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## **Welbehealth: Case Study of Adapting PACE Under COVID-19**

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## **WelbeHealth: Case Study of Adapting PACE Under COVID-19**

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## Abstract

As U.S. national and state policies for elder care evolve, this report offers a depiction of efforts by a provider of the Program of All-inclusive Care for the Elderly (PACE)—WelbeHealth—to adapt its care delivery in the face of the COVID-19 crisis. It is meant as an illustrative example of the adaptation of one elder care model, the PACE model, to a pandemic crisis in which remote care becomes essential. PACE providers offer high-touch, team-based care to frail seniors who live at home but regularly visit a center where medical, social, and other services are provided. Through interviews with leadership and staff the study describes WelbeHealth’s implementation of a hybridized model of home care under COVID-19, enabled by the flexible nature of PACE programs, allowing for a safe and context-appropriate response to patient needs, while also recognizing that certain memory and health conditions are much harder to treat without in-person engagement. WelbeHealth acted early and decisively to minimize exposure with an incident response strategy, dispersing tablets for telehealth visits, PPE, thermometers, food, medication and other essentials into participants’ homes, and providing nearly all care remotely, which proved effective. Notably, WelbeHealth reported a 2.4% death rate from the disease, other PACE programs nationwide averaged 3.8%, whereas nursing homes averaged a 11.8% death rate.<sup>1</sup> In the context of evolving policy debates, the study suggests that the PACE model merits consideration as part of a systematic study comparing models of long-term care including home and community-based services.

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<sup>1</sup> See: <https://www.npaonline.org/covid-19-information-and-resources/covid-19-data> (registration required)

## Introduction

This report is a case study depicting efforts by a provider of the Program of All-inclusive Care for the Elderly (PACE), WelbeHealth, to adapt its care delivery in the face of the COVID-19 crisis. It is meant as an illustrative example of the adaptation of one elder care model — the PACE model — to a pandemic crisis in which remote care becomes essential. This case study lays the groundwork for a systematic comparison of adaptation by other models, to strengthen the case for policy choices that support success across the various models of care for the elderly.

The Program of All-Inclusive Care for the Elderly (PACE) is a community-based, flexible and highly effective<sup>2</sup> value-based care model serving the most complex patients – frail elders. PACE services are authorized and coordinated by a dedicated PACE Interdisciplinary Team (IDT) of professionals who partner with the participants and their families to maintain their highest level of functioning, independence and quality of life. The PACE Center is the hub of service delivery -- combining a primary care clinic, adult day health care and the IDT care team at one location. PACE participants receive medical, rehabilitative, social and personal care services in the PACE center, in their homes and additional settings included in the PACE contracted network of outpatient and inpatient service providers.

To qualify, seniors must be 55 years or older, residing in the approved PACE service area, in need of nursing home-level care and able to be cared for safely in the community with PACE services. PACE programs primarily serve low-income, ethnically diverse seniors and the mitigation of significant social determinants of health adversity (such as access to a safe community, nutrition and healthcare), is central to the model.

Due to the highly flexible model and the fact that their members live primarily at home, PACE providers were in a position to safeguard their older populations during the COVID-19 pandemic. But to do so, they were required to assure not only their physical and “medical” well-being, but also their psychological and social well-being, while keeping them safely in their homes, away from the dangers of in-person social contact.

Given that the coronavirus was most deadly to the population they serve — the frail elderly — WelbeHealth quickly implemented their emergency Incident Command System, in order to save lives. They introduced adaptations in telemedicine, social engagement and other practical services to keep seniors safe (i.e., delivering groceries and incidentals) resulting in remarkably few COVID-19-related hospitalizations and deaths over the year-plus pandemic period beginning in February 2020.

This case study is based on interviews with leaders, staff and PACE participants. The interviewees themselves suggest which of the novel adaptations worked well and which did not, and which should be considered for adoption beyond the pandemic setting.

Key insights from the literature studying PACE programs include: (1) Aligned incentives promote preventive care. PACE’s capitated cost model moves the risk from payor to care provider, forcing

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<sup>2</sup> See Figure 2 *Pace by the Numbers* below.

companies to be innovative and efficient in keeping patients well. (2) Home-based care is more cost-effective and keeps elders healthier and happier longer than institutional care.

## The Traditional PACE Model

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid funded program designed to provide necessary medical and long-term care services to the frail elderly through community-based rather than institutional care. *PACE providers are organized to provide high-touch, team-based managed medical and social services to frail seniors.* A critical feature of the PACE model is that the programs provide and finance the entirety of a participant's care. Before focusing on this subject provider of this study, it is useful to understand the structure and function of the PACE model.

Care Provided. PACE model providers operate multi-purpose facilities for participants to see their primary care doctor, have regular meals and engagement activities that can provide exercise and socialization, and receive specialty care, such as physical therapy, mental health, podiatry, vision and hearing services. PACE programs supplement the care that participants receive in centers with care provided directly in patients' homes. In addition to providing skilled nursing services (such as wound care or injections) in homes, PACE programs work to meet all of a participant's needs required for independent living, and as such support participants with fall prevention, laundry, cooking, personal grooming, and as needed, other activities of daily living (ADLs). PACE also provides all necessary transportation between a participants' home, the centers, and any external appointments – traditionally a burden that falls on caregivers. PACE not only provides care, but they also provide a social community where seniors make friends and develop a sense of belonging. In short, PACE supports participants with everything they need.

