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Serving Adults with Serious Mental Illness in the Program of All-Inclusive Care for the Elderly: Promising Practices

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IN BRIEF

Program of All-Inclusive Care for the Elderly (PACE) organizations now serve a greater number of older adults with serious mental illness (SMI) than ever before, and increasingly include behavioral health providers in their care teams to meet the complex needs of this population. This brief highlights promising practices for assessment, care planning, and care coordination for older adults with SMI drawn from PACE programs, Medicare Advantage Special Needs Plans, and Medicaid plans. These approaches may be helpful for PACE programs seeking to improve or expand the delivery of behavioral health services for older adults with SMI.

The Program of All-Inclusive Care for the Elderly (PACE) provides medical care and long-term services and supports (LTSS) to more than 45,000 adults age 55 and older in the United States who meet a nursing facility level of care.[1] Over 40 percent of PACE participants have diagnoses that typically meet the criteria of serious mental illness (SMI), such as schizophrenia, schizoaffective disorder, major depressive disorder, and bipolar affective disorder.[2,3] The number of PACE participants with SMI is growing as the overall population of older adults with SMI increases.[4,5] Additionally, many PACE organizations are enrolling a higher percentage of participants between the ages of 55 and 64, and these participants have a higher rate of mental health diagnoses.[6]

Approximately 90 percent of PACE participants are dually eligible for Medicare and Medicaid, representing a population that has primarily received physical health, behavioral health, and long-term services and supports (LTSS) via different programs and payment systems.[7] Dually eligible adults with physical and behavioral health conditions, as well as functional limitations, often experience fragmented care with limited care coordination, which can result in poor quality of care and high costs.[8] Through a blended Medicare-Medicaid payment model, PACE organizations have the potential to deliver integrated behavioral and physical health services, and LTSS to participants with SMI.

Although PACE organizations are not required by the Centers for Medicare & Medicaid Services to include mental health and psychiatric specialists on the interdisciplinary care team, a growing number of these organizations are doing so to better meet the needs of participants with mental illness or substance use disorders and reduce psychiatric institutional stays.[9, 10] Smaller PACE organizations, however, may have fewer resources available to hire behavioral health clinicians. When identifying how to deliver behavioral health care for participants with SMI, PACE organizations need to develop strategies tailored to their size, participant health characteristics, and financial considerations, while considering relationships with and availability of community mental health providers.

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With support from the West Health Policy Center, the Center for Health Care Strategies (CHCS) conducted a scan to identify promising practices for delivering behavioral health care, and interviewed leaders of PACE organizations, Medicare Advantage Special Needs Plans, and Medicaid managed care plans to determine how they are meeting the needs of their enrollees with SMI. The practices profiled in this brief offer examples for PACE organizations seeking to improve services provided for adults with SMI and may be particularly relevant for newer and smaller PACE organizations as well as those in rural locations. Additionally, these practices may inform policy efforts to explore PACE expansion for other high-need, high-cost populations, especially as the PACE Innovation Act of 2015 spurs additional growth in PACE programs.[11]

PACE Basics

PACE is a Medicare program that serves adults age 55 and older who are eligible to receive nursing home care but are able to live safely in community settings. PACE can only be offered in states that elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit. Approximately 90 percent of PACE participants are dually eligible for Medicare and Medicaid.[12]

PACE organizations receive capitated Medicare and Medicaid payments to provide comprehensive care for participants and assume full financial risk for all covered services. Core PACE components include: (1) an adult day health center where services are provided; and (2) an interdisciplinary care team composed of required members including a primary care provider, registered nurse, master's level social worker, home care coordinator, physical and occupational therapists, dietitian, and others.[13] Since PACE organizations have the flexibility to deliver services that meet the needs of their participants, program design and composition of the interdisciplinary team, which typically extends beyond the required members, vary across PACE organizations.

