# Webinar Q&A: Caring for Older Adults with Complex Needs in the COVID-19 Pandemic: Lessons from PACE Innovations

During the June 30, 2020 Better Care Playbook webinar, *Caring for Older Adults with Complex Needs in the COVID-19 Pandemic: Lessons from PACE Innovations*, presenters received a questions for which there was insufficient time to address. Following are responses to those questions, organized by theme, provided by Peter Fitzgerald, MSc, Executive Vice President for Policy and Strategy at the National PACE Association.

## Program of All-Inclusive Care for the Elderly (PACE) Organization Operational Changes in Response to the Pandemic

In response to the COVID-19 public health emergency (PHE), many PACE organizations (POs) closed their PACE centers and/or clinics and others very substantially reduced the number of PACE participants receiving care and services in these settings. As the pandemic proceeds, POs are considering many factors in determining when and how best to use PACE centers and provide clinic services. This includes ensuring compliance with governmental guidance and state specific reopening guidelines; facility and transportation considerations (e.g., determination of capacity limits to accommodate physical distance recommendations); availability of personal protective equipment (PPE); infection control protocols; and workforce management.

It is possible that changes to how POs operate that were developed in response to the pandemic will continue into the future. One of the webinar's featured POs observed that they "would anticipate that the PACE model is indefinitely changed given the nature of this virus and the vulnerability of PACE participants. We have also seen the benefit of diversifying the service delivery platforms, and the flexibility to structure the setting of care in a way that best meets the individual's needs and preferences."

## Screening PACE Participants for COVID-19

POs have implemented an array of strategies to assess participants' status prior to receiving services in the home, services in the PACE center, and transportation services. This includes telephonic assessments prior to providing home care services; screening and temperature checks prior to transport; and screening and temperature checks upon arrival to PACE center.

## PACE Organizations' Use of Technology During the COVID-19 Pandemic

In response to the COVID-19 crisis, many POs have expanded upon their telehealth programs to meet the clinical, behavioral health, and social needs of those served. Enforcement discretion from the Centers for Medicare & Medicaid Services (CMS) allows for POs' use of remote technology as appropriate during the COVID-19 emergency, including for scheduled and unscheduled participant assessments, care planning, monitoring, communication, and other related activities that would normally occur on an in-person basis. This includes the increased use of remote patient monitoring devices to monitor varying medical data,

inclusive of vital signs, weight, blood pressure, blood sugar, blood oxygen levels, and heart rate; leveraging the use of basic technologies and software, e.g., telephone, smartphones, FaceTime, etc., to expand upon telehealth services; and acquisition and distribution of tablets specifically designed for seniors. Funding sources for technologies acquired vary among POs.

## Supplemental Information on Piedmont Health SeniorCare

During the webinar, specific questions were addressed to Piedmont Health SeniorCare. Below are the answers to these questions:

1. **What EHR system do you use at Piedmont Health SeniorCare?**
   GE Centricity / Athena Health.

2. **What are the demographics for the Piedmont Health SeniorCare location?**
   Average age is 74; Average time in our program is 3.19 years; Race: 45% Black or African-American, 43% Caucasian, 11% Hispanic, 6% Asian, <1% Native American; 23% chronic lung disease, 39% chronic heart disease, 19% stroke, 47% cognitive impairment, 14% BMI>40, 26% chronic renal disease, 42% diabetes, 39% depression; 45% high risk of fall, 65% needs assistance walking.

3. **Where is Piedmont Health located?**
   Piedmont Health SeniorCare is located in North Carolina. They serve the following counties: Alamance, Caswell, Chatham, Lee, and Orange.

## Use of the PACE Center as an Infirmary

One of the featured POs (Summit ElderCare) described their repurposing of their PACE center to serve as a 24-hour infirmary. The use of the center as an infirmary helped the PO reduce hospitalizations and post-acute care nursing home placements. Eleven PACE participants received services in the infirmary. Infirmary stays were short for most. Of the 11 participants, eight were discharged to the community and three passed away at the infirmary. None of the 11 returned to the hospital.

## PACE Financial Model and Sustainability during the COVID-19 Public Health Emergency

POs take on full financial risk for all Medicare and Medicaid covered services as well as any additional services necessary to care for their participants. They are able to bear this risk by using their comprehensive, interdisciplinary care team model to effectively address PACE participants' chronic care and functional support needs. POs reduce expensive acute and specialty care through their effective care model which enables them to provide the primary, preventive, and rehabilitative care and social supports their participants need.

During the COVID-19 PHE, POs continued to receive funding on a per person, per month basis allowing them to shift the delivery of many services into participants' homes and to expand their use of telehealth. The COVID-19 PHE increased PPE costs for all POs, and some reported increased costs related to hospitalizations and testing. At the same time, some POs experienced a reduction in their census, as fewer new participants enrolled and rates of disenrollments increased due to COVID-19 deaths. Overall, POs have been able to work within the capitated funding they receive to deliver the care their participants need

with an increased emphasis on in-home services. The higher costs of these increased services have been at least in part offset by reduced costs of PACE center-based services.