Eligibility. To be eligible for PACE, a senior must be 55 or older, deemed eligible by the State for nursing home care, live within a certain distance to the service center, and be able to live at home safely with PACE support. Chronic disease is common among PACE participants, and about half of the population experiences some level of dementia. Most participants are also low-income: nationwide, 90% are dually eligible for Medicare and Medicaid.<sup>3</sup>

Cost structure. PACE programs operate under a capitated model and are thus able to provide more flexible, coordinated coverage to meet all of a participant's needs. By contract with Center for Medicaid and Medicare Services (CMS) and State Medicaid agency (MediCal in California), PACE programs provide any service available through Medicare or Medicaid as determined necessary by the PACE interdisciplinary care team. From the State, a PACE provider receives a monthly rate for long-term care needs that is below the cost of a comparable nursing home eligible population and for healthcare, a monthly capitation from Medicare based on diagnoses and other factors. This complete care, in a capitated cost structure, has proven to yield higher quality and breadth of care at lower cost, through increased efficiency and decreased hospital and emergency room visits. States pay PACE programs 13% less than the cost of caring for a comparable population through

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<sup>3</sup> National PACE Association, "PACE Facts and Trends." <https://www.npaonline.org/policy-and-advocacy/pace-facts-and-trends-0>

other Medicaid services including nursing homes and home and community-based waiver programs.<sup>4</sup> In Medicare, payments to PACE organizations are equivalent to the predicted costs for a comparable population to receive services through the fee-for-service program.<sup>5</sup>

**Asserted Structural Advantages of PACE Programs.** A centrally coordinated interdisciplinary team (IDT) enables customized, preventive and cost-efficient quality of care. It is an *integrated model*, where the PACE IDT manages every aspect of care from long-term care, to psychosocial to medical care — primary care, medications, specialty care, hospital care including care transitions, and more. It *aligns incentives*: PACE directly provides or contracts for all services covered by Medicare and Medicaid and at full risk for total cost of care. The coordination seems to be key to the reported high satisfaction levels while reducing institutional care for the target population. Notably, only 5% of nursing home-eligible PACE participants currently reside in a nursing home, and hospitalization rates are 24% lower than dually eligible beneficiaries who receive Medicaid nursing home services.<sup>6</sup>

Central to the asserted advantages of the PACE program is that *participants live at home and engage actively with the community*. A more engaged, purposeful life helps participants take on the challenges of aging. PACE users live longer, healthier lives than those in long-term care.

*Figure 1: Structure of the PACE Interdisciplinary Team (IDT) <sup>7</sup>*



<sup>4</sup> NPA Analysis of PACE Upper Payment Limits and Capitation Rates, March 2017.

[https://www.npaonline.org/sites/default/files/PDFs/UPL\\_paper\\_FINAL.pdf](https://www.npaonline.org/sites/default/files/PDFs/UPL_paper_FINAL.pdf)

<sup>5</sup> Mathematica Policy Research. (2014). The Effect of PACE on Costs, Nursing Home Admissions and Mortality: 2006-2011. Evaluation prepared for U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy.

<sup>6</sup> Segelman, M., Szydlowski, J., Kinosian, B., et al. (2014). Hospitalizations in the Program of All-Inclusive Care for the Elderly. *Journal of the American Geriatrics Society*, 62: 320-24.

<sup>7</sup> NPA *PACE by the Numbers*

[https://www.npaonline.org/sites/default/files/images/infographic\\_images/pace\\_infographic\\_update\\_side1\\_may2021.pdf](https://www.npaonline.org/sites/default/files/images/infographic_images/pace_infographic_update_side1_may2021.pdf)

**Participant Demographics and Experience.** As part of its comprehensive approach to care, the PACE model emphasizes the importance of the patient experience that extends beyond health needs. Participants are actively engaged in social activities both in centers and in their homes, and participant mental health and well-being is a central focus of patient care.

Over the past 45 years of its operation, PACE population demographics have varied. In its most recent census nationwide, PACE enrollees have an average of 5.8 chronic conditions per person; 46% have dementia; 84% need assistance with 1 to 6 activities of daily living; 95% live in the community, and 90% are dual-eligible for both Medicare and Medicaid. PACE enrollment has more than doubled over the last 8 years.<sup>8</sup>

Because of PACE programs' capitated model and comprehensive coverage, participants are supported by an interdisciplinary team of caregivers that work to build a customized care plan – one that allows them to live safely in their communities. Not surprisingly, this uniquely tailored approach to patient care consistently results in better outcomes than those with similar populations residing in nursing homes. PACE has been successful by many measures over the 45 years in which it has operated.

