

PACE TELEHEALTH

PLAYBOOK

Using Telehealth to Care for Seniors at Programs
for the All-Inclusive Care of the Elderly



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FOREWORD



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The Program for the All-Inclusive Care of the Elderly (PACE) is an effective model that provides wrap-around care via an interdisciplinary team of providers to typically underserved, vulnerable seniors. As of 2021, the PACE model operates in 30 states. There are 139 sponsoring PACE organizations in the US, running 272 PACE centers, serving approximately 55,000, mostly dual-eligible, seniors. PACE uses a well-coordinated team of staff and providers from the following disciplines: primary care, social work, physical therapy, occupational therapy, nursing, recreation therapy, dietician, home care, transportation, PACE center manager, and personal care. PACE coordinates care across all care settings including specialty care, drugs, transportation, home care, and meals. Participants are transported by PACE an average of 16 trips per month. Nationally, PACE provides almost 22,000 meals every day to participants.

Finally, from a clinical standpoint, participants' average age is 77-years, they have an average of six chronic conditions, six different prescriptions, and almost half of participants have some form of dementia.

Managing such a clinically and socio-economically complex caseload of seniors is a complicated endeavor. For any PACE organization to become or remain economically sustainable, it must closely monitor operational efficiencies, particularly with respect to its highest expense categories, such as emergency department (ED) and hospital utilization, transportation, and exacerbations of chronic diseases, including mental health disorders. This guide describes new, innovative ways of using telehealth to manage clinical care and the expenses related to these high expense categories with the goal of supporting PACE in providing high-quality care to seniors in a financially sustainable manner. As you read this guide, think about your own PACE program and match the opportunities that are described with your highest priority areas. Deciding which problem(s) you want to solve with telehealth will help you determine which telehealth model you will deploy. At that point, we suggest downloading our implementation guides that more specifically describe implementation steps.

We wish you success on your journey using telehealth to provide high-quality and economically efficient care to your PACE participants.

Sincerely,

Zia Agha, MD & Ross Colt, MD



INTRODUCTION

The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive health care delivery system integrated with Medicare and Medicaid financing. PACE organizations provide comprehensive services, including medical care, personal care, supportive services, transportation, adult day health care, inpatient hospital and nursing facility care coordination, caregiver education, assistive devices, social services, and prescription drugs.

These services are provided in multiple locations including the PACE facility, participants' homes, and inpatient facilities. The PACE facility is a clinic and an adult day center setting, where participants gather for socialization, meals, and clinical care. Eligible individuals are age 55 years or older and meet the clinical criteria for nursing home admission but choose to remain in their own homes and communities.

PACE Terminology



Participant(s):

Seniors who are enrolled with a PACE Organization, similar to the terms “patient(s)” or “client(s)”.



PACE Organization:

The umbrella term used to describe an entire PACE entity, encompassing all staff and services. Some PACE Organizations manage several facilities, all under the same leadership or health system – in this case, “PACE Organization” is used to describe the entire program and each of their locations.



PACE Facility:

The physical site where participants receive care. For the purpose of this guide, “PACE Facility” will refer to the entire physical site, including both clinical/medical services and general day center services.

01

TELEHEALTH
AS A TOOL



Telehealth as a Tool

PACE providers must have many tools in their toolboxes to meet their participants' many needs. Using telehealth as a new way of caring for participants adds a new tool to that toolbox. Used strategically and pragmatically, telehealth can supplement and enhance care that is already being provided by enabling additional methods of surveillance, interactions, and support from afar.

There are a variety of ways that telehealth can be used – each way is its own type of tool for addressing a particular challenge. It is critical to the success of any telehealth program to identify a telehealth tool or model that adequately addresses the challenge at hand. For example, telehealth visits can be completed by telephone or by video.

Using the telephone to check in on participants requires very little upfront resources (technology, training, planning, etc.) and may be quite effective if the problem is straightforward – such as making regular contact with an isolated senior. Making regular contact with an isolated senior can also be accomplished through video visits. However, video visits require more upfront resources and there may be little added benefit to the video as compared to a phone call for a particular problem. In contrast, a video visit may be the right tool if the participant's problem needs to be visualized by a provider – such as viewing a wound or lower limb edema. In that case, a phone visit would not be the right tool, even though it is easier to deploy; instead, a video visit would be the best tool.

Successful telehealth implementation will not rely solely – or even primarily – on the technology, but on the programmatic planning and intervention surrounding it. As such, the best way to begin using telehealth within your PACE organization is to start by identifying and

prioritizing the problems you wish to address. Keep in mind that as you consider what to implement and how to get started, it is best to start small and tackle one problem at a time by defining the problem and determining which telehealth tool best fits the problem.



Tool A: AUDIO ONLY VISITS

Audio only visits refer to the use of telephone to connect with someone without using video or images. These visits typically consist of evaluation and management of a participant's condition and may include check-ins, follow-ups, and assessments.



Key Benefits:

- **Accessibility** – participants do not need any equipment other than a telephone (can be a landline)
- **Ease of use** – since most participants have experience using telephones, there is no additional training, instruction, or facilitation necessary
- **Affordability** – PACE does not need to purchase any new devices, transport participants, or pay for staff to travel to participants' homes.



Tool B: LIVE VIDEO VISITS

Live video visits refer to the use of audiovisual telecommunications technology for real-time two-way interactions that enable visualization

of participants and their environment. This tool enables PACE staff to see, examine, and talk to participants remotely in real time. These visits work well for evaluation and management, discussions with IDT members, participation in social activities, family meetings, and visits with outside specialists.



Key Benefits:

- **Physical assessment** – providers can see different parts of participants' bodies for assessment (inside of the mouth, show a rash, demonstrate mobility, visualize lower limb edema etc.).
- **Environmental cues** – video grants providers additional context about the participants' environment that can provide insights into their overall condition (house upkeep, personal hygiene, tripping hazards etc.).
- **Affordability** – relatively inexpensive devices can be used to complete live video visits. Also, PACE can reduce transportation needs and costs by conducting video visits as a replacement for some clinic visits and home visits.



There are two main factors that impact live video visits: (1) where is the equipment coming from; and (2) who is facilitating the participants' use of technology for the visit?

Although participants may own personal devices that could be used for telehealth encounters, we recommend that PACE provides the devices. This eliminates the concern that participants' devices are compatible with the telehealth software being used by PACE or specialists' staff and eliminates the need for participants to know how to navigate the technology (such as keep track of which apps to download, know how to set up, remember which usernames or passwords are needed, troubleshoot problems, etc.). We also recommend using a facilitator - someone who helps the participant navigate the visit. The facilitator does not need to have a specific role or specialty, nor do they need to be hired for this purpose only - any staff member can learn the necessary steps and assist. Often, Medical Assistants (MAs) and Personal Care Attendants (PCAs) act as facilitators.



Tool C:
REMOTE PATIENT MONITORING (RPM)

RPM refers to the use of digital technologies to collect health data from participants and electronically transmit that information securely

to health care providers. RPM allows participants to obtain biometrics, such as blood pressure, pulse, weight, glucose level, and oxygenation that are then transmitted to the clinical team at PACE to monitor, assess, and adjust treatment plans if necessary.