As of January 2018, there were 124 PACE organizations in 31 states serving more than 45,000 participants.[14] PACE enrollment has more than doubled from under 20,000 participants in 2011.[15]

Approaches to Delivering Behavioral Health Care

To identify promising approaches to delivering behavioral health care, CHCS interviewed leaders of PACE organizations, Medicare Advantage Special Needs Plans, and Medicaid managed care plans (*see Exhibit 1, page 3*). The interviews addressed:

- The organization's model of care for serving enrollees with behavioral health needs;
- Whether the organization had behavioral health practitioners on staff or contracted out for these services;
- How behavioral health providers were integrated into the interdisciplinary care team;
- How the organization approached staff training and education; and
- What outcomes measures the organization used to assess the effectiveness of its behavioral health model.

Many of the profiled PACE organizations have contributed to resources created by the National PACE Association's Behavioral Health Workgroup, which was formed to help PACE programs address the needs of participants with SMI and other behavioral health issues.

Exhibit 1. Approaches to Delivering Behavioral Health Care across Organizations Interviewed

Organization Name	Location	Primarily Staff or Contracted Behavioral Health Providers*
PACE Organizations		
CentraCare	Michigan	Contract
PACE Southeast Michigan (PACE SEMI)	Michigan	Staff
PACE Organization of Rhode Island (PACE RI)	Rhode Island	Mixed
Providence ElderPlace Portland	Oregon	Staff
Rocky Mountain PACE	Colorado	Mixed
Health Plans		
Commonwealth Care Alliance (CCA)	Massachusetts	Mixed
Community Care Behavioral Health Organization, part of UPMC Insurance Services	Pennsylvania	Contract
South Country Health Alliance	Minnesota	Contract

*Organizations classified as **contract** primarily contract with county and/or community mental health providers to deliver behavioral health services. Organizations classified as **staff** primarily have behavioral health providers on staff. Organizations classified as **mixed** use a combination of contract and staff models: PACE RI uses different approaches across its two centers, Rocky Mountain PACE contracts with external providers for psychiatry and other neuropsychological evaluations, and CCA is an integrated provider and payer that uses contracted providers and internal clinical interprofessional teams based on the complexity of member needs.

***Source**: Center for Health Care Strategies based on interviews with PACE organizations and health plans.*

Through a literature review and interviews with the organizations listed in Exhibit 1, key themes emerged as promising practices for serving the needs of older adults with SMI. PACE organizations seeking to improve the delivery of behavioral health services may consider the following approaches:

1. Design participant assessment processes that identify and immediately support complex needs;
2. Align interdisciplinary care team roles to meet the needs of older adults with SMI;
3. Prioritize training during implementation of new behavioral health models of care and for continuous improvement;
4. Create a therapeutic environment to meet participant needs; and
5. Create collaborative partnerships by contracting with external providers.

Following is more detail on each of these approaches.

1. Design participant assessment processes that identify and immediately support complex needs

The first step in providing comprehensive behavioral health services for PACE participants is to design pre-enrollment, intake, and ongoing assessments that effectively identify those individuals with behavioral health needs. While organizations use various clinical tools for behavioral health

assessment, innovative processes and staffing structures may increase the effectiveness of these tools. These approaches include: (1) beginning assessment prior to enrollment; (2) designing assessments to be culturally competent; and (3) using comprehensive assessments to stratify participants to effectively tailor the intensity of care provided.

PACE Southeast Michigan (PACE SEMI) conducts a behavioral health screening during the participant intake process. If the results of this screening suggest the presence of behavioral health issues, a behavioral health specialist conducts a full assessment prior to enrollment and schedules a follow-up appointment within the first week of enrollment. The entire participant population is then screened at six-month intervals for behavioral health vital signs, including depression, anxiety, alcohol use, and opioid use. By periodically screening *all* participants, PACE SEMI reduces the stigma of behavioral health assessments. Participants who screen positive are transitioned through a warm handoff to an on-site staff behavioral health provider who conducts a full assessment and brief intervention. In addition, PACE SEMI uses assessments such as the ESFT (explanatory/social/fears/treatment) screening for adherence to treatment to provide care that is respectful and responsive to the health beliefs, practices, and cultural and linguistic needs of a diverse population of older adults.[16]