*Figure 2: PACE by the Numbers*

<b>45</b>	Years as operational model serving frail seniors
<b>97.5%</b>	Families who would recommend PACE <sup>9</sup>
<b>16%</b>	Cost reduction in rate of hospitalizations <sup>10</sup>
<b>44%</b>	Reduction in hospitalization rate compared to duals in nursing homes <sup>11</sup>
<b>60%</b>	Reduction in hospitalization rate compared to duals in other HCBS <sup>12</sup>
<b>80%</b>	Reduction in participant depression rate <sup>13</sup>
<b>31%</b>	Increase in life expectancy <sup>14</sup>
<b>\$10K</b>	Tax-payer savings per patient <i>An Oklahoma state-sponsored study showed that PACE saves \$1,000,000 annually per 100 patients.</i> <sup>15</sup>

<sup>8</sup> National PACE Association, "PACE Facts and Trends." <https://www.npaonline.org/policy-and-advocacy/pace-facts-and-trends->

<sup>9</sup> National PACE Association, "PACE Reduces Burden on Family Caregivers." <https://www.npaonline.org/about-npa/press-releases/pace-reduces-burden-family-caregivers>

<sup>10</sup> Segelman, Micah et al. "Hospitalizations in the Program of All-Inclusive Care for the Elderly". *Journal of the American Geriatrics Society*. <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.12637>

<sup>11</sup> Ibid

<sup>12</sup> Ibid

<sup>13</sup> Center for Consumer Engagement in Health Innovation, "Care That Works: Program for All-inclusive Care for the Elderly." <https://www.healthinnovation.org/resources/publications/care-that-works-pace>

<sup>14</sup> Ibid

<sup>15</sup> Oklahoma Department of Health with University of Oklahoma School of Community Medicine, "State Demonstrations to Integrate Care for Dual Eligibles." <https://www.cms.gov/medicare-medicaid->

## WelbeHealth – A Case Study of One PACE Provider

Our case is an examination of the adaptation of WelbeHealth, a California PACE provider, to the COVID-19 pandemic. WelbeHealth is a physician-led healthcare services company, founded on the mission of serving the most vulnerable seniors with quality, compassion and value through the PACE model of care. All employees, partners and investors of WelbeHealth are advised before joining that WelbeHealth’s mission<sup>16</sup> is the focus and “true north” of the company.

WelbeHealth currently operates four PACE centers across California in Stockton/Modesto, Fresno, Long Beach and Pasadena/Glendale/Burbank. WelbeHealth opened its first center in Stockton in January 2019, currently serves over 750 frail seniors and has the capacity to serve thousands more seniors in need.

WelbeHealth has a simple organizational structure intended to enable agile decision-making which, in the context of COVID-19, seems to have worked well. Three of the five-member executive team are physicians, and one member has 25 years of PACE leadership experience. Welbehealth President Dr. Matt Patterson’s military experience in both emergency response logistics and remote medicine are reflected in the organization’s preparedness and actions taken last year.

When COVID-19 hit in early 2020, concerned about the deadly consequences of exposure for its frail population, WelbeHealth leaders sought to respond decisively by closing the centers, limiting in-person contact, shifting to telehealth and launching its incident command system (ICS) to protect their participants. By rapidly transforming its care model, WelbeHealth had exceptional results: as COVID-19 cases rose across the country — and in particular within nursing home populations — WelbeHealth did not have a single COVID-19 death during the first 8 months of the pandemic. The first WelbeHealth loss from COVID-19 occurred on November 21, 2020 and 10 WelbeHealth participants died of COVID-19 since the beginning of the pandemic.

WelbeHealth and the PACE community overall performed better than nursing homes. The National PACE Association has been collecting COVID-19 data from the majority of their membership since late April 2020. As shown in Figure 3 below through April 25, 2021 the PACE COVID-19 death rate was 3.8%, a number nearly one-third the 11.8% death rate in nursing homes. WelbeHealth, applying the NPA methodology during a similar timeframe – total deaths divided by the 12-month rolling average census between May 1, 2020 and April 30, 2021 – calculated a death rate of 2.4%.

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[coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/okproposal.pdf](#)

<sup>16</sup> WelbeHealth three core values are:

- **“Courage to Love:** We prioritize human connection and value every precious life we touch.
- **“Pioneering Spirit:** We relentlessly pursue resourceful solutions to support participant health and independence.
- **“Shared Intention:** We work as a team with a common purpose. We start by listening, promote and contribute diverse perspectives and support team decisions.”



Figure 3. Nursing home and NPA Member Organization COVID-19 Data.<sup>17</sup>

Data.CMS.gov COVID-19 Nursing Home Data Week Ending 4/25/2021				
Total Confirmed Cases	Total COVID-19 Deaths	AVG Total Occupied Beds	NH Confirmed Cases Rate	NH Deaths Rate
650,497	132,293	1,117,161	58.2%	11.8%

  

NPA Member Organization Data Reporting Period 4/26/2021				
Cumulative Confirmed Cases	Cumulative COVID-19 Deaths	AVG Total Participating PO Census	PACE Confirmed Cases Rate	PACE Deaths Rate
8,303	1,582	42,136	19.7%	3.8%

Early Action. As news of COVID-19 began emerging as early as January 2020, WelbeHealth physician leaders drafted a plan in the face of what was, at the time, considered extremely unlikely: what to do in case the distant rumblings of an exotic disease in China became a pandemic. The plan was to implement a full program of care with minimum in-person contact for the entire elder membership as quickly as possible. By March 2020, WelbeHealth had deployed a 4G LTE “WelbeLink” tablet, PPE supplies and a thermometer in each participant home to allow the care teams to maintain regular video communications and deliver telehealth services, including COVID-19 symptom monitoring, doctor’s appointments and socialization. In addition, WelbeHealth provided essential services and supplies to the seniors including meals, medication delivery and incidentals such as toilet paper enabling them to stay home.