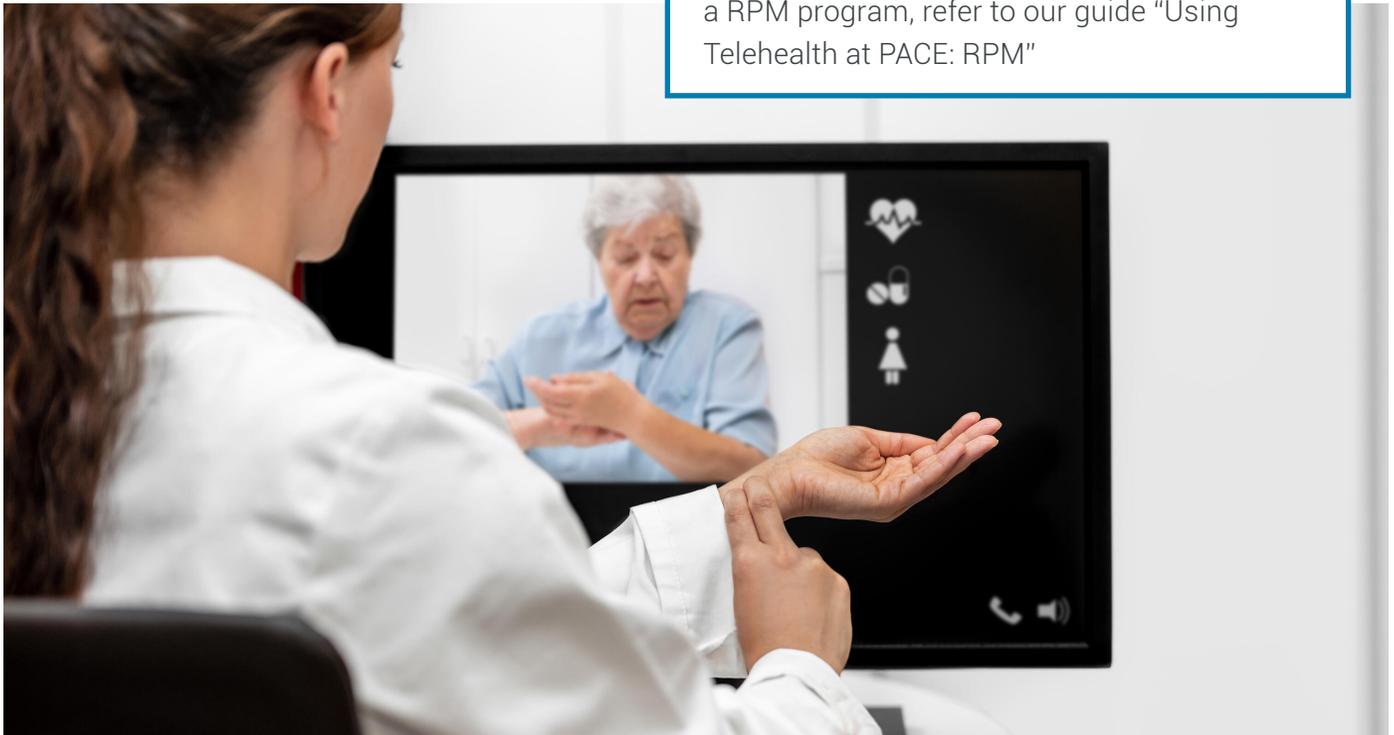
Key benefits:

- **Access to additional data** – RPM provides PACE with day-to-day biometric information about participants' health. The data RPM supplies can support better short- and long-term management of symptoms and potentially avoid unnecessary urgent/acute care and associated costs.
- **Development of participant baselines** – more frequent measurements are helpful in creating accurate baselines and identifying anomalies in participants' conditions, particularly if there is a recent medication change, discharge from a hospital, or chronic condition, such as congestive heart failure or diabetes.

- **Timely alerts** – in many situations, closer monitoring of biometrics can be used to inform the PACE IDT when participants' health is decompensating, allowing for more timely medical intervention and avoidance of potential emergency room utilization.
- **Wireless data sharing** – many RPM devices can upload the data they collect automatically and wirelessly, minimizing mistakes and inconsistencies that arise when relying on a participant to capture, record, and share their biophysiological data. Wireless data also provides time stamps indicating when the data was captured, which is useful in understanding participant patterns and identifying gaps in monitoring.



For more information about how to implement a RPM program, refer to our guide "Using Telehealth at PACE: RPM"





Tool D: E-CONSULTS

e-Consults refer to the asynchronous and secure electronic transmission of medical information, such as digital images, documents, and pre-recorded videos. e-Consults are a method for PACE providers to communicate with outside specialists and gather information to improve care for their participants. e-Consults allow asynchronous, provider-to-provider written communication and consultation that can be accessed either through a shared electronic health record (EHR) or a third-party web portal/platform.



Key benefits:

- **Timeliness** – e-Consults typically have a 72-hour turn-around time; often much faster than scheduling and waiting for an appointment with a specialist.



For more information about how to utilize e-Consults, refer to our guide "Using Telehealth at PACE: e-Consults"

- **Minimal workflow disruption** – the results of the e-Consultation can be faxed or electronically provided to PACE for uploading into the EMR as a standard process. This allows for a consistent approach in managing participants' plans of care after specialists' consultations.
- **Documentation of learnings** – unlike curbside consultations, where providers rely on each other for informal advice or recommendations, e-Consults are available as part of the medical record and can be reviewed by any provider at PACE. This encourages staff to make formal updates to participants' care plans, with clear references to the specialists' input that informed decisions.
- **Affordability** – the cost of an e-Consult is much less than the cost of transporting participants to specialists' site and reimbursing the average specialists fee.

02

OPPORTUNITIES TO

IMPROVE CARE AND
REDUCE COSTS

OPPORTUNITIES TO IMPROVE CARE AND REDUCE COSTS

Given the advanced age and numerous health complexities of PACE participants, many problems arise that are both costly to the organization and detrimental to the participants' health-related quality of life (HRQoL). These complicated problems often require that PACE organizations employ multiple

approaches to strategically overcome them. The examples listed below demonstrate ways in which telehealth can be used as an extension of in-person efforts to reduce costs and improve participant care.

ED and Hospital Utilization Management

Managing ED and hospital utilization is a vital part of running an effective PACE program. PACE Medical Directors and Quality Improvement Directors keep a close eye on utilization of acute services to determine whether participants are receiving appropriate care, particularly because ED and hospital visits are one of the biggest cost drivers at most PACE organizations. Directors must balance utilization management with risk management, participant wellbeing, and appropriate access to care.

According to the Centers for Disease Control, 20% of all ED visits in the United States are made by people over the age of 60, which is equal to an annual average of about 29 million ED visits (2014-2017).¹ The rate of ED visits increases in all age categories above 60.¹ Not only are ED visits expensive themselves, averaging about \$1,100 each (facility and physician charges only), but they also tend to entail the need for transportation via



ambulance for people over the age of 60, which is also costly.¹⁻² In addition, the percentage of ED visits that result in hospitalization increases with each age category over 60.¹ PACE participants are vulnerable to risks that accompany hospital stays, such as hospital acquired infections and delirium. Hospitalization is one of the costliest medical expenses, averaging \$13,600 per stay when Medicare was the primary payer in 2017.³

Program Goal:

Reduce avoidable ED and hospital utilization without sacrificing quality of care.

Steps:

01

Assess participant for new or recurrent changes in medical condition.

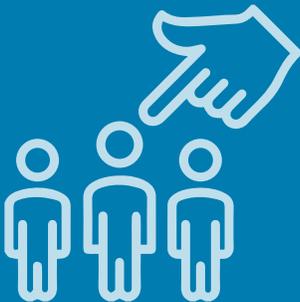
02

Maintain a multi-pronged approach to communicating, interacting, and supporting participants that call the ED for medically unnecessary visits.

03

Monitor and develop protocols for commonly avoidable hospitalization signs/symptoms for pneumonia, CHF, dehydration, and UTI.

Participant Selection:



01

All PACE participants, OR..

02

High utilizers of ED and hospital resources that, after review, are deemed unnecessary or avoidable, OR..

03

Participants that are new to PACE, have incomplete past medical records, and have challenges managing their health while at home

Clinical Practice and Operational Spotlight: Improving Medication Management

Adherence to prescribed medications is associated with improved clinical outcomes, however 40% to 50% of patients who are prescribed medications for management of chronic conditions, such as diabetes or hypertension, do not take them as prescribed.⁴ Additionally, nonadherence is associated with

higher rates of hospital admissions, suboptimal health outcomes, increased morbidity and mortality, and greater health care costs. Understanding and addressing the causes of nonadherence can help the clinical team adjust the medication regime, treatment, and communication plan.⁵⁻⁶

Telehealth Opportunity: Audio Only Visits

Increase communication about medication between the participant and the clinical team by making daily phone calls after medication changes are made. This will allow the staff to better determine if the medications are having

their desired effect; to provide medication education, such as 'what side effects to expect'; and to reinforce changes to the medication regimen.

Clinical Practice and Operational Spotlight: Decrease Emotional Distress Among Participants with Dementia

Individuals with dementia experience increasing fear and loneliness as their disease progresses. Changes that impact their sense of self, environment, or medical condition may exacerbate feelings of distress, loneliness, and self-worth.⁷

Unfortunately, individuals with dementia have high rates of ED use.⁸ Minimizing travel, avoiding changes to the environment, and addressing needs with familiar faces may help decrease the participant's emotional distress.

