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Better Care after Hospital Discharge

By Shawn Bloom *October 11, 2012*

The PACE model uses technology and communication to prevent hospital readmissions.

When a patient is discharged from the hospital, coordinating his or her follow-up care is often a challenge. Hospital and non-hospital providers alike have long struggled with information flow, medication management and patient compliance issues.

One way to address these challenges is by focusing on collaboration and communication among providers, patients and their families. It is a focus that the Program of All-inclusive Care for the Elderly organizations have aimed to maintain for nearly 40 years.

The idea behind the PACE care model is that it is better for seniors with chronic conditions to receive care at home whenever possible. PACE coordinates and provides participants with preventive, primary, acute and long-term care services so they can continue living in their communities. The program serves patients who are 55 or older and certified by their state to need nursing home care, but who are able to live safely, at least at the time they enroll, in their communities.

The PACE program traces to 1973, when San Francisco's Asian-American community wanted to develop a new method of home-based care for the elderly. In 1986, the Robert Wood Johnson Foundation provided funding for six sites to develop PACE demonstration programs, made possible by Congressional authorization for additional Medicare and Medicaid waivers. Based on the success of the demonstrations, the Balanced Budget Act of 1997 granted provider status to PACE programs under Medicare and gave Medicaid agencies the option to include PACE as a benefit. Today, 86 PACE organizations in 29 states manage the care of hundreds of seniors.

A technologically connected interdisciplinary team carefully assesses, monitors and reassesses PACE participants to spot new conditions, complications or other possible causes of readmission. As hospitals and health systems face greater financial penalties for preventable readmissions, PACE organizations offer insight into how to improve the patient's care experience immediately upon hospital discharge as well as afterward.

Interdisciplinary Collaboration

Patients discharged from the hospital typically have significant care needs and follow-up instructions as they recuperate. For some — especially the elderly population served by PACE — the instructions can be confusing or hard to manage, especially if the patient has limited support at home. Rather than leaving patients to care for themselves, a PACE team assumes responsibility for all post-hospital care.

The team typically comprises, but is not limited to: a primary care physician, registered nurse, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietitian, PACE center manager, home care coordinator, personal attendant and driver. These providers work with specialists from home care, therapy, pharmacy and other disciplines to ensure that each participant is following his or her care plan, taking medications as directed, attending follow-up visits and progressing on track.

The multidisciplinary nature of the PACE model offers the full complement of transition services that a patient might need. Home care specialists and social workers can provide both acute and long-term services to help patients adapt to their home settings. Primary care, nursing and therapy provide for post-acute care needs, but also continue the care plan for chronic conditions and other disabilities. In short, PACE treats the whole patient — not just the episode that landed him or her in the hospital.

Hands-on Care and Capitation

There are two elements that make the PACE model especially effective at preventing hospital admissions, readmissions and nursing home stays. The first is the hands-on nature of the model.

On average, PACE patients visit a PACE center two to three days a week. As a result, they have almost constant interaction with a wide array of trained professionals. Team members can spot changes in a patient's appetite, cognition, gait or mood and quickly administer preventive therapies or treatment. Primary care physicians can keep a closer watch on chronic conditions and ensure adherence to treatment plans. In addition, meetings allow team members to exchange information and ensure they are working together to improve patient outcomes.

The second factor is the capitated nature of PACE reimbursement. Because PACE is at financial risk for all services, there is a powerful incentive to provide care that keeps individuals healthy and in their homes. By investing in primary and preventive care, organizations avoid costly acute episodes while maintaining a participant's health and quality of life.

Technology for Patient Centeredness

The most important factor for addressing the challenges of any care transition is patient centeredness. While a dedicated care coordination staff and other resources are important, the individual patient — his or her care needs, social needs, support and environment — must remain the focus.

To preserve this focus, technology plays a critical role. Electronic health records, for example, assist PACE interdisciplinary teams in monitoring and managing each participant's care. Due to the risk-based nature of payments, PACE invests a significant portion of revenue in data management and benchmarking to measure quality improvement and cost control. The EHR systems and other tools used throughout the PACE network significantly enhance analysis.

These systems, however, must be flexible and adaptive to the needs of the individual patient. Currently, half of the PACE organizations use EHRs, with several more planning to transition over the next 12 to 18 months.

Putting Patients First

Whether it is to curb hospital readmissions or simply to improve continuity of care, the PACE model addresses each patient's unique needs. To encourage collaboration among hospital and non-hospital providers, PACE organizations have experimented with changes to the traditional PACE model and identified promising practices and techniques that are adaptable to a range of health care settings. For example, some PACE organizations are contracting with community-based physicians, rather than relying solely on staff physicians. Through the use of EHR technology and nurse practitioners, community physicians are being integrated into interdisciplinary care teams.

PACE organizations are exploring both formal and informal arrangements to share the benefits of the model with hospitals and health systems. Either by subcontracting certain PACE services, or joining other emerging models of care such as accountable care organizations, PACE organizations have emerged as trusted, experienced partners that will continue to address some of our nation's most pressing health care challenges.

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