By the time the lockdown was official in mid-March 2020, WelbeHealth had already made the transition to what they called “Incident Command Mode,” where participant care was provided entirely remotely, and they quickly deployed the technology and processes to engage, serve and monitor every participant in their home. To do so, WelbeHealth deployed Abbott’s ID Now instruments for rapid molecular point of care testing for COVID-19 to obtain results on team members and participants within minutes ensuring that WelbeHealth staff deployed to participants’ homes were free of COVID-19.

In several ways, WelbeHealth believes it was already well prepared for this quick transition to remote care: (1) Customized care: Because the PACE IDT provides highly customized care, being flexible and accommodating with patient care was already standard practice. (2) Decentralized economics: Because PACE programs operate under a capitated model, WelbeHealth had the financial flexibility to quickly change what type of care they provided without concern about reimbursement. WelbeHealth also benefited from its nimble organization structure: as the pandemic struck, the WelbeHealth executive team were able to act rapidly and aggressively without

<sup>17</sup> <https://www.npaonline.org/covid-19-information-and-resources/covid-19-data> (registration required)

having to navigate a parent entity. (3) Culture: Lastly, much of WelbeHealth's leadership emphasized the significance of the company's culture in their success. Dr. Patterson credits the company's mission-driven focus – in particular the idea that “quality comes first, everything else is secondary” – for their exceptional outcomes during the pandemic, in contrast to nursing homes focused primarily on economics.

Quick Response to Lockdown: Transition to Remote Care, Technology Decisions. WelbeHealth quickly procured Personal Protective Equipment (PPE) and testing equipment. It also moved to distance care, which required tele-health tools. (1) Acquisition: In February, the WelbeHealth leadership team negotiated the purchase of several hundred Grandpad tablet devices (senior-friendly tablets that enable remote care, branded as “WelbeLink” by WelbeHealth) and home thermometers, one for each participant. By purchasing these tablets early, WelbeHealth beat the later supply chain delays. WelbeLinks are easy to hold, charge, and prop up, with large print and simple buttons; the ones WelbeHealth provided to their participants initially had only three functions: a central WelbeHealth video function, messages, and games. (2) Rollout: The device rollout posed several challenges: WelbeHealth was faced with sanitizing, transporting, installing, and maintaining hundreds of tablets; training staff to provide care remotely; quickly modifying staffing structures to accommodate the needs of the new program; and, critically, ensuring that each participant was able to receive the care they needed remotely. (3) Remote is the new normal: Despite the challenges, WelbeHealth Technology Director, Kate O'Leary successfully led the implementation of the program: fully configured WelbeLinks were delivered to participants' homes, and within a week, WelbeHealth had transitioned all their participants from regularly visiting centers in-person to receiving fully remote, video-enabled care by March 20th. But of course it's not only the application of technology that enables effective response to emergencies and crisis, but organizational agility.

Another action WelbeHealth took early was a wholesale move from regular operations to its emergency response incident command system (ICS). The WelbeHealth Chief Regulatory Affairs Officer, Elizabeth Carty, trained the entire workforce on a special all-hands meeting March 16th. “We explained that it was no longer business as usual”, Ms. Carty said. “We needed to re-organize our leadership and staff to respond to the crisis. We actually launched three ICS’ – one for the central team and one for each of the two PACE programs open at that time.” Each of the three incident command teams consisted of an appointed Incident Commander with 6 section chiefs. In this ICS structure, the PACE Executive Director was purposely not the Incident Commander but responsible for decisions on roles, delivery model and resources. The Incident Commander managed the crisis. In another example of the difference from normal operations, the Quality Improvement Coordinator switched to the role of Incident Command Logistics Section Chief, focusing exclusively on maintaining and compiling data on supplies, equipment, people and other resources as requested by the Incident Commander. Many line staff were re-trained to assume new duties required in Incident Command Mode. For example, center-based aides were re-assigned to deliver equipment or groceries to participant homes or make daily check-in calls to monitor for COVID-19 symptoms.

Combining both technology and organizational adaptations enabled WelbeHealth to provide high-level care remotely. Under Incident Command, clinical directors immediately used remote

monitoring devices to substitute for the regular visits at the centers and began daily participant calls to check their health and wellness. For in-person care that was essential, staff was provided with the necessary PPE, testing and sanitization measures, even in the early days of the pandemic. As the CDC guidance shifted, all members of the WelbeHealth workforce providing in-person care (providers, nurses and home care aides) were repeatedly trained in the evolving infection control protocols, by Nurse Educator Cheryl Coleman.

Adjusting for the Duration. After several weeks in ICS mode, Dr. Patterson, decided that it was time to plan to roll off Incident Command and, in partnership with the Chief Business Development Officer, Dr. Vaneesh Soni, built the WelbeHealth “HomePACE” model. “HomePACE” is a long-term, more encompassing program that maintains the regular check-in calls and telehealth programs established during ICS mode, but incorporates other solutions aimed to address the less urgent health needs that had been de-prioritized while addressing the immediate focus on survival.

In particular, WelbeHealth began bringing participants into the centers in limited ways to address in-person primary care visits and non-urgent health needs, set up contracts for phlebotomy in the home for labs, and increased focus on social activity and therapy through the tablets to address issues of isolation and mental well-being. With the Abbott testing kits, Dr. Patterson felt confident they could bring participants to the centers on a limited basis safely. “With Abbott point of care tests, we could test everybody walking in the building. It was literally like the NBA bubble — we’re screening everybody.” Recognizing the limits of remote care, the WelbeHealth PACE programs brought participants back for “theme days”. Dr. Patterson described how they would rotate theme days and cycle participants through. “We do dentistry on Tuesday, podiatry on Wednesday, wound care on Thursday. It was only one activity, small group of team members, individual participants, one at a time.”