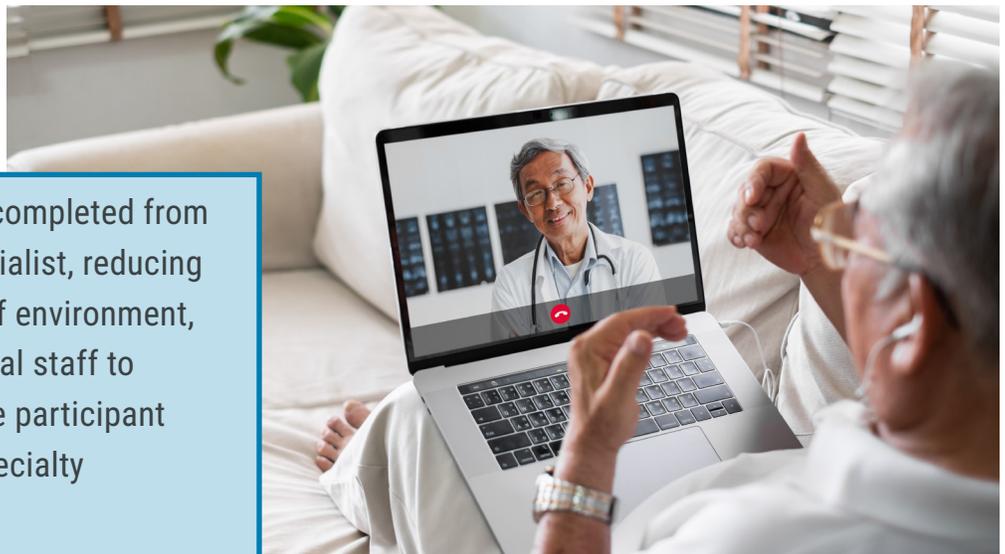
Telehealth Opportunity: Live Video Visits

PACE staff assisted video visits from the participant's home for changes in medical and emotional condition can help avoid additional participant distress while enabling PACE staff to provide care that is participant-centric, due to

their knowledge of the participant's preferences and capabilities. The video visit capability is especially useful for further assessing commonly avoidable hospitalization signs/symptoms for pneumonia, CHF, dehydration, and UTI.



Video visits can also be completed from the PACE Clinic to a specialist, reducing the impact of a change of environment, and the need for additional staff to transport and care for the participant while at an outpatient specialty appointment.



Clinical Practice and Operational Spotlight: Monitor for Changes in Oxygen Saturation and Respiration Rate Among Participants with Flu-like Symptoms

People 65 years and older bear the greatest burden of severe flu disease.

It is estimated that between 70% and 85% of seasonal flu-related deaths have occurred in people 65 years and older, and between 50% and 70% of seasonal flu-related hospitalizations have occurred among people in this age group.⁹

Identifying changes in oxygen levels and respiration rate will allow staff to determine if the participant can be treated at home with supplemental oxygen, fluids, or analgesics or help determine if the symptoms are being caused by something else, such as pneumonia.¹⁰

Telehealth Opportunity: RPM

Remote monitoring of oxygenation levels and respiration rate gives PACE staff important data that is typically only gathered during clinic visits. This information helps more effectively manage

participants' care and provide an opportunity to educate participants about their condition so they can be more empowered and active in their own care.

Measuring the Effectiveness of your ED and Hospital Utilization Program:

It is important to assess the quality and impact of your program against your program goals, no matter the type(s) of telehealth you include in your ED and hospital utilization management program. As an example, the stated program goal (above) was to reduce avoidable ED and hospital utilization without sacrificing quality of care. To assess whether your program is achieving those goals, we suggest monitoring the following outcome measures:

1. Reduction in the number of ED visits by XX%
2. Reduction in the number of hospitalizations by XX%
3. Reduction in rates of admission for specific symptoms and presentations



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03

**CHRONIC
CARE
MANAGEMENT**



CHRONIC CARE MANAGEMENT

The average PACE participant is living with approximately eight medical conditions, many of which are chronic conditions, such as diabetes, dementia, and congestive heart failure. As such, a vital function of PACE is to proactively manage these multiple chronic conditions.

PACE's IDT-based and patient-focused approach lends itself to the management of chronic conditions. Below, we report some of the most common and difficult-to-manage chronic conditions and describe how telehealth can be used to improve clinical outcomes, increase operational efficiencies, and reduce costs.

Program to Improve Diabetes Management:

Diabetes is a chronic disease caused by too much glucose in the blood. Unmanaged diabetes can cause damage to vital organs and reduce the lifespan. Diabetes is quite prevalent in the PACE population. According to a 2018 MEDPAC report, approximately 35% of dual-eligible Medicaid/Medicare beneficiaries aged 65 or over have diabetes.¹ Diabetes also impacts quality of life and is costly to treat. For example, compared to individuals without Type 2 Diabetes, those with Type 2 Diabetes have worse HRQoL, greater decrements in HRQoL over time, and tendencies towards greater depressive symptomology.²

With respect to costs, diabetes is the most expensive chronic condition in our nation.³ Excess medical costs per person associated with diabetes are close to \$10,000 per year and diabetes is one of the top 10 leading causes of death in the United States.⁴ Diabetes-related complications, such as having hypoglycemic episodes and developing diabetic foot ulcers, further reduce HRQoL and increase the costs to treat.²⁻³ In fact, 48% to 64% of lifetime medical costs for a person with diabetes are for complications related to diabetes.⁵ As such, it is imperative that PACE staff effectively manage their participants with diabetes.

Program Goal:

Reduce avoidable diabetes-related complications, such as hypoglycemic episodes and diabetic ulcers, and their related utilization and costs.

Steps:

- 01

Obtain more data about glucose levels in your diabetic participants to lower or maintain HgbA1c levels.

02

Obtain more detailed information about diabetic-related ulcers and other complications in your diabetic participants.

03

Explore and better understand each diabetic participant's personal barriers to controlling glucose levels.

Participant Selection:



- 01

Newly enrolled diabetic PACE participants

02

Participants who have uncontrolled diabetes or are non-compliant with treatment plans

03

Participants with diabetes who have new or changed prescriptions

Clinical Practice and Operational Spotlight: Improving Personal Care

More than 95% of diabetes care is done by the person with diabetes, therefore successful management of diabetes is heavily tied to lifestyle modifications. Improving and increasing

communication promotes the opportunities to build strong relationships, and further enables coaching opportunities and compliance to treatment plan modifications.⁶

Telehealth Opportunity: Audio Only Visits

Increase communication between the participant and the clinical team by making weekly phone calls to provide diabetes-related information, such as nutritional counseling, emotional

support, impacts of medication changes and refills, blood sugar control education, and treatment plan adjustments.

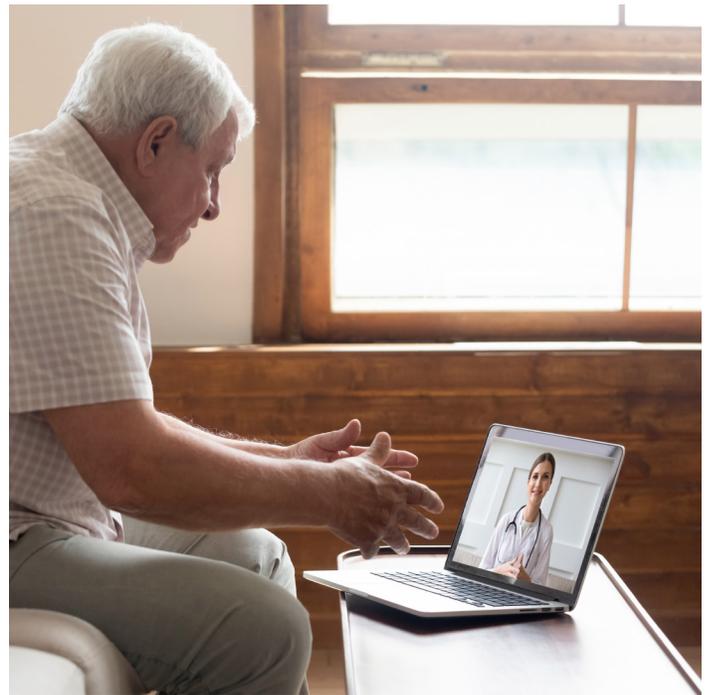
Clinical Practice and Operational Spotlight: Understanding Participants' Self-Directed Care

Research has shown that providing regular foot exams and patient education could prevent up to 85% of diabetes-related amputations.⁷ More frequent check-ins allow providers to visualize participants' feet and to look for any warning signs of new or existing foot ulcers, for example. Another advantage is having the ability to

visualize the administration of medication (for example, is the participant administering the fast-acting medicine instead of the slow-acting medicine), which can help providers catch and react to problems more quickly and before major complications arise.

