Caring for Older Adults with Complex Needs in the COVID–19 Pandemic: Lessons from PACE Innovations

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Welcome & Introductions

Logan Kelly
Senior Program Officer, Center for Health Care Strategies
Agenda

- Welcome and Introductions
- Overview of PACE Program and Enrollee Needs During the COVID-19 Pandemic
- Lessons from PACE Innovations
- Policy Considerations
- Implications for Health Care Stakeholders Responding to Older Adults’ Needs in the Pandemic
- Moderated Q&A
Today’s Presenters

- Peter Fitzgerald, MSc, Executive Vice President for Policy and Strategy, National PACE Association (NPA)
- Mia Phifer, MSJ, Vice President of Quality, NPA
- Chris van Reenen, PhD, MPP, Vice President of Regulatory Affairs, NPA
- Marianne Ratcliffe, MHA, Executive Director, Piedmont Health SeniorCare
- Samantha Black, LCSW, Executive Director, TRU PACE
- Robert Schreiber, MD, Vice President and Medical Director, Summit ElderCare
- Anne Tumlinson, CEO, ATI Advisory
About the Better Care Playbook

Online resource center offering the latest knowledge on evidence-based and promising practices for people with complex health and social needs

Provides practical how-to guidance to inform health system leaders, payers, policymakers and others on strategies to improve care for high-need, high-cost populations

Coordinated by the Center for Health Care Strategies through support from seven leading national health care foundations — Arnold Ventures, The Commonwealth Fund, The John A. Hartford Foundation, Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation.

www.BetterCarePlaybook.org
Overview of High-Need, Dually Eligible Individuals

- Over 12 million individuals are dually eligible for Medicare and Medicaid
- Dually eligible individuals are a high-need, high-cost population
  - 70% have been diagnosed with at least 3 chronic conditions
  - Over 40% have a behavioral health condition
  - Over 40% use long-term services and supports
- High risk of receiving uncoordinated care
- Less than 10% receive integrated care nationally

Sources:
PACE Evidence

- The Program of All-Inclusive Care for the Elderly (PACE) is an integrated model of care that serves individuals who need long-term care
  - 90% of PACE participants are dually eligible individuals

- Evidence of positive outcomes
  - Fewer hospitalizations
  - Improved quality of care for certain aspects of care
  - Effective in reducing institutional care, especially for people with dementia
  - High levels of participant satisfaction

Dually eligible individuals are more than 4 times more likely than Medicare-only beneficiaries:

- To be diagnosed with COVID-19
- To be hospitalized with COVID-19

Black dually eligible individuals have the highest rates of cases and hospitalizations.

Overview of PACE Program and Enrollee Needs During the COVID-19 Pandemic

Mia Phifer, MSJ, Vice President of Quality, National PACE Association
Chris van Reenen, PhD, MPP, Vice President of Regulatory Affairs, National PACE Association
What is Program of All–Inclusive Care for the Elderly (PACE)?

An integrated care model and delivery system

- Community-based
- Capitated
- Comprehensive
- Coordinated
Who does PACE serve?

- 55 or older
- Live in the service area of a PACE organization
- Need a nursing home-level of care (as certified by the state)
- Able to live in the community at the time of enrollment – with support of PACE
PACE in the States (as of June 2020)

31 states have PACE programs

133 Sponsoring Organizations
263 PACE Centers

as of June 2020
PACE Enrollment (as of June 2020)

- **2016**: 41741
- **2017**: 45437
- **2018**: 49156
- **2019**: 53200
- **2020**: 54000

**Characteristics of PACE Participants**
- **Women**: 69%
- **Men**: 31%
- **Chronic Conditions**: 5.8%
- **Dementia**: 46%
PACE Services

- All Medicare- and Medicaid-covered services
- Other services determined necessary by the interdisciplinary care team (IDT) to improve or maintain overall health status
- The PACE Organization is responsible for provision and integration of all services inclusive of medical care, behavioral health care, and long-term services and supports across all settings and over time
PACE Services

- Adult day care
- Behavioral health services
- Durable medical equipment
- Emergency services
- Home care
- Hospital care
- Laboratory/x-ray services
- Meals
- Medical specialty services, including audiology, dentistry, podiatry, optometry
- Nursing home care
- Nursing services
- Nutritional counseling
- Prescription drugs
- Primary and preventive care
- Recreational therapy
- Rehabilitation therapy
- Social services, including caregiver training, support groups, and respite care
- Social work counseling
- Transportation
Integrated, Team-Managed Care

