



National
PACE
Association



Setting the PACE for Rural Elder Care: A Framework for Action



National Rural Health Association

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America is graying. In response, governments, health care providers and citizens across the country are seeking ways to better serve the growing number of elderly. The search for solutions in rural areas, however, is often complicated by a relative lack of health care providers and facilities, long distances between patients and services, and lower population densities. Fortunately, help could be on the way.

PACE: A Rural Possibility

Since 1983, Programs of All-inclusive Care for the Elderly (PACE) have been serving frail senior citizens in ways that enable them to live as independently as possible, keeping them in their own homes and communities. The model began in San Francisco as an effort to help Chinese-American families avoid placing their elderly in nursing homes. It accomplished this goal by offering a comprehensive set of services including medical care, physical and occupational therapy, nutrition, transportation, respite care, and socialization that kept people happier and healthier. It also created a way to pay for this care using federal, state and private funds that can be pooled at the program level, allowing maximum flexibility, effectiveness, and even cost-savings.

The beauty of the PACE approach and the success it has had in keeping hospitalizations and nursing home admittance to a minimum have prompted its replication around the country. Congress authorized a national demonstration program in 1986 and authorized permanent provider status for PACE programs in 1997. Today, there are 27 PACE programs across the country. All, however, serve predominantly urban settings. That need not be the case. Rural communities and rural elders can and should benefit from PACE programs.

Indeed, the need for PACE in rural America—home to one-fifth of the nation's elderly—is in some ways greater than in urban America. Compared to their urban counterparts, the rural elderly:

- report worse health status;
- are generally older;
- have more functional limitations;
- are more likely to live alone at age 75 and older;
- are more likely to be poor or near poor; and
- are at a greater risk of being placed in a nursing home.

Unfortunately, many rural areas lack the full range of long term care services that rural elders need. PACE can help meet some of this need.

A Flexible Blueprint

Bringing PACE to rural America will require creativity and flexibility on the part of providers, regulators and policymakers. Because rural areas differ from urban ones in some very important ways, rural PACE programs will likewise differ from urban programs. One size will not fit all. Successful PACE programs are tailored to meet individual community needs rather than pulled from a rack, ready to wear.

That said, there are five core elements of PACE that, according to the Centers for Medicare and Medicaid Services (CMS), must be maintained:

- **Serve the frail elderly**—participants in PACE programs must be 55 or older and nursing-home eligible.
- **Provide a comprehensive set of services**—participants must receive a coordinated and integrated range of preventive, acute and long term care services.
- **Use an interdisciplinary team of service providers**—participants' care must be provided and managed by a team of providers ranging from primary care physicians and nutritionists to physical and occupational therapists.
- **Accept capitated payment**—PACE providers receive a capitated rate that pools payment from Medicare, Medicaid and private payers.
- **Assume full financial risk**—PACE providers must pay for all required services without compensation beyond the capitated rate; there are no benefit limitations, co-payments or deductibles.

Because rural areas have smaller populations of PACE-eligible seniors and have fewer health care providers, and also cover larger patches of ground, maintaining these core elements in a rural PACE program presents challenges that urban PACE programs do not face. Those challenges, however, can be met. The key will be to focus on achieving the goals of PACE and its core elements while allowing for flexibility in the means used to achieve those ends. Possible adaptations include:

Alternative Centers. The traditional urban PACE program uses a center to administer many of its services. Participants are brought to the center several times a week (often by PACE-operated transport) to take part in recreational activities, receive therapy, eat and be evaluated by a physician or other care provider.

In a rural PACE program, a PACE center as it is currently operated by urban PACE organizations may not be as feasible. Long distances between participants and a center as well as a lack of suitable buildings are two reasons why the center approach may not be the best. Other

approaches, however, might be used to achieve the outcome: providing a coordinated, comprehensive set of services. Such approaches could include the use of a mobile center outfitted with the necessary personnel and equipment to deliver services to the participant rather than bringing the participant to the services. Another alternative might be the creation of several “outreach” centers that would be closer to, and serve, a smaller number of participants. Such centers might be co-located with other entities or even be in private residences.