Rocky Mountain PACE and Providence ElderPlace Portland also evaluate behavioral health needs prior to enrollment. Both organizations use the time between a participant's date of initial intake and enrollment to engage the interdisciplinary team in collaborative planning. Rocky Mountain PACE uses this information to design the care planning and interdisciplinary team composition for each incoming participant. The team identifies individuals with the highest level of risk, and ensures that they quickly receive a complete behavioral health evaluation and interventions. Through this process, Rocky Mountain PACE reported that it increased the enrollment and retention of participants with behavioral health needs as well as the level of care provided. Providence ElderPlace Portland focuses on high-risk participants with significant histories of mental health treatment, and shares their pre-enrollment evaluations with the interdisciplinary team and psychiatric nurse practitioners to conduct full psychiatric assessments within the first month of enrollment. Both organizations continue screenings every six months for depression. Providence ElderPlace Portland also screens all participants with SMI for dementia.

PACE organizations with a larger population may benefit from using assessments to broadly tailor approaches to behavioral health care coordination. To meet the needs of a growing population of members with mental illness, the Commonwealth Care Alliance (CCA) stratifies members with SMI based on their medical, behavioral, and social needs. CCA then tailors its care coordination approach based on complexity of needs, using the following strata:[17]

- Members with extremely complex needs receive intensive medical and/or behavioral health support, and work with a behavioral health specialist to coordinate all care;
- Members with moderately complex needs receive in-home care coordination;
- Members with low-complexity needs receive telephonic care coordination; and
- Members with strong prior relationships with CCA's community partners, such as community behavioral health providers, continue to see those providers to facilitate long-term, trusting, and therapeutic relationships.

This stratification system for delivering care coordination helps CCA to meet members' needs while efficiently targeting resources. All CCA members continue to receive needed physical and behavioral health services.

These promising practices in assessment design and participant stratification, as implemented by leading PACE organizations and health plans, may guide other PACE organizations seeking to more effectively deliver care to a growing population of older adults with SMI. When there is a shortage in behavioral health clinicians, these approaches can help effectively target resources to meet participant needs.

2. Align interdisciplinary care team roles to meet the needs of older adults with SMI

While all PACE organizations have an interdisciplinary care team with a defined core membership, each has the option to vary the team's structure and composition according to participants' needs. Innovative PACE organizations and health plans have designed the interdisciplinary team to meet the needs of older adults with SMI by: (1) creating new staff roles; (2) incorporating behavioral health delivery into primary care through a collaborative care model; (3) emphasizing wellness; and (4) altering the size of participant panels to provide the appropriate level of care for their needs.

For the PACE Organization of Rhode Island (PACE RI), a behavioral health liaison manages participant triage, schedules initial psychiatry and counseling visits, facilitates monthly meetings with the interdisciplinary care team to review participant progress, sets up transportation, and closely monitors participants' records. Since PACE RI employs social workers who lead both counseling and case management services, the behavioral health liaison ensures that no one social worker performs both roles for a participant. The liaison also ensures that participants who need close supervision can receive additional one-on-one care. PACE RI limits the number of counseling cases for social work case managers conducting intensive case management for individuals with SMI. South Country Health Alliance, a health plan that serves Medicaid and dually eligible members, also reduces member panels for case managers working with adults with SMI to provide greater support to its members.

PACE SEMI and Providence ElderPlace Portland both use a collaborative care model to incorporate behavioral health into all elements of the interdisciplinary team within a primary care setting. The key elements of the collaborative care model, which has been implemented in a range of settings, include care delivered by primary care providers, care management staff such as behavioral health specialists, and a psychiatric consultant.[18] At PACE SEMI, behavioral health specialists provide screening and assessment, engage and educate participants and caregivers, lead follow-up care, conduct brief counseling and/or psychotherapy sessions, and facilitate communications and referrals between the primary care physician and the psychiatric consultant. At Providence ElderPlace Portland, psychiatric nurse practitioners and mental health case managers provide both individual care to participants with SMI as well as consultations to the interdisciplinary team for any participants with behavioral health needs, and a geriatric psychiatrist is available for case consultation.