Telehealth Opportunity: Live Video Visits

Regular video visits enable PACE staff and participants to see each other and see the home environment while discussing the participant's diabetes. Importantly, this can be accomplished without requiring travel or transportation. For instance, a video visit enables PACE providers to regularly visualize participants' feet to see whether they are healthy rather than relying on self-report. Video visits also allow providers to assess participants' refrigerators and pantries to find out what types of food are available to eat and understand whether nutritional counseling or access to nutritious foods is needed. Video visits also allow providers to watch participants self-administer insulin to see whether any additional guidance or training is needed.



For additional information about how to deploy telehealth with participants in their homes, refer to our guide “Using Telehealth at PACE: PACE Clinic-to-Home”

Clinical Practice and Operational Spotlight: Accessing Specialists:

Effective management of diabetic participants often entails accessing the expertise of endocrinologists. However, a typical route to a specialist involves waiting for an appointment

and providing transportation to and from the specialist office, both of which can be avoided using telehealth.

Telehealth Opportunity: e-Consults

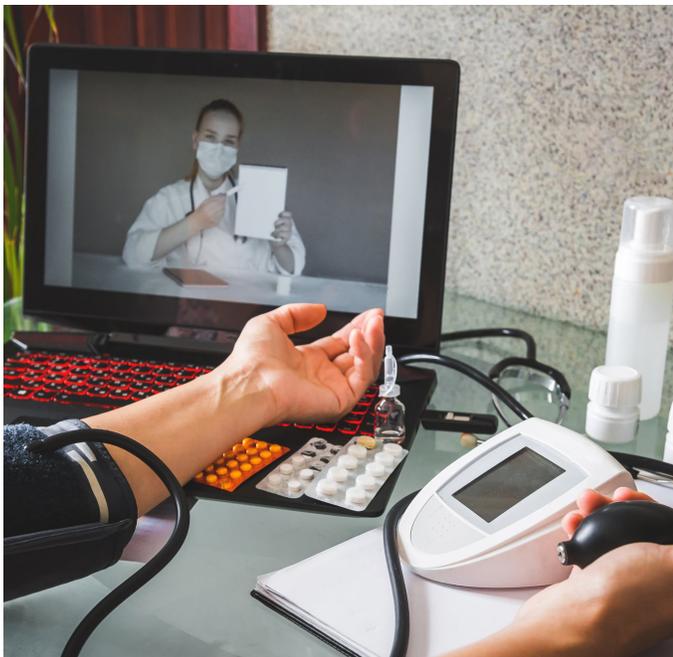
e-Consults allow PACE to avoid potentially unnecessary in-person appointments between the endocrinologist and the participant, minimizing delays in treatment and costs associated with office visits and participant

transportation. The e-Consult allows for a written electronic consultation to occur between the PACE provider and the specialist. This is particularly effective when the PACE provider has one or two specific questions for the specialist.

Clinical Practice and Operational Spotlight: Increasing Glucose Level Readings

Effectively managing diabetes entails knowing when participants' glucose levels are getting out of a safe range. In fact, effective blood sugar management can reduce the risk of eye disease, kidney disease, and nerve disease in seniors

with diabetes by 40%.⁸ Timely access to this information allows PACE providers to respond to those changes more effectively, such as by titrating medications before a larger, more complex, and costly problem arises.



Telehealth Opportunity: RPM

Including RPM in your diabetes management program, particularly for your participants with uncontrolled diabetes, provides a relatively automated way for participants to share their daily blood glucose readings, allowing for more accurate and frequent clinical data. By having this level of detail, the IDT can improve dosing recommendations and be alerted if values fall dangerously outside of parameters.

Measuring the Effectiveness of your Diabetes Management Program:

It is important to assess the quality and impact of your program against your program goals, no matter the type(s) of telehealth you choose to include. As an example, the stated program goal (above) was to reduce avoidable diabetes-related complications, such as hypoglycemic episodes and diabetic ulcers, and their related utilization and costs. To assess whether your program is achieving those goals, we suggest monitoring the following outcome measures:

1. Reduction in the number of glucose level fluctuations into unsafe ranges by XX%
2. XX number of visits to specialists are replaced with e-consultations
3. XX% reduction in the number of transports/trips required to care for participants with diabetes to access specialists or urgent/emergent issues related to complications of diabetes
4. XX% reduction in ED visits to treat diabetes or complications related to diabetes

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Program to Improve the Management of Congestive Heart Failure (CHF):

Congestive Heart Failure (CHF) is one of the most common chronic conditions in seniors 65 and older; more than 5 million Americans are estimated to have the disease.¹ CHF is also a major contributor to potentially avoidable hospital utilization. In fact, CHF accounts for more than half of all potentially avoidable hospitalizations for nursing home-eligible seniors and is the most frequent reason for hospitalization for people over the age of 65.^{2,3} The global economic cost of treating heart failure was estimated at \$108 billion per year in 2013, with the United States incurring about \$31 billion of those costs.⁴ Those costs are projected to increase annually. As such, it is imperative that PACE staff effectively manage their participants with CHF.

Program Goal:

Reduce the number of CHF-related exacerbations, such as weight gain and edema, and their associated hospital and ED utilization.

Steps:

01

Maintain oversight and management of participants' weight.

02

Monitor participants for signs of edema and intervene when appropriate.

03

Support the management of and adherence to medication regimes.

04

Assess participants' access to nutritious food and provide support (education and resources) as needed.

Participant Selection:



01

Participants with CHF

Clinical Practice and Operational Spotlight: Monitoring Weight

Increases in body weight are associated with an increased risk of hospitalization for people with heart failure. Typically, weight gain precedes hospital admission by at least one week.⁵

Given this 'advanced warning,' PACE staff can intervene as weight is climbing and before a hospitalization becomes necessary through close monitoring of participants' weight.

Telehealth Opportunity: RPM

Deploying a Bluetooth-enabled scale into participants' homes allows for the automatic uploading of weight-related data to providers. This automatic data collection can assist in the ongoing monitoring of participant weight and stability. By gathering daily data, providers can be alerted to any changes or increases in weight

and set up alerts based on a pre-determined threshold. For example, providers can set an alert for an increase of 5 pounds, triggering a protocol that would set up an in-person visit as soon as possible to assess for other signs of exacerbation, like renal failure, which could lead to hospitalization.

Clinical Practice and Operational Spotlight: Monitoring Self-Directed Care

Controlling CHF entails weight self-management, sodium intake, and prescription medications, among other things. In addition to weight fluctuations, poor diet can contribute to exacerbations of fluid retention and other risks associated with CHF. Monitoring excessive sodium intake and supporting a balanced diet can be helpful in lowering the chances of fluid retention.⁶ With respect to medications, it is estimated that the average senior with CHF takes more than six prescription medications on an ongoing basis, which is an increase of more than 50% over the past 2 decades.⁷ Managing so many medications increases the risk of non-adherence, drug interactions, and adverse events.⁸ Given the risks of complications and mismanagement, it is in the best interest of PACE staff to remain in close contact with these participants to assess any changes, complications, or concerns.



Telehealth Opportunity: Audio Only Visits and Live Video Visits



Regular phone and video calls allow for providers and staff to better understand the participants' home context and social needs. Asking questions around food security and access, as well as visually seeing participants' food supplies, can provide insight into gaps or challenges that may be contributing to their condition, such as lack of fresh produce or excessive consumption of processed foods. In addition to check-ins or assessments, staff can provide dietary education and discuss any potential resource referrals to support their treatment, such as utilizing food delivery services.

Additionally, increasing regular medication-related communications provides PACE staff with the opportunity to ensure understanding of and adherence to participants' complex medication protocols. These calls also allow participants to share any side effects, health exacerbations, or related concerns which may inform decisions regarding medications adjustments. Additionally, staff can use these calls to troubleshoot any issues influencing adherence, such as setting reminders for participants to take medications or engaging family/caregivers in conversations to convey the importance of adherence and the necessary steps to maintain the participants' health.