- An interdisciplinary team
- Team managed care vs. individual case manager
- Continuous process of assessment, treatment planning, service provision and monitoring
- Focus on primary, secondary, tertiary prevention
Capitated, Pooled Financing

- Medicare capitation rate adjusted for demographic and diagnostic characteristics, and frailty of PACE enrollees
  - 2020 Mean Medicare PMPM Rate: $2,797

- Medicaid capitation rate based on UPL rate-setting methodology
  - 2020 Mean (Dual) Medicaid PMPM Rate: $3,981

- Integration of Medicare, Medicaid and private pay pay payments
PACE Response to COVID-19

- Transformation into largely home-based model
- Expansion of telehealth services
- Workforce redeployment
- Use of remote technology to meet participants’ social needs
- Repurposing of PACE center resources
  - PACE Center
  - Transportation vans
Impact of COVID–19 on PACE Participants

- 100 of 133 PACE organizations (PO) have reported COVID-19 data to NPA, beginning April 27

- Analysis of PO data reported as of June 14 indicates:
  - ~4% of participants reported to be confirmed with COVID-19
  - ~1% of participants reported to have COVID-19 related death
  - Regional variations in POs’ experience resemble national experience

- Although data are limited, it appears that the majority of COVID-19 related deaths occur among residents of skilled nursing facilities and other congregate living settings
Pivoting Chronic Care Management in the Era of COVID-19

Marianne Ratcliffe, MHA
Executive Director, Piedmont Health SeniorCare
Background

- **Piedmont Health Services**
  - Federally Qualified Health Center established in 1970
  - 10 community health centers
  - Mix of rural and urban service areas

- **PACE – Piedmont Health SeniorCare**
  - 1st site opened 2008, 2nd site 2014
  - Serves 325 frail, financially needy seniors
  - Average 8 chronic conditions, 12 Rx upon enrollment
    - 23% chronic lung disease
    - 39% chronic heart disease
    - 19% stroke
    - 26% chronic renal disease
    - 42% diabetes
    - 39% depression
    - 47% cognitive impairment
    - 14% BMI>40
Participants’ Needs vs PACE’s Challenges to Serve

- PACE – Full responsibility, full spectrum care
- Participants vulnerable for serious complications from COVID-19
- Congregate settings high risk for exposure
- PACE - high touch, low tech; inverse of COVID
- Center-based services → Home-based services
- Intensive Care Management: Primary Care, Behavioral Health, & Functional Supports
New Service Delivery Platforms

- Risk stratification
- Care plans → new delivery platforms
- Regular review of patients’ chronic conditions & wellbeing
- Protocols for monitoring highest risk
- Telehealth equipment & technology
- Home care license – temporary waiver during emergency response
- Reassigned / redeployed staff
- Mobile exam room
Implementation

- Telehealth alerts – management of chronic issues
- Televideo – evaluations of acute or episodic issues
- Weekly review of systems
- Aides are additional eyes & ears
  » Prompt clinic visit with PCP, home visit, clinic visit, ER referral, or specialty consult
- Functional supports for CCM: Infections, Rx adherence, Nutrition, Falls, Depression
- Care Management huddles 2x/day per team to coordinate care
Lessons Learned, Future Plans

- Continue to evolve service delivery platforms, staffing, and allocation of resources to meet patient needs in era of COVID
- Risk/benefit of attendance at the day center, in-home care, remote/telehealth
- Impact Outcomes – access, quality, margin
- Appreciation of capitated structure
Mitigating the Impact of COVID–19 on the Social Determinants of Health

Samantha Black, LCSW
Executive Director, TRU PACE, Colorado
An Overview of TRU PACE Participants

- Location: Lafayette, Colorado / Boulder County
- Census: 190
- Average age: 76
- 75% White/Caucasian, 18% Hispanic, 3% African American, 4% Asian American, Native American, or other
- 76% live in private home/apt, 18% AL, 6% SNF
- Of those in private homes, 60% live alone
- 37% have cognitive impairment
- All meet NF-eligibility criteria
COVID: Impact on Social Determinants of Health among Older Adults

- Poverty / economic hardship
- Stable, safe, affordable housing
- Nutrition / food security
- Transportation
- Access to preventive medical care
- Social relationships / engagement