When the third surge hit Los Angeles and the Central Valley hard late 2020, Dr. Patterson made the difficult decision to return to ICS mode and close the centers. By that time, WelbeHealth had opened both a third PACE program in Long Beach over the summer and was opening a fourth program in Fresno. Incident Command teams at the first two WelbeHealth programs taught the other two programs how to operate in the much more restrictive ICS mode.

As soon as vaccines were available in December 2020, WelbeHealth collaborated with county public health officials to secure and rapidly deploy the vaccine to their healthcare team and frail elders in accordance with State guidelines. In addition, WelbeHealth responded to county officials’ pleas in early 2021 to help vaccinate other eligible community residents. WelbeHealth coordinated drive-through Saturday vaccination events inoculating 2000 eligible members of the LA and Central Valley communities unaffiliated with WelbeHealth.

Mental Well-Being. Beyond issues of physical health and safety, the program also had to determine how to engage and support the mental well-being of participants without the regular mealtimes and group activities at the centers. WelbeHealth began using the WelbeLink tablets to engage participants remotely in the types of games and activities that would have occurred at the centers; later in the pandemic, the program also incorporated a companion app into the tablets that allowed participants to socialize with one another. Like all aspects of the transition to remote care, this brought its own challenges. Many participants struggled to consistently use the technology to

participate in events, and others were simply hesitant about the prospect of socializing virtually. Anecdotally, even participants who did not find the time or motivation to participate in remote activities such as games and exercises appreciated that they were part of a community that provided those options, enjoyed occasional participation, and liked the chance to see their doctors, nurses and physical therapists through the WelbeLink devices.

WelbeHealth leaders took steps to support the workforce immediately and as the situation evolved. Beginning in March, CEO Dr. Si France and President Dr. Matt Patterson led weekly all-hands meetings to nurture the Welbe community operating in the remote model as well as provide practical support. Each week the physician leaders provided accurate, up-to-date facts about the pandemic and assured the group that — due to WelbeHealth’s aggressive infection control actions and the pandemic reserve — their jobs were secure from pandemic layoffs. To support team members working at home, each staff member had a laptop and access to up to \$400 in funding to pay for adjustments to working at home.

“Our team's approach to this crisis was a simple three-point checklist with our founding Core Value - Courage to Love- as its guide: to protect our participants' safety and well-being, to protect our team's safety, well-being, and job security, and to protect the organization with a cash reserve to weather the storm and protect our culture,” said WelbeHealth CEO Dr. Si France. “Courage to love is about seeing the other person through the eyes of their loved ones - knowing that they would want the best care possible for that loved one. And that starts with our team members - making sure we take care of our team. By doing that first, our team can then bring their Courage to Love to our participants to help them thrive - because otherwise you can't give what you don't have. And because every participant is a valued patriarch or matriarch of their community, the impact of their thriving through this approach has ripple effects beyond what we can see or even comprehend, probably for generations.”

Financial Adaptation. As WelbeHealth fundamentally changed how it delivered care, the financial model of the company adjusted as well. Given that PACE programs are at full financial risk and the disease had the potential to cause unprecedented hospital expenses, WelbeHealth took unique steps to ensure it was financially capable of protecting patients, taking care of employees and ensuring the longevity of the company. WelbeHealth did this by allocating \$15 million to a pandemic cash reserve based on worst-case projections for claims costs. WelbeHealth also renegotiated lines of credit to extend availability through the duration of the pandemic. Lastly, WelbeHealth built a custom re-insurance stop-loss program in January 2020 (prior to broad understanding of COVID-19) to cover catastrophic cases.

WelbeHealth invested in new pandemic-related expenses such as large quantities of PPE, testing equipment and WelbeLink tablets, including ongoing connectivity fees. For staffing, WelbeHealth continued to employ the same number of aides, but transitioned them from working in the centers to newly necessary jobs like making check-in calls, prepping delivery kits or grocery shopping. Similarly, transportation costs shifted from providing a high frequency of rides with multiple participants to providing a lower frequency of rides with single participants. An instance where costs did significantly increase was in home care; not surprisingly, home care costs rose as patients stopped receiving bathing, meals, safety monitoring and other vital care at centers. WelbeHealth’s

efforts were successful: few participants were hospitalized, no employees were laid off and the program remains fiscally stable.

PACE Clinical Provider Perspective. To understand the medical provider experience of WelbeHealth's pandemic response and learnings from the remote care experiment, we interviewed Dr. Colin Robinson, the WelbeHealth Medical Director in Pasadena. "WelbeHealth did just a phenomenal job of getting resources in place ASAP," Dr. Robinson said. "Participant tablets, point of care testing equipment, PPE, specialist eConsults was super helpful because then I didn't have to worry as much about logistics." At first, they were "just focusing on COVID screening and education with daily calls, limited home visits and providing incidentals." But within weeks they were able to do more by setting up mobile labs for home blood draws and set up rotating skeleton crews in clinic, he explained. With a provider in clinic, "I no longer had to make that calculus" of whether it was worth canceling other appointments to travel to the person's home... "if there is a question of whether in-person is necessary, we bring them to the PACE clinic." Also, he said, when it is appropriate "it is satisfying to see someone really quickly remotely... we didn't have to waste all their time to bring them in."