Clinical Practice and Operational Spotlight: Assessing Signs of Edema

Edema is often an early sign of a worsening condition in people with CHF. When untreated, edema can lead to high morbidity and mortality.⁹ Frequent assessments and check-ins allow

providers to maintain oversight of participants' condition and be prepared to intervene as soon as possible in advance of a more serious decline.

Telehealth Opportunity: Live Video Visits

Video calls enable providers to visually assess for lower body/peripheral edema. Although participants may be able to provide updates on any swelling or related symptoms via telephone, the potential for inaccurate self-reporting further supports the need for providers to conduct a

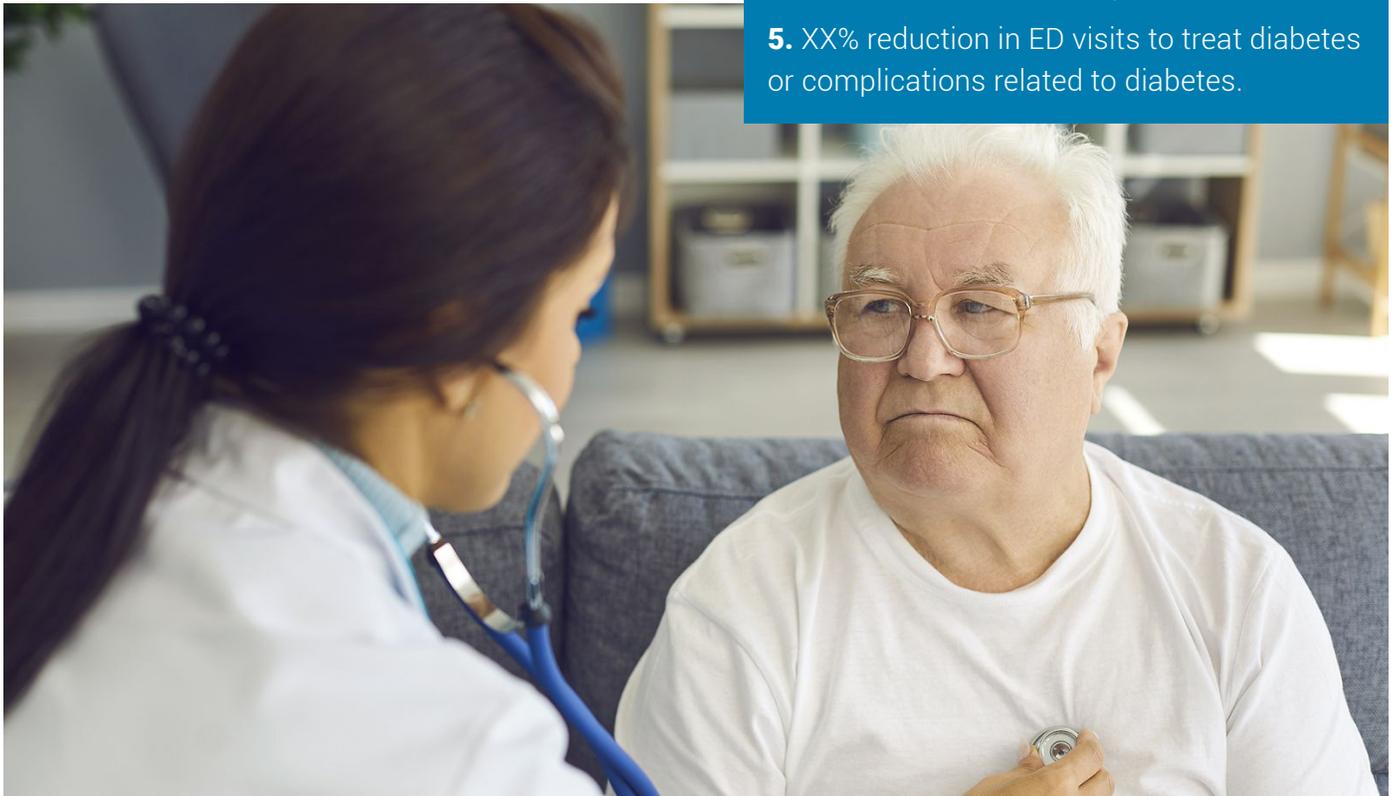
visual assessment. Based on the results of their video assessment, providers may be more prepared to initiate an in-person follow-up visit or implement a new treatment, such as prescribing diuretics to reduce buildup of fluid.

Measuring the Effectiveness of your CHF Management Program:

It is important to assess the quality and impact of your program against your program goals, no matter the type(s) of telehealth you include in your CHF management program. As an example, the stated program goal (above) was to reduce the number of CHF-related exacerbations, such as weight gain and edema, and associated hospital and ED utilization.

To assess whether your program is achieving those goals, we suggest monitoring the following outcome measures:

1. Reduction in the number of weight fluctuations into unsafe ranges by XX%.
2. Reduction in the number of edema-related escalations by XX%.
3. Self-report medication adherence increased by XX%.
4. XX% reduction in the number of transports/trips required to care for participants with CHF to access specialists or urgent/emergent issues related to CHF complications.
5. XX% reduction in ED visits to treat diabetes or complications related to diabetes.



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Program to Improve the Management of Mental Health Conditions:

An estimated 50% of all Americans will be diagnosed with a mental disorder at some point in their lifetime.¹

People with high mental health care costs incur nearly 30% more health care costs than the usual high-cost patients and are three-to-four more times likely to result in hospitalization than other types of ED visits.² With respect to seniors specifically, at least 25% of seniors have a mental health disorder, such as depression, anxiety, or dementia. Living with chronic illnesses, such as cancer, heart disease, or diabetes makes seniors even more likely to have or develop a mental health condition. Seniors are also prone to suffer from sleep disorders, cognitive deterioration, and confusion brought on by physical disorders.³ According to the National Institute of Mental Health, having a stroke or Parkinson's Disease can cause changes in the brain that make seniors more likely to develop a mental health condition.⁴ Additionally, coping with stressful illnesses, such as cancer, can cause illness-related anxiety and depression.⁴

Depression is the most prevalent mental health disorder experienced by seniors. In fact, seniors aged 85+ are at the highest risk for suicide of any age group.³ Depression can be triggered by life events, the loss of loved ones, the loss of independence and mobility, and the use of certain medications to treat illnesses.⁴ Furthermore, depression can impact the treatment of chronic conditions, such as heart disease and diabetes, because depression makes it harder for seniors to make lifestyle changes and to care for themselves properly.⁵ Finally, seniors with depression are at an increased risk of developing new physical illnesses, such as cardiovascular disease, stroke, pain, and Alzheimer's disease.⁴ According to the World Health Organization (WHO), depression not only reduces seniors' HRQoL, but it also increases the utilization of health care services and costs.⁶

For a variety of reasons, depression and other mental health conditions among seniors often go underdiagnosed and undertreated. Mental health provider shortages, particularly those with an expertise in geriatrics, make the situation even more dire. One way to increase access to providers and timely treatment is to use telehealth.

Program Goal:

To increase access to mental health providers to improve the HRQoL of participants with mental health conditions and to reduce unnecessary care utilization resulting from such conditions.

Steps:

- 01 Obtain more data about participants' mental health status.

- 02 Connect participants with mental health providers.

- 03 Develop stronger connections (check in more regularly) with participants suffering from mental health disorders and reduce symptoms and utilization of acute services.

Participant Selection:



- 01 Participants who have new or existing mental health conditions

- 02 Participants who are taking medications that are known to increase the risks of depression or other mental health conditions

- 03 Participants that have experienced a significant life event, such as loss of a loved one, loss of independence or mobility, or a new diagnosis

Clinical Practice and Operational Spotlight: Provide Therapy and Supportive Communication

Mental health concerns can manifest in a variety of ways, including depression, anxiety, and cognitive impairment.⁷ Seniors experiencing mental health issues may withdraw socially, which can lead to further depression or

anxiety symptoms. When recognized, increase supportive communication and therapeutic services to the participant in ways that are easy for the participant to incorporate.

Telehealth Opportunity: Audio Only Visits

Social workers, nurses, and mental health clinicians can use phones as means to communicate with patients, provide therapy, and provide medication management related to mental health. Phones have been used for years by clinicians to communicate with their patients and are particularly useful for reaching low-

resource populations who may not have access to a smartphone or reliable internet connection. Research has shown that telepsychology delivered by video and phone is just as effective for depression, anxiety, and adjustment disorder as in-person visits.⁸⁻⁹

Clinical Practice and Operational Spotlight: Improve and/or Maintain Mental Health Continuity of Care

Maintaining engagement allows for therapeutic dialogue and timely changes to the treatment and medication plan.

