



Advancing Senior Care through Data-Driven Innovation at Not-for-Profit Organization's Florida PACE Centers

Background

This customer is a not-for-profit organization with a legacy spanning over 85 years, dedicated to providing healthcare and living options for older adults. Based in South Florida, they employ over 900 professionals committed to delivering high-quality, compassionate care and services to the population they serve. A cornerstone of their services is **Florida PACE Centers (Program of All-Inclusive Care for the Elderly)** – a comprehensive, federally funded initiative through the Centers for Medicare & Medicaid Services (CMS). PACE is designed to provide coordinated medical and social services to frail, community-dwelling older adults who are eligible for nursing home care but wish to remain living independently.

Serving over 1,200 participants across Miami-Dade and Broward Counties, Florida PACE Centers empower seniors to maintain independence and thrive within their communities while championing healthy aging and quality of life.

Situation

Evolving from its origins as a nursing home, the customer has become a leader in senior healthcare and living options which include independent and assisted living, affordable senior housing, a 32-bed hospital, a state-designated memory disorder clinic and clinical research site, integrated rehabilitation, a home health agency, and a growing focus on PACE. As they deepened their commitment to the PACE model, they needed a scalable, data-driven solution to support operational efficiency, improve patient outcomes, and ensure financial sustainability.

The leadership team envisioned the organization becoming a PACE-focused equivalent of an Accountable Care Organization (ACO), with a strong emphasis on population health, cost management, and quality of care. However, they faced several operational barriers, including the manual preparation of KPI reports, which consumed nearly a week each month for two full-time staff members. These inefficiencies limited visibility into performance data and delayed action on key initiatives. To move forward, the customer required a platform that could automate analytics, support proactive care planning, and fuel strategic decision-making.

Solution

To address these challenges, the customer partnered with The Garage to implement **BRIDGE**, a comprehensive population health platform designed to unify and activate data across their ecosystem. BRIDGE integrates data from multiple databases and sources—memberships data, medical & pharmacy claims, and clinical records—into a centralized system, providing real-time visibility and actionable insights.

At the heart of the implementation was the development of the **PACE Quality KPI Dashboard**—a dynamic, automated dashboard tailored to the customer's PACE program. Previously, compiling essential metrics was a manual process that took two full-time team members nearly a week each month. With the Dashboard, the customer now has access to up-to-date performance data refreshed weekly, allowing



leadership and the PACE Interdisciplinary Team (IDT) to make faster, more informed decisions. The automation has significantly improved operational efficiency, freeing up staff to focus on delivering high-quality, person-centered care.

Supporting this transformation, The Garage also integrated BRIDGE with the **Florida Health Information Exchange (FLHIE)** to provide real-time ADT (admission, discharge, transfer) notifications. This capability enhances care coordination by alerting the IDT to critical patient events in real time, enabling quicker interventions and better continuity of care for participants.

Together, these innovations have empowered the customer to drive operational excellence, strengthen outcomes, and position their PACE program for scalable, sustainable growth.

Outcome

The implementation of BRIDGE enabled the customer and Florida PACE Centers to transform how they manage and deliver care. By automating data aggregation and analysis, the customer can make faster, more informed decisions that drive better outcomes and organizational growth. BRIDGE provides advanced analytics and deep visibility into their PACE patient population, offering insights into clinical distribution, utilization patterns, cost trends, risk stratification, and care gaps.

These capabilities allow the care team to identify high-risk individuals, prioritize interventions, reduce avoidable hospitalizations, and enhance overall program efficiency. Using the tools in BRIDGE, the customer can better track performance against quality benchmarks, monitor social determinants of health, and align care delivery with value-based goals—key factors in improving outcomes and achieving long-term sustainability in a PACE model.

Most importantly, by automating manual processes such as reporting and performance tracking through the **PACE Quality KPI Dashboard**, staff can focus on what matters most: providing compassionate, personalized care that supports aging adults in living healthier, more independent lives.

"Partnering with The Garage and implementing the BRIDGE platform has been transformative for us. With advanced data aggregation and real-time analytics, we now have clear visibility into our PACE population. Automating our PACE Quality KPI Dashboard has eliminated weeks of manual work, allowing our teams to focus more fully on delivering high-quality, compassionate care. BRIDGE empowers us to elevate care coordination, optimize costs, and drive sustainable growth as we expand our impact in PACE."

– EVP PACE – President, Florida PACE Centers

Interested in learning how The Garage can empower your organization?
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