While there were benefits, Dr. Robinson articulated limitations with remote care for the PACE population. He explained "you can do a fair amount of really good care... manage things like Hepatitis C, HIV or Diabetes remotely. You need some labs, maybe initial exam and then you follow up on vitals and have ongoing discussions. It gets trickier when you're looking at someone who's got new back pain... you want to feel exactly where it is — is it a fracture on the spine or a really tense paraspinal muscle, which is a totally different approach to care... if you're trying to do it without examining them in person, then you might be more likely to order an imaging study." Also, he found limitations with the technology itself — with the unpredictable lighting and camera resolution he could not always get the information he needed. He said, "if you wipe something out with a very bright light one telehealth visit and the next visit it's different lighting, you can misinterpret things."

Dr. Robinson reflected on the change in the experience for both him and the participants after closing the PACE Center. PACE care teams meet every day to exchange medical and psychosocial information and discuss the care plan. He found that, while the group was able to problem-solve effectively, there was a sense of disengagement without reading facial expressions and being in a room all together. He described an even stronger sense of disengagement for the participants. "The PACE Center provides so much benefit and, in this population, isolation leads to dominoes falling... At the PACE center they form bonds and being at home were not as physically active — both of these effect mood... Some participants were holding on but others, you can see them decompensating... there were more falls and I've wondered if they had been exercising at the center, would that have happened." Dr. Robinson discussed the importance of face-to-face time in developing the doctor-patient relationship. "There is comfort your patient gets from seeing you in person... they are putting their health in your hands and they want to know that you care about them... and they open up a little more". In PACE normally, participants come to the center on average twice a week. Dr. Robinson added, "the more contact you have with someone, the more likely they are to bring up an issue" that can be addressed earlier.

“I am a big fan of hybridizing,” Dr. Robinson declared. “You don’t want barriers to in-person visits when appropriate.” But, he explained, when in-person care is not necessary, by leveraging telehealth, you increase convenience and access to care for more people. “What I love about PACE is the incentives are aligned... providers can do the right thing for the condition.”

PACE Participant Perspective. For this case study, we interviewed a number of staff and participants in WelbeHealth’s PACE program. Below, we highlight key moments from these interviews.

Paco. Paco described himself as a private person with up and down moods. “Pacific PACE help[ed] me so much.” He did not spend time at the PACE center before the COVID-19 shutdown except to see the doctor. Upon shutdown, “they gave me equipment — WelbeLink, thermometer, blood pressure. Educated me to not go to market, provided me with everything. People calling asking what your blood pressure is, temp... also email me on the [tablet]... how are you doing... check[ing] on me all the time...”

Paco admitted that he was “not a technology guy” but when asked if he used the WelbeLink he said yes: “You answer it just like a telephone, the only difference is you see the face... it’s easy”. When the pandemic is over, he said “I might go to the center but right now I live moment to moment” and would like to keep his WelbeLink — “people call me on it”.

Paco’s perspective suggests that the WelbeLink was accessible, useful, and a tool for social connection and support — even for someone who was not initially very familiar with technology. It also demonstrates that PACE’s high-touch approach was crucial to making remote care work, with regular check-ins keeping tabs on Paco’s needs.

Christine. Christine is a family caregiver who has been caring for her mother-in-law for ten years. When her mother-in-law’s dementia took a precipitous decline, she signed up for Pacific PACE because of the day center where her mother-in-law could spend the day while she worked at home. Unfortunately, the pandemic meant that the center had to close. With her mother-in-law at home during the entire day, it was a big struggle for Christine to manage her work life with her caregiving responsibilities, even with aides in home. During our interview, she needed to step away to help her mother-in-law several times.

The remote model of care also presented difficulties for her mother-in-law’s experience of care. Sometimes, the WelbeLink’s connection was unreliable in different parts of the house. Christine tried to set up her mother-in-law with remote physical therapy and activities like bingo but “nana turns on and off *herself*, so even on big screen, nothing will engage her”. She expressed eagerness for the center to open, “She needs to be engaged for a good portion of the day — come home exhausted and sleep through the night.”

From this interview, we see the limits of remote care in the instance of both dementia and family caregiving. The on-screen activities failed to provide the same level of mental and physical engagement that the PACE center can offer mentally frail seniors. Additionally, the day center provides an important respite for family caregivers so that they can focus on their own needs and work, while also ensuring that they are able to remain close with elderly relatives during the evenings. It is clear that remote care is no replacement for the PACE center’s essential services.

Arthur. Arthur described himself as an outgoing person who was enthusiastically engaged in PACE before and during the shutdown. “This program is awesome. Never had so much personal care in my life!” When asked if he had taken advantage of programs and how he connected socially through PACE, he said he had “taken advantage of every program. I am a recovering alcoholic and they hooked me up with a recovery group every Thursday”. He explained that online AA during the pandemic “did not work for me... [it was] text only, I need to see faces.” He also participated in bingo, painting, cutting fingernails. He said that he was able to stay connected to people he had met in the center but was also eager to reconnect with them in person: “I wish they would hurry up and open the day center.”