Unfortunately, attrition from mental health services ranges from 35% after one session to 65% before the tenth session.¹⁰

Decreasing barriers to access clinicians, reducing inconvenience for participants, and enriching the information clinicians obtain from participant



interaction are important to the sustained and successful management of a participant's mental health issues.

Telehealth Opportunity: Live Video Visits

Because of the varying ways and stages at which patients can disengage from treatment, different strategies need to be employed to help influence and support attending treatment sessions.¹⁰ One strategy to enhance engagement, reduce attrition, and gather additional information about the participant is to use video visits for mental health encounters. Video visits can either be done for individual or small group therapy

sessions. Video visits allow the clinician to gather unique information, such as information about the participants' surroundings. For instance, a clinician may be able to gather if the participant is living in a cluttered environment, has a lot of noise or loud sounds at their home, does not have privacy, or is accompanied by someone that is influencing their on-video behavior.

Measuring the Effectiveness of your Mental Health Management Program:

It is important to assess the quality and impact of your program against your program goals, no matter what type(s) of telehealth you choose to implement. As an example, the stated program goal (above) was to increase access to mental health providers to improve the HRQoL of participants with mental health conditions and to reduce unnecessary utilization resulting from such conditions.

To assess whether your program is achieving those goals, we suggest monitoring the following outcome measures:

1. Reduction in the number of ED visits related to mental health exacerbations by XX%.
2. XX% increase of participants with mental health screening.
3. XX% increase of participants receiving on-going mental health care (counseling, medications, etc.).
4. Reduction in the number of after-hours calls related to mental health exacerbations by XX%.



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Social Isolation & Loneliness

When thinking about conditions that may result in avoidable ED and hospital utilization or conditions that can significantly reduce participants' HRQoL, social isolation and loneliness may not immediately come to mind, especially prior to the COVID-19 public health emergency (PHE). However, these conditions take a serious toll on emotional, mental, and physical wellbeing, particularly for seniors.¹ Social isolation and loneliness are prevalent among the senior population;

10% to 43% of older adults in North America experience social isolation and 43% experience loneliness.²

Frail older adults living in long-term care facilities are particularly vulnerable to social isolation

and loneliness.⁵⁻⁷ Social isolation and loneliness impact participants' health dramatically. In fact, social isolation is associated with about a 50% increased risk of dementia and other serious medical conditions. Both social isolation and loneliness increase the chance of early death from all causes, a risk that rivals those from smoking, obesity, and physical inactivity. Loneliness among heart failure patients specifically is associated with a nearly four times increased risk of death, 68% increased risk of hospitalization, and 57% increased risk of ED visits.⁸ As such, managing these conditions is critical for any PACE organization. Telehealth provides an effective and efficient opportunity for staff to maintain eyes and ears on participants, stay alert to changes or challenges regarding their emotional wellbeing, and provide tangible methods to increase their social connectivity.

Program to Improve Social Isolation and Loneliness Management:

Determining how to manage your participants' social isolation and loneliness is not as simple as bringing all isolated or lonely participants into the day center at an increased rate. Doing so brings its own operational and logistical challenges, in addition to the extra costs associated with transporting more participants

to and from the day center on a frequent basis. Given these challenges, it is particularly helpful for staff to stay engaged with isolated and lonely participants through less complex and less costly methods to support participants' social and emotional health. This can be achieved by using technology.

Program Goal:

Reduce participants' social isolation and loneliness and related complications that lead to increased hospital/ED utilization.

Steps:

01

Increase opportunities for participants to connect with their existing social supports/networks.

02

Foster a sense of community and rapport among participants and between participants and PACE staff.

03

Establish more frequent communication between PACE staff and participants to identify problems or warning signs and intervene before they escalate.

Participant Selection:



01

Participants who visit the PACE center infrequently and/or who are hesitant about attending in-person social activities

02

Participants who express feelings of isolation or loneliness, who have recently lost a loved one, or who staff believe may be lacking social connections

03

Participants who have higher than expected utilization (frequently calling PACE and/or frequently using the ED, for example)

Clinical Practice and Operational Spotlight: Defining Social Networks

Addressing social isolation requires understanding of the nuances associated; it is not a simple binary of isolated versus connected, but rather is dependent on the existence of relationships, their perceived functionality, and quality (including relationship strains and potential feelings of exclusion).⁴ The physical presence of others does not innately suggest that a person is socially connected.

On average, older adults tend to prefer maintaining current social networks rather than building new ones, which might further add to issues of social isolation as they age.⁹⁻¹⁰ Having a comprehensive understanding of participants' existing social networks can help staff to encourage communication and connection with participants' loved ones.

Telehealth Opportunity: Audio Only Visits or Live Video Visits

Increase awareness of existing social networks by engaging in phone or video calls with participants to define and explain their connections. This can occur during an informal conversation as well as by using a detailed assessment, such as the [Care Map](#) from the Atlas of Caregiving.¹¹ These conversations

should provide the names and information for individuals who play a significant role in the participants' emotional wellbeing, such as friends, neighbors, or family members. This information will provide a baseline understanding of participants' social status that can inform and provide context for future interventions.



Clinical Practice and Operational Spotlight: Staff Individual Interventions

Implementing a brief, structured behavioral activation intervention with seniors has been

shown to reduce measures of social isolation and loneliness.¹²

Telehealth Opportunity: Audio Only Visits or Live Video Visits

In addition to informal check-ins, where staff ask participants how they are feeling and if they have any updates or concerns, PACE staff can implement a structured behavioral intervention to address their social and emotional needs. This intervention may include:

1. Helping participants identify and schedule meaningful social activities, while reducing and problem-solving barriers to social connection.
2. Reviewing current daily activity patterns, setting personal goals, and targeting areas for improvement.
3. Working collaboratively to hear, support, and achieve participant goals.



Clinical Practice and Operational Spotlight: Promoting Group Activities

Providing opportunities for social connections via day-center activities is a major part of what makes the PACE model distinct. When participants are unable to attend in person,

whether due to health concerns; appointment cancellations; travel costs; or limited building capacity, these opportunities for connection are missed. The use of telehealth can provide

innovative ways to keep participants connected and feeling a sense of comradery with other

members of the organization.

Telehealth Opportunity: Audio Only Visits or Live Video Visits

Audio and video calls can be used to conduct social activities, similar to those that are typically hosted in-person at the PACE center. These activities may include stretching classes, meditation workshops, health education, BINGO, or simply provide a virtual room/meeting space for casual conversations between participants. These activities are typically already provided and managed by a recreational/activities coordinator

and can be easily adapted for telehealth by informing participants in advance of time slots and required steps to join. In the case of video-based activities, for example, preparation may include sending a schedule of virtual activities for the week, calling participants to confirm their attendance, and providing tech or troubleshooting support if needed.

Measuring the Effectiveness of Your Social Isolation Program:

Social isolation does not always influence outcomes directly, but often acts as a contributing factor to the onset and development of conditions, such as dementia, depression, and anxiety, that are more directly tied to clinical

outcomes and related costs. As such, evaluating the impact of your program can be done in several ways. Suggestions are included below.

1. Reduction in the number of participants with a cut-off score indicating social isolation and/or loneliness via standard assessment tools by XX%.
2. Increase in the number of PACE social activities attended by XX%.
3. Increase in the number of engagements or touchpoints with PACE staff by XX%.

4. Increase in participants' self-reported engagement with friends/family.
5. Reduction in behavioral health-related ED and hospital admissions by XX%.
6. Reduction in behavioral health-related visits for exacerbations of depression or anxiety by XX%.