The collaborative care model has been demonstrated to be effective for individuals with SMI.[19] A core component of the model is utilizing measurement-based care to track changes with validated scales, and adjusting treatment as needed. The interdisciplinary teams at both PACE SEMI and Providence ElderPlace Portland track the following key measures: (1) behavioral health referrals and

services; (2) psychotropic medication use; (3) psychiatric hospitalizations and emergency department visits; and (4) depression screening, treatment, and outcomes.

Health plans have also introduced new staffing positions to reflect an emphasis on integrated care. Community Care Behavioral Health Organization (Community Care),[20] a managed care organization serving Medicaid and dually eligible beneficiaries in Pennsylvania, has trained existing case managers and peers to be wellness coaches. These wellness coaches, under supervision from a wellness nurse, are embedded at community mental health providers where they: (1) develop tailored wellness plans for members with SMI; (2) coach members and other behavioral health staff to identify and take steps toward wellness goals; (3) communicate with primary care providers; and (4) provide referrals.

CCA employs geriatrics support coordinators who address all long-term services and supports needs. These coordinators support members in accessing key services that can help them remain safely in a community setting, such as medication reconciliation and adherence interventions. CCA has found that staff in this position develop trusting relationships with members since they facilitate the delivery of crucial services. While they do not specifically focus on behavioral health needs, they frequently communicate with the behavioral health team to coordinate care.

These approaches for structuring the interdisciplinary care team may be helpful for PACE organizations that are incorporating behavioral health services into their overall model of care. Organizations may focus on developing care coordination staff roles, integrating behavioral health into the delivery of primary care, and emphasizing wellness to effectively meet the needs of older adults with SMI.

3. Prioritize training during implementation of new behavioral health models of care and for continuous improvement

Leading-edge PACE organizations and health plans invest in training and design continuous improvement initiatives to better meet the needs of older adults with SMI. Promising practices include: (1) extending training to frontline staff, caregivers, participants, and contracted partners; and (2) investing in training and improvement models to rapidly diffuse new care models. As PACE organizations plan for behavioral health services expansion, tailored training approaches may be particularly beneficial to prepare staff and other stakeholders to drive organizational change.

PACE organizations have designed trainings for contracted providers, participants, caregivers, and frontline staff. CentraCare provides training to its contracted county mental health agency on working with the PACE population, and the agency conducts topic-specific training on mental health for PACE staff. PACE SEMI leads trainings for caregivers and participants to support self-management and supported living environments. Topics have included trauma-informed care, motivational interviewing, and behavioral medicine. PACE SEMI also offered an all-day training for frontline staff in Mental Health First Aid,[21] which addressed risk factors and symptoms of mental health issues and equipped staff with strategies to develop an action plan with individuals in crisis. After this training, which is listed in the SAMHSA registry of evidence-based programs, PACE SEMI staff reported being more comfortable and better prepared to support an increasing population of participants with behavioral health needs.

Community Care has used workforce training and learning collaboratives with contracted partners to implement its innovative behavioral health home model for adults with SMI. This model, known as

Behavioral Health Homes Plus, integrates physical health and wellness coaching into case management and peer support services delivered by community mental health providers.[22] Community Care organized wellness trainings with community mental health provider staff to increase staff awareness and skills regarding physical health conditions for members with SMI. Plan leaders used a "train-the-trainer" approach to implement the Behavioral Health Homes Plus model cost-effectively across 11 sites. The model has since been spread to over 50 mental health programs. By using the Institute for Healthcare Improvement's Breakthrough Series model for learning collaboratives, wellness nurses and other behavioral health providers monitored interventions and shared data to enable rapid-cycle improvement across the sites.[23] This comprehensive approach to shared learning led to improvements in the development of wellness goals, patient self-management tools, communications between behavioral and physical health providers, and provider confidence in working toward health and wellness.[24] Community Care also organized monthly webinars and a fidelity tool for agency self-assessment to foster continuous learning and improvement.

As PACE organizations seek to build or expand behavioral health services, implementing these training approaches may help prepare staff to more effectively engage and serve this vulnerable population. These trainings may also help forge positive relationships with contracted behavioral health providers who may be unfamiliar with the PACE model of care. PACE organizations and health plans interviewed emphasized the importance of training not only for adoption of new models of care, but also for continuous improvement.