In terms of Arthur’s medical needs, he had been engaged in a physical therapy exercise program at the center for knee pain before the pandemic. When the center shut down, the physical therapist set up the WelbeLink so that he could lean against the kitchen counter to do his exercises. He said he has kept this up with the physical therapist’s support and his knee is now “pain free.”

From Arthur’s experience, we can see that the social interactions through the PACE program are essential to the well-being and health of the patient. Keeping up one’s spirits by connecting with care providers and fellow participants can help with maintaining healthy habits.

Ester. Ester de Santiago, Engagement Supervisor, described challenges with running a remote activity program for seniors through the WelbeLink. A large variety of issues emerged: patients had difficulty hearing, trouble holding the device due to arthritis and cognitive impairments and care could be hindered by the need for slow step-by-step instructions. The experience for the seniors may be analogous to the difference between help troubleshooting a home appliance by phone versus having in-person technician support.

In addition, the logistics of the activity program changed significantly and presented new difficulties. Interactions that are natural and fluid in person are replaced by inefficient substitutes. For example, when the center is open, seniors may move across the room to join an activity but with remote care, the staff need to remind the participants several times and help them with connectivity to convene.

One encouraging development, Ms. de Santiago learned, was “participants have discovered an ability that they didn’t know they had, when it comes to technology.” However, it is clear to her they are craving social interaction, “they want to see and be around each other, laugh and, some of them are suggesting that we put on a dance for them.”

General Insights. These interviews highlight many different types of patients and the diversity of their care needs which make the center so critical to the PACE model. It is impossible to replace the social aspect with technology, and face-to-face engagement is crucial to quality of care as well as participant well-being and happiness. Additionally, the center provides an important container for elder care, which frees up time for family caregivers and ensures timely attention to detail for any issues which may come up. For certain users, the WelbeLink provides more opportunities to regularly access PACE’s trademark high-touch approach to care, but for others it doesn’t work nearly as well — especially for memory care. Remote care is an important tool which should be

used when appropriate, but it has important gaps which are much more effectively addressed with in-person care.

## Longer-term Impacts

While participants reported to be initially quite grateful for the safety and protection that the remote care provided them, they expressed frustration that they were not yet able to receive as much care in-person at the PACE center as they had before the pandemic began. The experience of WelbeHealth can give us some insights into the future of remote care and its specific applicability to certain kinds of care.

There are many positive insights from the quick response to the pandemic, however. The PACE model proved flexible and nimble in making necessary changes on a tight timeline. The fact that patients have their own home, and that staff are committed to working with each participant's specific needs meant that care could be remote when possible and only in-person when necessary. Compared to a nursing home model of care, which is highly rigid and based on patient residence, PACE was able to quickly make complex changes based on emergent conditions and assess patient needs on an individual basis rather than attempting a one-size-fits-all solution.

Technology provided an important amplification to PACE's model of care, in that it allowed for regular check-ins and informed decision-making about care needs. However, it is clear that in-person visits are vital both for quality of care and for patients' well-being and mental health. The social aspect of the PACE center cannot be replaced by technology, and there are certain gaps in what can be effectively monitored remotely. Further enabling remote care through regulatory clearance, greater digital access, and digital literacy will bring gains for long-term care, but it cannot be viewed as a way around the necessity for high-touch, hands-on care. Especially in areas of memory care and mental health, in-person engagement appears essential.

## Conclusions

This study provides an illustrative example of adaptation undertaken by a provider of care for the elderly in the PACE model. It sets the stage for a systematic comparison of adaptations for elder care models. The ultimate aim is to suggest which policy choices will support the success of the various models of care.

WelbeHealth acted early and decisively to minimize exposure with an incident response strategy, dispersing tablets for telehealth visits, PPE, thermometers, food, medication and other essentials into participants' homes, and providing nearly all care remotely, which proved effective.

This study is particularly timely at this moment as PACE and other alternatives to nursing homes are gaining support. In response to the tragic rates of death for nursing home patients during the pandemic, policymakers and business leaders are re-evaluating the nursing home model and exploring innovative alternatives like home and community-based services (HCBS) and PACE. Providing adequate care for America's aging population has long been recognized as a looming



problem, with the number of senior citizens projected to more than double by 2040.<sup>18</sup> And by 2030, the demand for long-term care will double, while the supply of caregivers is already insufficient to meet current demand and is in fact rapidly shrinking.<sup>19</sup> However, the pandemic has provided an immediate catalyst for work to begin right now to prepare adequate long-term care infrastructure for vulnerable elders.

Policy momentum is growing in Washington, with significant HCBS funding already being dispersed from the American Rescue Plan Act. President Biden has promised \$400 billion in funding for HCBS, which was originally included in the American Jobs Plan and is now included in the Better Care Better Jobs Act, along with a permanent 10% increase in federal matching funds for HCBS. Additionally, several issue-specific bills including the PACE Plus Act and HCBS Access Act seek to provide financial support, regulatory clearance, and workforce development to support HCBS and facilitate a shift away from the current dominance of the nursing home model. Elizabeth Carty, Chief Regulatory Affairs Officer of WelbeHealth, welcomes the shift from the long-standing institutional bias towards the nursing home model of care: “While PACE has a 45-year track record of success, it remains optional in Medicaid while nursing home benefits are required — it’s time for every vulnerable elder in the country to have access to this gold standard of long-term care.”