Linked Providers. In the urban PACE model, the interdisciplinary team comes together at one physical location to coordinate and deliver care. In rural areas, all the necessary team members are unlikely to be found in any one community. Rather, team members may be tens, even hundreds, of miles apart. In the information age, however, distance need not prevent providers from consulting one another or even from providing care. The use of advanced telecommunications technology can allow the team to “meet” face-to-face via two-way, live video. It also can enable a provider to monitor patients, assess their conditions, diagnose problems, and even administer care—all at a distance.

Nontraditional providers. Just as nurse practitioners and physician assistants have extended care by taking over many of the duties formerly carried out by physicians, so too can nontraditional providers play a critical role in rural areas that lack traditional providers. For example, many communities already are using lay people to fill in some of the gaps. Community health workers, promotoras and health navigators are some of the names these trained lay people go by as they help people obtain needed care.

Other nontraditional providers could help overcome one of the biggest challenges to rural health care: lack of transportation. Since few rural areas have public transit and since the distance from participant to provider is often great, transportation to and from health care is a huge obstacle in rural America. The urban PACE model of transportation—the purchase and use of specially equipped vans—could be prohibi-

tively expensive in rural areas. Instead, family members or neighbors of participants could be enlisted (or even employed) to provide taxi service—using their own vehicles to take participants to care, perhaps dropping them off at the center on the way to work. Alternatively, school buses—unused most of the day—could be put to service in creative ways.

Creative Partnerships. Because few health care organizations in rural areas have all of the necessary PACE team members, partnerships will be critical to building the requisite interdisciplinary team and offering the full array of services. Such partnerships can be as simple as contracting directly with practitioners to provide a service. They also could involve, for example, a rural hospital joining forces with a clinic in a neighboring community, a group practice in a large city, and a nursing home two counties away. The goal is to ensure that the PACE program offers the full range of care and assumes all responsibility for oversight, liability and financial risk.

Expanded Populations. In rural areas with few eligible seniors, it may not be possible to generate enough demand to create a PACE program or for the program to break even. In such instances, it may be possible and desirable to expand the population served by including, for example, the younger disabled or patients with HIV/AIDS—populations that require similar types of coordinated care over an extended period of time.

Risk Management. Covering financial risk is a fundamental issue for PACE programs, who are paid on a fixed, per-person basis, rather than for specific costs or procedures. For that payment, the PACE program meets all of the health care needs of an individual. To manage their resources, PACE programs in rural areas, like current PACE programs, will need to rely on effective care management. In PACE, care management emphasizes preventive care and maximizes care in a community setting—leading to better health outcomes, higher participant satisfaction and lower costs. Unlike the management of very large populations

RURAL PACE SUMMIT

On September 18-19, 2002, PACE providers and rural health experts, along with state and federal policy makers from across the country, gathered in Roanoke, VA, to find ways of bringing this successful—and heretofore urban program—into rural areas. This “Rural PACE Summit” was sponsored by the National PACE Association and the National Rural Health Association. Its findings are synthesized in this report.

For more information about the meeting and how PACE can become a successful and integral part of rural elder care, please contact:

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(1000+) by individual case managers found in other managed care organizations, PACE care is managed by an interdisciplinary team of the individual's own health care providers (10-15 health professionals). Each member of this care management team knows the PACE participant directly and collaborates to develop a highly individualized care plan. This level of collaboration and hands-on information results in the delivery of health care resources that maximizes good health while minimizing costs. The interesting thing with PACE is that, unlike managed care, it doesn't take a large number of enrollees to be financially viable. Some of the longer-standing PACE programs in urban area have less than 250 enrollees.

Of course, there always will be individuals that require extensive resources. Expanding the range of populations served by PACE in rural areas to increase a program's total census is one way rural providers can reduce the impact of a single, extraordinarily expensive individual on the overall program. Other approaches to bearing the financial risk include some form of risk-pooling across a number of programs, reinsurance programs, and stop-loss arrangements. Stop-loss arrangements would limit the expense a provider could incur given a particular diagnosis, procedure or cost limit.

The Capacity to Stretch

Fortunately, several mechanisms exist to give rural PACE programs the flexibility they will need to succeed in their individual contexts.