4. Create a therapeutic environment to meet participant needs

The day center is the primary location in which PACE services are provided. Participants with SMI may exhibit behaviors that have an impact on staff and other program participants; therefore one significant consideration for PACE organizations serving older adults with SMI is how to foster a therapeutic day center environment that balances the needs of all participants — both with and without SMI — as well as day center staff.

To minimize disruptive behavior and address staff feelings of disrespect at the center, PACE RI created the Respect Campaign. In this campaign, a Respect Committee draws representatives from day center nursing, transportation, behavioral health, activities, social work, and operations staff. Together this team creates a behavior plan for disruptive participants, which is reviewed by the full interdisciplinary team for approval and attached to the electronic health record. All new staff members are educated on these plans to avoid triggers, use distraction techniques, and mitigate emerging issues. The Respect Committee meets regularly and reviews all plans bi-annually. By emphasizing consistent, effective management of behavioral disruptions in the day center, PACE RI has prioritized staff empowerment and participant dignity.

Commonwealth Care Alliance conducts clinical visits in the setting preferred by members with SMI, including home visits. This approach seeks to meet the needs of members with SMI who often encounter barriers to accessing care, and who may choose to avoid health care system settings based on previous negative experiences and stigma.[25]

These promising practices may be applicable for PACE organizations to design different pathways for participants with SMI to engage with PACE services and ensure that the day center is welcoming to all participants, while being an empowering environment for staff. PACE organizations may also explore developing day center programming specifically for participants with SMI.

5. Create collaborative partnerships by contracting with external providers

PACE organizations, particularly those with smaller numbers of participants, frequently contract with external specialty behavioral health providers, including psychiatrists, mental health social workers, and inpatient psychiatric facilities. While these contractual relationships can create challenges involving coordinating care and sharing information, many PACE organizations and health plans have successfully contracted with external partners to expand services while advancing integration of care. Many organizations profiled in this brief have forged partnerships with community mental health providers who have existing trusting, long-standing relationships among adults with SMI. Such relationships are central to meeting the needs of this population.[26]

CentraCare contracts with Kalamazoo County Mental Health and Substance Abuse Services (KCMH) to meet the needs of participants with SMI. In this contract, CentraCare pays KCMH a fixed per member per month (PMPM) amount to provide psychiatric consultations, assessments, and care planning by a social worker as well as emergency mental health services. This PMPM payment structure provides staff the flexibility to access services at any point when they identify a potential behavioral health need. KCMH clinicians participate in the interdisciplinary care team as needed, and CentraCare designates a single staff point of contact for each participant interacting with KCMH to closely coordinate all communications. CentraCare reports that this collaboration improved participant outcomes and led to increased participant referrals from KCMH. Additionally, CentraCare contracts with a medical school for the services of a physician certified in psychiatry and internal medicine who provides advice and guidance to PACE staff through weekly attendance at interdisciplinary team meetings and availability for phone calls with PACE clinicians.

Through Community Care's behavioral health homes, a full-time wellness nurse supported by Community Care but employed by the behavioral health provider is embedded at each participating behavioral health provider. This wellness nurse provides ongoing staff training and consultation on the interconnectedness between mental health and physical health for members with SMI, and facilitates periodic meetings between physical and behavioral health staff. By integrating physical and behavioral wellness goals into existing mental health care delivery settings, Community Care has increased member activation scores and medication adherence while decreasing hospitalizations.[27] Community Care built on the deep relationships of many Medicaid plan members with community mental health providers to effectively integrate into existing care delivery settings.

Another health plan, South Country Health Alliance, developed the Healthy Pathways program for members with SMI in partnership with local counties in their service area and county-based mental health providers. Healthy Pathways' case managers are trained to build trust with members while focusing on member engagement, self-management, and medication management. South Country embeds case managers at county human service agencies and local mental health providers, who assist with emergency services for individuals in crisis as well as with "step down" services for those who need a maintenance level of services. The plan reports that this partnership, driven by close collaboration across positions, has led to improved member health and social outcomes.