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
Making Meaningful Contact

- Daily staff calls
- Tablets, smartphones, and social platforms
- Weekly Town Halls
- Engaging the Participants:
  - Phone Tree
  - New Participant Phone Buddies
- Socialization Groups
- Trishaw Program
- Adopt-a-Grandparent – intergenerational pen pals

Cycling Without Age: https://cyclingwithoutageboulder.com; Circle Talk: https://www.circletalk.org/
Adopt-a-Grandparent Program

- Intergenerational socialization
- Community engagement
- Pen pals, phone calls, zoom calls
- Lifelong friendships

Implementation:
- 1-2 hrs / week
- Consents
- Screening / video interview
- Background checks
- Activity materials, list of ideas
- Storytelling interviews
Lessons Learned, Next Steps

- “Active participants, not passive recipients” of care
- Generational characteristics – engaging national / global events
- “Venerable, Not Vulnerable”
- The Power of PACE: COMMUNITY
- Belonging, inclusion, contribution

Next Steps:
  » Vibrancy Program
  » Teen Tech volunteers
Fallon Health’s PACE Program in the Age of COVID-19: Repurposing the Day Center for 24-Hour Care

Rob Schreiber MD, AGSF
Fallon Health Summit ElderCare
Worcester, Massachusetts

June 30th, 2020
Summit ElderCare®: An Overview

- 7th largest PACE program in the country, largest in New England
- 6 PACE sites located in Massachusetts and one in Western New York
- 1,323 participants as of June 1
- Celebrating 25th anniversary in 2020

Fallon Health’s newest PACE site located in Worcester, Mass.
Participant Needs During the Pandemic

• COVID-19 Related Challenges
• All 6 Summit ElderCare Centers remained open, but only half had participants attending
• Adjusted to deliver care and social services to participants in their homes
Summit ElderCare® Infirmary

- Delineating vision and goals for an alternative care setting
- Getting approval from the Executive Office of Health and Human Services (EOHHS)
- Rapidly developing implementation and budget plan
- Approval and sign off from all Stakeholders
Implementing a 22-bed Skilled Care Unit

Readiness
- Operational planning, policies & procedures
- Identifying/ training site leadership and staff
- Covid-19 Testing
- Obtaining PPE
- Building code upgrades

Operations
- Admissions
- Food
- Medications
- Therapy
- Family Visits
- Discharge planning
Key Dates & Short Term Wins

- Opening date April 22
- First participant admitted April 23
- 11 participants served
- Longest stay 23 days
- Shortest stay 7 days*
- Last participant discharged June 5

After a 10-day stay, the first participant to be discharged was celebrated as she headed home.
Lessons Learned

- PACE can uniquely transform to meet the needs of frail older adults in novel ways
- Innovations can give families hope, hospitals options
- Now more than ever, PACE should be available to all eligible older adults
- What does PACE look like moving forward?

Participants enjoy a socially distant music therapy program while receiving care at the Summit Infirmary.
Policy Implications

Peter Fitzgerald, MSc, Executive Vice President for Policy and Strategy, National PACE Association
Policy Implications

- It's the PACE Interdisciplinary Team (IDT), not the Center, that integrates care
  - IDT communication
  - Trusting, established relationships with participant and caregiver
- PACE Center might evolve to address
  - Respite care
  - Overnight care
  - Temporary shelter
- Increasing role of telehealth
  - Intake, assessment and care planning
  - Care delivery
- Expedited access to post-acute care
Policy Questions

- How to assess a PACE organization’s capacity
- Retaining flexibility for telehealth – assessments, care delivery
- Role of paid and unpaid family caregivers
- Timely access to PACE
  - Expediting eligibility determinations
  - Mid-month enrollment
- Adaptations and expanded scope of populations served by PACE
  - Under 55
  - At-risk
Implications for Health Care Stakeholders Responding to Older Adults’ Needs in the Pandemic

Anne Tumlinson, CEO, ATI Advisory
Question & Answer
Questions?

To submit a question, click the Q&A icon located at the bottom of the screen.
Share Your Successes on the Playbook

- Have you established a promising practice?
- Published a study about your complex care program?

The Playbook welcomes content submissions to help spread best practices in complex care.

www.BetterCarePlaybook.org
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Please submit your evaluation survey.