Approximately 80 percent of POs are sponsored by a nonprofit entity. The missions of these nonprofit entities support their PACE operations. Nonetheless, the PACE financing model is able to support a reasonable operating margin for most POs and a nonprofit sponsorship is not required for the PO to be sustainable. Of the over 140 POs that have started operations, over 95 percent continue to operate today. For those POs that have closed, closures have been due to state elimination of Medicaid funding, insufficient enrollment growth, and site-specific cost drivers that could not be supported under the program's capitated revenues.

## Service Utilization During the COVID-19 Public Health Emergency

There was interest in how service utilization patterns may have shifted during the COVID-19 PHE. NPA does not have access to data that addresses changes POs may have experienced. Anecdotal information provided to the association indicates that hospitalizations, emergency room visits and specialist care have declined during the PHE. Similarly, anecdotal information does not indicate an increase in nursing home placements as a result of PACE participants not being able to receive services in the PACE center. This reflects the POs' shift to providing many previously center-based services in participants' homes.

## Comparing COVID-19 Cases and Deaths in PACE to other Care Models

A speaker noted that four percent of PACE participants had tested positive for COVID-19 and one percent of all PACE participants had died from the virus. It is not yet known how these rates compare to other health care models; NPA is in the process of identifying data sources to support a comparison in the future.

## PACE Organizations' Locations and the Role of States

Currently there are 134 POs in 31 states. A complete list of POs can be found on the NPA website. Operationally, PACE is unique and implemented through three-way program agreements among the CMS, states, and POs. Therefore, before a PO can open in a state, the state must select it as an optional benefit under its Medicaid program. Reasons cited by states without PACE include uncertainty about how the PACE program can complement existing Medicaid benefits and budgetary considerations. State reimbursements to PACE are required to be less than the state's estimate of what it would spend otherwise for a person comparable to a PACE enrollee. Nonetheless, states may see PACE expenditures as adding to, rather than substituting for, other state-funded services and therefore may not choose PACE as an option.

## Serious Mental Illness Care and PACE

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), serious mental illness (SMI) includes a range of diagnoses: "SMI is a diagnosable mental, behavioral, or emotional disorder that an adult has experienced in the past year that causes him or her serious functional impairment that substantially interferes with or limits at least one major life activity. Examples include schizophrenia,

bipolar disorder, and major depression, as well as other disorders that cause serious functional impairment."

Over the years, POs have experienced an increase in the number of PACE participants with at least one behavioral health (BH) condition. Between 2014 and 2019, the percent of PACE participants with a BH condition increased from approximately 60 to 65 percent (please see data tables below). This population continues to grow in PACE, and programs vary in their approach to providing BH services. POs must furnish all Medicare and Medicaid services, in addition to other services determined medically necessary to improve or maintain participants' overall health. This includes meeting participants' behavioral health needs.

Behavioral health needs are met through either employment of a behavioral health specialist(s) on the PO's staff or by contracting out for services. POs often engage social workers to support with screening of participants to determine BH need, and for overall case management. PACE participants, as needed, are then referred to a BH specialist to receive necessary care (be it in-house or through contracted providers in the community). Smaller programs are more likely to contract out for BH services. Overall, BH specialists work closely with the PACE interdisciplinary team, hence providing a holistic approach to meeting all of participants' medical and behavioral health needs.

**2014:** The data is based on 100 POs, with a total enrollment of 36,866 participants, of which 22,010 (or, 59.7%) had at least one BH condition.

| Psychotic | Bipolar | Major Depressive Disorders | Anxiety Disorders | Personality Disorders | Development Disorders | Substance Use |
|---|---|---|---|---|---|---|
| 16.3% | 8.3% | 71.7% | 49.5% | 4.1% | 3.5% | 17.3% |

**2019:** The data is based on 107 POs, with a total enrollment of 46,352 participants, of which 29,942 (or, 64.6%) had at least one BH condition.

| Psychotic | Bipolar | Major Depressive Disorders | Anxiety Disorders | Personality Disorders | Development Disorders | Substance Use |
|---|---|---|---|---|---|---|
| 18.7% | 10.7% | 86.0% | 62.6% | 4.4% | 4.5% | 20.6% |

## About the Better Care Playbook

The Better Care Playbook is an online resource center designed to help health care stakeholders find the best in evidence-based practices and promising approaches to improving care for people with complex health and social needs. It is made possible by six leading health care foundations — Arnold Ventures, The Commonwealth Fund, The John A. Hartford Foundation, the Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation — that are working together to accelerate health system transformation. To learn more, visit **bettercareplaybook.org**.