of PACE
- Common communications strategy for members
- Social media support for members
- Cross-marketing with like-minded organizations
- Data analytics demonstrate value
- Standards and performance based quality assurance system

TAKE HOME LESSONS



- UNDERSTAND INTEGRATION
- INNOVATION IS THE KEY TO THE FUTURE
- ADVOCATE FOR MODELS OF CARE LIKE PACE
- PUBLISH WHAT YOU ARE DOING
- LOOK FOR OPPORTUNITIES
- EDUCATION, EDUCATION , EDUCATION
- WRITE TO SEEMA .VERMA@CMS.HHS.GOV





Sustainability

- PACE Innovation Act
- Federal and state policy interest
- General knowledge thru research
- Increasing the skill set for those who will take care of this population
- Elimination of "Ageism"



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