For additional information about how to use telehealth to combat social isolation and loneliness, refer to our guide “Using Telehealth at PACE to Address Social Isolation”

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04

**OPPORTUNITIES TO
INCREASE OPERATIONAL
EFFICIENCIES**

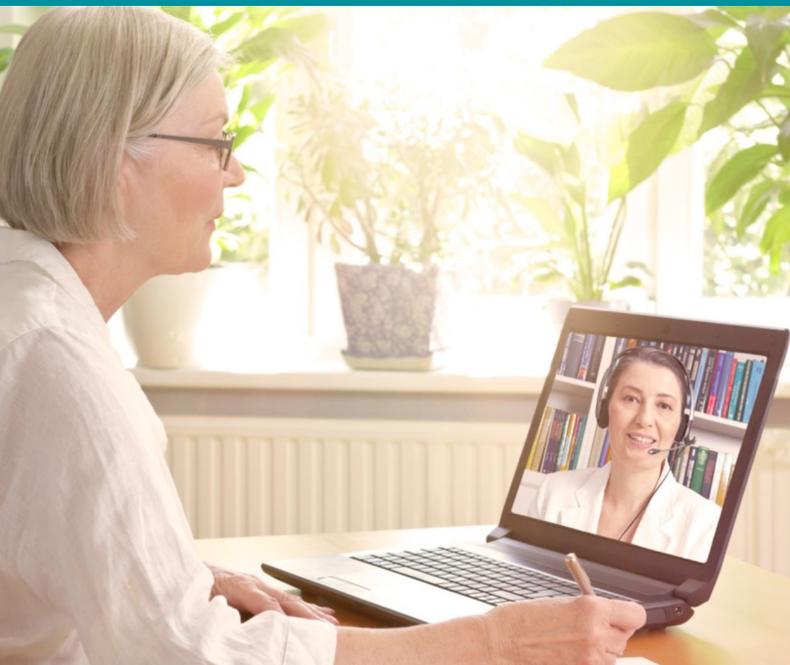
OPPORTUNITIES TO INCREASE OPERATIONAL EFFICIENCIES

Telehealth Can Help Optimize Transportation:

Running a successful PACE organization involves managing both the clinical and administrative sides of the business efficiently and effectively. Accomplishing this requires closely tracking and managing the biggest expenses. For most PACE organizations, the expenses associated with providing transportation are among the biggest, as was especially true during the COVID-19 PHE. Some typical ways of managing these costs include bringing transportation services 'in-house', optimizing routes, and overlapping clinic visits with pre-scheduled day center visits. Additionally, PACE organizations can use telehealth services to reduce the number of

transports needed. For example, some clinic visits, particularly those that do not overlap with a day center visit, may be avoided by conducting a telehealth visit between the PACE provider at the clinic and the participant who is at home or in the community. Similarly, some specialist appointments, particularly those that involve straightforward questions and no procedures, can be avoided by using e-Consults instead. Reducing the need for emergency transportation, as described in section of this guide titled [ED and Hospital Utilization Management](#), can also contribute to an overall reduction in transportation expenses.

Decrease In-Person Specialty Visits with e-Consults:



The cost of specialist visits can also be a large expense for many PACE organizations. Scheduling, transporting, and if needed, providing additional staff to escort the participant to the specialty appointment add additional budgetary pressure and impact resource allocation. Some specialty visits, however, can be replaced by e-Consults. e-Consults are a tool which the PACE provider can use to receive written consultation from the specialist. These consultations allow the PACE provider to ask one or two questions of the specialist without having to send the participant to the appointment. This often results in timelier, more economical, and less disruptive interactions for the participant and clinic operations.

05

IMPLEMENTATION AND SUSTAINABILITY

IMPLEMENTATION AND SUSTAINABILITY



Staff Communication:

When possible, engage staff in the decision-making process, particularly when it comes to selecting devices and developing workflow processes and protocols. They will be most directly involved in the implementation and ongoing maintenance of the program and it is important that they support it.

Building staff's awareness of the new service and the value it brings will help create buy-in. Engage staff early and provide formally scheduled updates to establish communication expectations for the new service line. As your organization approaches the full implementation of the service, information should be shared more often, such as at weekly meetings and during staff gatherings.



Training & Education:

Education and training are essential to ensuring competency and confidence, as well as successful implementation and continued utilization of telehealth, and should be undertaken regardless of your staff's level of familiarity with technology. Overall, PACE staff should have enough training to feel confident that they can independently facilitate a telehealth consultation from start to finish.

Providers who are new to telehealth will likely need to practice to become familiar with how to communicate effectively via video and utilize the software correctly, while maintaining quality care for participants. Providers and staff may benefit from online courses related to best practices, such as the education programs from Stanford University¹, and from hands-on trainings and mock visits to walk through the workflow and understand the participant perspective.



Your selected telehealth vendor may provide telehealth training sessions directly to your staff. Live demonstrations of any new technology and service are especially informative and impactful. They provide an opportunity for staff to become more familiar with the tools, workflows, and expectations. Demonstrations allow staff to ask questions and get hands-on experience using devices. At a minimum, most telehealth service or equipment vendors include training materials, such as “how-to” videos and tip sheets.

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Technology Selection:

The hardware and software you choose will depend largely on what problem(s) you are trying to solve. One of the most important factors that organizations typically focus on is the user experience. Whether it be for a video visit or RPM, the ease of use is often the guiding force for adoption. However, the reliability of the software and hardware is another important factor to consider. When looking at technology, ensure that you are weighing the potential risks and benefits of incorporating them into your program.



Focus on simple steps for program improvement, use technology that is easy and already established. If not, use a vendor that is wrap-around and has full support.

For example, although some devices may be less expensive, they might require extensive hands-on troubleshooting or more training, which could end up costing the program additional money and staff time later.



TIP: For some programs, the step of selecting technology can become overwhelming and cause a delay in the implementation. Instead of letting decisions around technology overwhelm staff, consider starting first with what you have available.

06

**LEGAL
CONSIDERATIONS**

LEGAL CONSIDERATIONS

It is important to consider the state and federal laws and regulations that address the provision of care via telehealth. Remember, telehealth is not a separate and distinct service; telehealth is a *means of* (or a tool for) providing service. Therefore, all rules that typically apply when PACE organizations supply a particular service will continue to apply regardless of whether the service is done via telehealth. Also, there may not be any specific telehealth policies within many of the rules and regulations. For example, in many jurisdictions, specific telehealth licenses do not exist. Instead, a physician or other health care provider using telehealth to provide services would just be expected to get a typical license.



What follows are some of the important considerations around legal and regulatory issues that may arise when a provider or organization begins providing care via telehealth. It is important to keep in mind that these policies can vary widely from state-to-state, requiring each PACE organization to check state and local laws and regulations.

Providers:

PACE organizations must ensure that all providers utilizing telehealth are properly licensed, credentialed, and have malpractice coverage, just as they would for any providers delivering services in-person. If the providers utilizing telehealth are PACE staff, there is very little else that needs to be done, besides seeking malpractice coverage.

Not all malpractice plans cover services delivered via telehealth, so it is necessary to check with the provider's carrier to see what their policies are around delivering services via telehealth. Additional coverage may need to be purchased to cover telehealth. In some cases, carriers may not cover telehealth at all which may necessitate seeking out malpractice insurance from a different carrier.



Regardless of whether you are providing telehealth through employees or contracting with an outside provider, you will need to verify that providers are licensed, credentialed, and that they have adequate malpractice coverage. All legal requirements necessary for contractors still apply for any telehealth contractor you engage.

All providers, including contractors, who have direct contact with PACE participants must:

- Be legally authorized (licensed, registered, or certified) to practice in the state in which he or she performs the function or action;
- Act within his or her scope of practice;
- Have one year of experience working with frail or elderly population or, if he or she have less than one year of experience, meet certain other requirements and receive appropriate training from the PACE organization on working with a frail or elderly population;
- Meet a standardized set of competencies for the specific position established by the PACE organization before working independently; and
- Be medically cleared for communicable diseases and have all immunizations up-to-date. Seek CMS guidance for further clarification



Public Health Emergency (PHE): During the COVID-19 pandemic, some states made exceptions to their licensure laws. These were temporary waivers and will only last the duration of the PHE or until the waivers' specific expiration date.