While the WelbeHealth team, like much of the rest of the world, eagerly awaits a return to normalcy, many members have expressed a hope that the remarkable strides made in telehealth will continue into the program’s future. Technology Director Kate O’Leary notes that “telehealth is... the preferred method of care for many individuals,” adding that she hoped the recent emphasis on telehealth “provided a catapult to innovation, attention and thought behind technology in this realm.”

WelbeHealth’s President Matt Patterson explains that a “silver lining” of the COVID-19 pandemic was that “the crisis helped to accelerate operational innovation” as well as regulatory flexibility. To this end, Chief Regulatory Affairs Officer Elizabeth Carty is engaged with other California PACE programs in a campaign to convince the California legislature to enact Assembly Bill (AB) 523, which would require the Department of Health Care Services (DHCS) to make certain PACE flexibilities that were approved during the COVID-19 public health emergency permanent and Assembly Bill (AB) 540 which would require DHCS to increase awareness of the highly effective PACE option. “These bills are critical”, Ms. Carty says. “PACE saved lives during this pandemic and inherently mitigates social determinants of health; but, despite its proven track record of success, frail seniors, their caregivers and doctors have never heard of it!”

That may soon change, as lawmakers in Washington and State houses across the country consider fundamental changes in how to approach long-term care. Nursing homes have been struggling since long before the pandemic, and their inability to respond to a health crisis has brought them under scrutiny.<sup>20</sup> Biden’s administration has responded by proposing historical levels of funding for HCBS

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<sup>18</sup> “The US Population Is Aging.” Urban Institute, 3 Apr. 2015, [www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/data-warehouse/what-future-holds/us-population-aging](http://www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/data-warehouse/what-future-holds/us-population-aging).

<sup>19</sup> Hayes, Tara and Kurtovic, “The Ballooning Costs of Long-term Care.” American Action Forum. <https://www.americanactionforum.org/research/the-ballooning-costs-of-long-term-care/>

<sup>20</sup> Werner, Rachel et al. “Long-term Care Policy After COVID-19 – Solving the Nursing Home Crisis.” *New England Journal of Medicine*. <https://www.nejm.org/doi/full/10.1056/NEJMp2014811>

programs, which have traditionally languished due to Medicaid's institutional bias towards nursing homes. Biden's proposal would increase HCBS funding by 33% year-over-year, whereas it has averaged only 5% growth historically.<sup>21</sup> This transformational commitment to new models of long-term care for frail seniors highlights the seriousness and urgency of this issue. Biden's commitment to HCBS in Medicaid may be just the beginning of an effort to revamp and restructure long-term care, sparking conversations about even larger changes like making long-term care a Medicare benefit or having a dedicated long-term insurance program covering all Americans.<sup>22</sup>

HCBS, PACE and other models are being seen as more flexible, affordable ways to care for America's aging population. Telehealth is also being promoted, with regulatory hurdles being cleared for diagnoses to be made over video calls. Innovation in long-term care is both more possible than ever before, and more urgent. WelbeHealth's pandemic experience suggests a model which can be flexible and responsive to patients' specific needs, while remaining tied to a strong foundation of high-touch care. The PACE model certainly deserves further consideration as part of a systematic study comparing models of long-term care including home and community-based services.

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<sup>21</sup> Prindiville, Kevin. Justice in Aging. "It's Obvious: We Need to Invest in Our Care Infrastructure." <https://justiceinaging.org/its-obvious-we-need-to-invest-in-our-care-infrastructure/>

<sup>22</sup> Gleckman, Howard. "Biden Should Look Beyond Medicaid to Expand Long-Term Care." *Forbes*. <https://www.forbes.com/sites/howardgleckman/2021/04/22/biden-should-look-beyond-medicaid-to-expand-long-term-care/?sh=478aa5bb460f>

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## Appendix: Interview Schedule

The observations in this report were compiled from interviews with WelbeHealth leadership, staff and participants, in addition to public sources and the cited references. Because the COVID-19 pandemic was a long-term public health crisis, the interviews took place during changing contexts, ranging from strict stay-at-home orders as hospitals overflowed, to slightly more open settings of reduced restrictions. To help with that context, we provide the schedule of interviews below.

Date	Time	Name	Position
4-Sep-2020	11:00 AM	Elizabeth Carty, MSW	Chief Regulatory Affairs Officer
9-Dec-2020	8:00 AM	Elizabeth Carty, MSW	Chief Regulatory Affairs Officer
10-Dec-2020	2:00 PM	Dr. Matt Patterson	President
21-Dec-2020	2:00 PM	Cheryl Coleman	Nurse Educator
21-Dec-2020	3:00 PM	Cindy Voorhies	Outreach Specialist
22-Dec-2020	3:30 PM	Dr. Marie Earvolino, RN	Clinical Services Director
22-Dec-2020	4:30 PM	Ester de Santiago	Engagement Supervisor
23-Dec-2020	2:00 PM	Dr. Colin Robinson	Medical Director
23-Dec-2020	4:00 PM	Randall Ramirez, LCSW, LMFT	Behavioral Health Specialist
30-Dec-2020	3:00 PM	Ethan Epstein, CPA, CFA	Chief Financial Officer
30-Dec-2020	1:00 PM	Kate O'Leary	Director of Technology
11-Mar-2021	4:00 PM	Paco	Participant
12-Mar-2021	10:00 AM	Nana's daughter-in-law Christine	Family caregiver
12-Mar-2021	1:30 PM	Arthur	Participant