PACE RI contracts with social workers to expand its capacity to provide counseling and psychotherapy services. Additionally, PACE RI contracts with psychiatrists to visit the PACE center weekly and participate in monthly behavioral health team meetings for all interdisciplinary team members to review behavioral health participants. Since the psychiatrists are affiliated with a local

geriatric psychiatric facility, PACE participants who enter the psychiatric hospital experience continuity of care with the same providers after discharge.

Finally, PACE SEMI frequently receives participant referrals from group homes for individuals with diagnoses of bipolar disorder, schizophrenia, or schizoaffective disorder. Since ensuring the safety of the living environment is critical for the health of older adults with SMI, PACE SEMI has begun contracting with group homes and other property management and home health care organizations that provide 24-hour per day staffing and medication management protocols that align with PACE SEMI. These contractual relationships allow PACE SEMI to ensure a high quality of care within the living environment. They have also helped prevent assisted living and nursing facility placements, and increased referrals for the organization.

These approaches to contracting, as designed by PACE organizations and health plans, provide potential strategies for other PACE organizations to foster collaboration while expanding capacity to deliver person-centered care for older adults with SMI. PACE organizations may develop contractual relationships to provide core behavioral health services as well as additional supports for clinicians and interdisciplinary team members, and to ensure a safe living environment that supports staff-led behavioral health services. Throughout all of these contracts, PACE organizations can focus on ensuring continuity of care for this vulnerable population.

Project ECHO: An Innovative Model to Improve Care for Older Adults with SMI

The Extension for Community Healthcare Outcomes (Project ECHO) focuses on improving specialty care in primary care settings, and has increased provider capacity to care for older adults with SMI. In the Project ECHO 'hub and spoke' model, specialist teams from an academic medical center connect with primary care clinicians in local communities.[28] Using teleconferencing technology, primary care clinicians participate in ongoing learning communities and receive expert support from specialist teams.

The University of Rochester Medical Center trained clinicians at 75 primary care practices and 90 nursing homes in New York through ECHO clinics that focus on geriatric mental health in long-term care and adults with mental illness in primary care settings. Participating clinicians receive support on providing care for older adults with SMI through case discussions and didactic presentations on topics such as pathophysiology of mental illness, medication management, motivational interviewing, and provider self-care. These ECHO clinics have led to improvements in mental health care knowledge and treatment practices by increasing the skills, knowledge, and self-efficacy of clinicians in management of older adults with behavioral health needs.[29]

The Project ECHO model may help PACE programs address a shortage of geriatric psychiatrists and improve frontline clinician capacity to deliver care to participants with SMI. In particular, this model may support PACE organizations in managing care transitions for an increasing population of participants with SMI.

Conclusion

The promising practices of the PACE organizations and health plans described in this brief can be blueprints for PACE organizations considering expansion or improvement of behavioral health service delivery for older adults with SMI. For organizations that either focus on contracting with or hiring behavioral health providers, these models demonstrate approaches to delivering person-centered services, fostering increased collaboration and knowledge, and measuring outcomes to drive continuous improvement. Specific strategies are shaped by a range of factors, including program size, participant health characteristics, financial considerations, and relationships with community mental health providers, but the most successful strategies proactively identify participants with SMI and coordinate the delivery of comprehensive medical, behavioral, and social services. PACE organizations identified multiple priority areas for ongoing efforts to further meet the needs of this population, including tracking behavioral health outcome measures over time, and addressing social determinants of health, such as housing.

PACE organizations profiled in this brief have developed new strategies to meet the complex needs of a changing participant population with increased rates of SMI. As PACE organizations have expanded their capacity to provide behavioral health services, they have also increased overall enrollment. Improving the quality of services provided to participants with SMI will continue to be a significant area of focus for PACE organizations looking to expand this model of care. This focus may be amplified by the November 2015 passage of the PACE Innovation Act, which, once implemented, will permit PACE organizations (and other interested entities) to establish PACE-like pilots to serve new populations of participants (including those under the age of 55).[30] As PACE organizations consider enrolling a younger population with more diagnoses of mental illness, these promising practices from inside and outside of PACE settings will assist PACE organizations in meeting the complex needs of this growing population.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

ENDNOTES

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