- CMS, which oversees the PACE program, recently released a regulation that specifies a process for approving variations in the PACE model on a case-by-case basis. While the five core elements cannot be waived, other requirements can.
- CMS can authorize even greater flexibility through Medicare-Medicaid waiver demonstration programs. A rural PACE demonstration program could modify elements of the PACE regulation that might not be a good fit for implementation in rural settings.

PACE

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Moving Forward: Two Promising Models

Given the diverse characteristics of individual rural areas and the flexibility that the PACE model offers, rural PACE will likely take many forms. Some will be better suited to frontier areas, others to close-in adjacent ones. Some will better fit the culture and norms of the Delta; others will work best in the West. That said, two models hold great promise for many rural areas and could be implemented right away. Both build on existing models of health care already used in rural America. Both have track records of success.

The Rural Network Model. Collaboration is a way of life in rural areas. From community barn raisings to electric cooperatives, rural residents have always worked together. Indeed, it is sometimes the only way to survive. No one entity can do everything—especially in rural America. Likewise, rural health care providers have joined forces in many instances to provide a greater continuum of care. Rural health networks, many with funding from the federal government, already have formed to tackle a wide range of health care needs and issues. PACE is a logical next step.

Using the network model to create a rural PACE program would help overcome several obstacles:

- Interdisciplinary team members could come from a variety of organizations, even those not within the community.
- Facilities and equipment from network members could be shared, and therefore the need for new construction or purchase could be avoided.
- Excess, unused capacity—and its costs—could be avoided by network arrangements that piggyback on existing service provision.
- Because a network would likely cover a large territory, the population base needed to support a PACE program could more easily be reached.

The Rural-Urban Linkage Model. Another way of getting PACE into rural areas is by linking rural and urban providers and efforts. One way would be to have an existing urban PACE program expand its efforts into nearby rural areas. Another would be to create a new PACE program that connects rural and urban providers together to serve rural seniors. Already, many rural residents drive to the city to get specialized care that is not available in their rural community. In some remote areas, residents can even see the doctor via telecommunications technology. A rural-urban PACE program takes such existing efforts one step further.

Utilizing linkages between urban and rural providers to offer a PACE program to rural areas offers several benefits:

- Specialized services generally not found in rural areas could be made available.

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- Administrative costs could be spread over a larger combined population.
- Financial risk could be shared across urban and rural populations.
- Community resources provided by, and known to, rural providers could be utilized.

A Little Help

Many of the resources and know-how needed to implement these models already exists. Still, some assistance will be required. In addition to the flexibility offered by the PACE regulatory waiver and demonstration project processes, two types of assistance will be most helpful.

Start-up funding. Few rural health care providers have surplus capital lying about. And while both models rely on leveraging resources and avoiding huge outlays, some capital is needed to fill in the gaps—hire and train staff; purchase facilities, equipment, and supplies; contract for services; and market the program. Grants from the federal and state governments, as well as local, regional and national philanthropic foundations, will be needed to get rural PACE off the ground. Because PACE ultimately can save money, these grants should

not be viewed as subsidies, but rather as investments in the future.

Technical assistance. Likewise, expertise—in topics ranging from the purchase and operation of telecommunications technology to the use of lay persons as providers to the navigation of the federal regulatory requirements—also will need bolstering. As in any new enterprise, adequate training and assistance can mean the difference between success and failure.

PACE: A Rural Opportunity

The need for coordinated, comprehensive, community-based care—the need for PACE—is just as great in rural America as it is in urban America. It makes just as much sense for rural seniors and their communities as it does for urban seniors and theirs. Likewise, it makes just as much sense from a budget standpoint, especially in a time of shortfalls and cuts.

PACE can succeed in small towns and in the country just as it has in big cities. Indeed, many of the requisite pieces are in place—sense of, and commitment to, community; trusting relationships; and a history of cooperation. All that is needed is to begin.

The PACE Series of Financial Planning Resources includes:

- PACE Business Planning Checklist
- Case Study: Total Longterm Care, Denver, Colorado
- Case Study: Alexian Brothers Community Services, Chattanooga, Tennessee
- PACE Financial Proforma Baseline Scenario Version 1.1
- PACE Financial Proforma User's Guide Version 1.1

For more information about PACE and PACE development resources contact the National PACE Association at 703-535-1517 or visit www.NPAonline.org