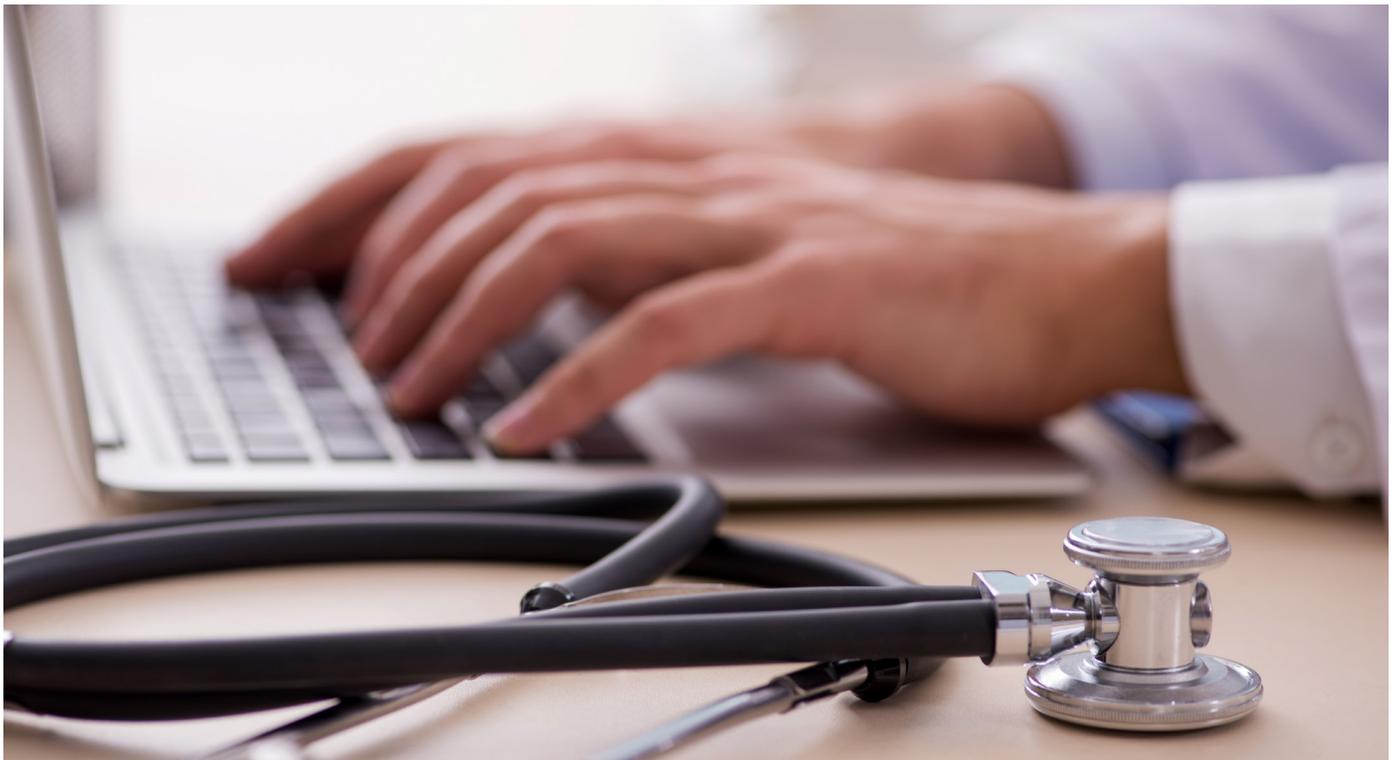
Further, PACE organizations must not employ individuals or contract with individuals or organizations

- Who have been excluded from participation in the Medicare or Medicaid programs, or are included on the CMS preclusion list;
- Who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under Title XX of the Social Security Act;
- Who have been determined to pose a potential risk to participants due to convictions of criminal offenses related to physical, sexual, drug, or alcohol abuse or use;
- Who have been found guilty of abusing, neglecting, or mistreating individuals or who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of resident, or misappropriation of their property; or
- Who have been convicted of specific crimes for any offense described in section 1128(a) of the Social Security Act.

All states require that physicians maintain current state licensure from the state that each patient is located within. There are very few exceptions to these rules. Exceptions are usually for special circumstances, such as if a patient is located within a certain distance from the border between two states. Licensing works similarly for other health care professionals. Some states have joined professional licensure compacts that make it easier for out of state physicians to practice, but it depends on the state.

If telehealth services are provided through outside individuals, organizations, or agencies, PACE organizations must have a written contract in place (42 CFR Section 460.70(a)). Additionally, under 42CFR Section 460.70(b), the contract must meet certain requirements:

- (1)** The PACE organization must contract only with an entity that meets all applicable Federal and State requirements, including, but not limited to, the following:
 - (i)** An institutional contractor, such as a hospital or skilled nursing facility, must meet Medicare or Medicaid participation requirements.
 - (ii)** A practitioner or supplier must meet Medicare or Medicaid requirements applicable to the services it furnishes.
 - (iii)** A contractor must comply with the requirements of this part with respect to service delivery, participant rights, and quality improvement activities.
- (2)** A contractor must be accessible to participants, located either within or near the [PACE organization's](#) service [area](#).
- (3)** A [PACE organization](#) must designate an official liaison to coordinate activities between contractors and the organization.





Regulation CFR 460.70(b)(2) states that any contracted provider who will see participants in person needs to be accessible and “located either within or near the PACE organization’s service area.”

Professional Boards:

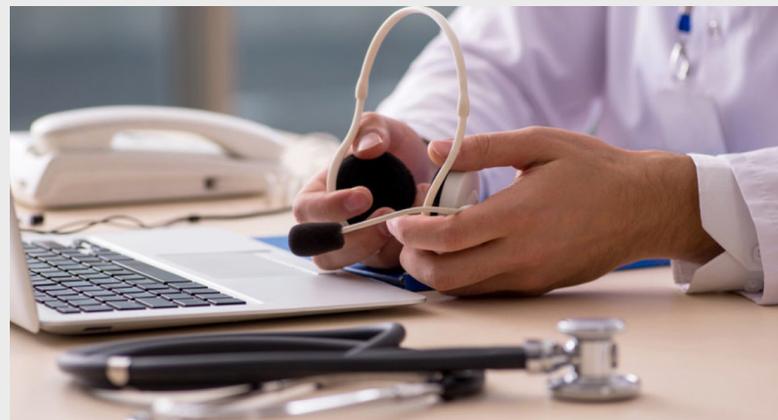
PACE organizations must also be aware that professional boards may have their own, more explicit, requirements on how licensees utilize telehealth. These additional requirements may include that the provider show proof

of identification to the patient and transmit information about the interaction with the patient to a primary care provider. In the context of PACE, this may be the primary care physician, nurse practitioner, or other member of the IDT.

Regulatory Exclusions:

There are other regulatory requirements for PACE organizations that may require additional protocols to ensure compliance. For example, 42 CFR 460.71(a)(4) requires a PACE organization to designate a staff member to work with a PACE contractor to ensure compliance by the PACE contractor. The PACE organization must determine how this will be accomplished given much, if not all, of the interaction with the contractor may be virtual.

Some of the federal PACE regulations limit or exclude the use of telehealth. For example, federal regulations for PACE organizations require that an initial comprehensive assessment of a participant be completed, and a comprehensive plan of care must be created within 30 days of the date of enrollment. Federal regulations state that this must be an “in-person” assessment (CFR 460.104(a)). The “in-person” requirement eliminates the option for using telehealth. Semi-annual and “change in participant status” reassessments also must be conducted “in-person” (CFR 460.104(c) & (d)(1)). Finally, unscheduled reassessments in response



to service determination requests require in-person reassessments before the IDT can deny the request either in part or in full.

Many states allow telehealth to be used to conduct a physical exam which is typically one of the elements of establishing a patient-provider relationship and/or for writing a prescription. However, in most states, these must be through live video-conferencing or synchronous telehealth. Very few states will allow asynchronous telehealth to be used to conduct an examination.



Medicare payment to PACE organizations is based, in part, on participants' diagnoses identified in face-to-face encounters with eligible professionals including physicians, nurse practitioners and physician assistants. At the time that this guide is being written, the COVID-19 public health emergency (PHE) is in effect. The PHE has allowed for diagnoses resulting from telehealth services to meet the risk adjustment face-to-face requirement when the services are provided using interactive audio telecommunication simultaneously with video telecommunication to permit real-time interactive communication. At this time, it is not clear whether diagnoses resulting from interactive audio and video telehealth visits will continue to be allowed for risk adjustment once the PHE is declared over. It is critical that PACE organizations adhere to all requirements related to the identification and submission of diagnoses for risk adjustment.

ACKNOWLEDGEMENTS:

West Health

Shelley Lyford – President and CEO
Zia Agha, MD – Chief Medical Officer and Executive Vice President
Liane Wardlow, PhD – Director of Clinical Research
Michael Kurliand, MS, BSN, RN – Director of Telehealth and Process Improvement
Virginia Suarez – Program Coordinator



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