

PACE in Rural Areas: Staffing Challenges and Strategies

America is aging. In response, governments, health care providers and citizens across the country are seeking ways to better serve the growing number of elderly persons, particularly persons at risk for permanent nursing home placement. The search for solutions in rural areas, however, often is 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 keep their elders with their families and in their communities. 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.

PACE serves persons who are:

55 or over

Certified to meet the state's criteria for nursing home level of care

Living in a designated PACE service area

Able to live safely in the community, with the help of PACE services, at the time of enrollment

The success the PACE model has demonstrated in keeping people out of hospitals and nursing homes has inspired providers around the country to adopt this model of care. Today, there are 32 PACE programs operating in 18 states. All of these programs, however, serve predominantly urban settings. That need not be the case. Rural communities and rural elders can and should benefit from PACE programs.

The need for PACE in rural communities 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 greater risk of being placed in a nursing home.

Although one-fifth of the nation's elderly live in them, 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

Undoubtedly, bringing PACE to rural America will require creativity and flexibility on the part of providers, regulators and policymakers. Because rural communities differ from urban areas in some very important aspects, 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 being pulled from a rack, ready to wear.

PACE programs are able to effectively serve elders in the community by being flexible and bridging the gaps that often exist in today's health care. PACE programs have several basic features that enable them to tailor their care and services to the needs and situation of each individual.

- A focus on empowering individuals to live in the least restrictive and most pleasing setting possible.
- Interdisciplinary teams composed of persons who are both providers and decision-makers for the health care and supportive services each PACE participant receives
- A capitated payment that pools financial resources from government and private payers so that providers have the freedom to provide preventive and holistic care and support that can often postpone or avoid the need for more intense acute or long term care
- A responsibility to provide or pay for the provision of all needed preventive, acute and long term care services so the organization has a financial incentive to provide the best and most effective care possible

Rural Challenges and Emerging Strategies

In September 2002, PACE providers and rural health experts, along with state and federal policy makers from across the country, gathered in Roanoke, VA, to explore the possibilities for PACE in rural communities. This “Rural PACE Summit” was sponsored by the National PACE Association (NPA) and the National Rural Health Association. Its findings are captured in a report entitled “Setting the PACE for Rural Elder Care: A Framework for Action.” Participants at the Summit identified some of the critical issues and challenges that rural organizations will face in adapting the PACE model:

- Staffing
- Financing and Risk Management
- Developing the Necessary Infrastructure
- Using Information Technologies

As part of the Rural PACE Technical Assistance Program, funded by the Health Resources and Services Administration, NPA convened workgroups of rural health and PACE providers to further discuss these issues. The following issue brief on staffing is part of a series summarizing the workgroups’ discussions on each of the topics listed above. Collectively, the issue briefs are designed to help rural organizations identify and meet the challenges they will face in bringing the PACE model to their service areas.

Rural PACE Issue Brief #1: **Recruiting and Retaining Staff**

Overcoming workforce shortages remains one of the most daunting challenges for health care providers in the 21st Century—especially in rural areas. Acquiring and maintaining adequate staffing is crucial to the success of any rural health care provider, but none more than rural PACE programs, for which staffing challenges may be even more difficult.

Because PACE provides such a comprehensive range of care (everything from nursing, social work and physical therapy to prescription drugs, surgery and nursing home care), PACE programs require staff in virtually every field of health care. In addition, they must coordinate and manage that wide range of staff. Finally, rural PACE programs operate in areas that are typically underserved by health care professionals, and involve sparse populations, long distances, and a relative lack of infrastructure.

Fortunately, a number of strategies drawn from rural health care suggest how the PACE model might be adapted to meet these challenges.

Challenges and Strategies

Challenge 1: Recruiting and Retaining Qualified Staff

Like other health care providers, prospective PACE providers will likely find it difficult to obtain and retain skilled professionals in rural communities. Some may find it difficult to compete for staff with nearby urban providers. For example, a health care provider recruiting staff in rural Kentucky reports that in 2004 salaries for registered nurses in rural Leslie County ranged from \$65,000 to \$75,000, while in urban Louisville registered nurses earned only \$55,000 to \$60,000. Thus, rural health care providers may be forced to offer higher salaries than those offered in nearby metropolitan areas in order to attract qualified staff.

For other programs, distance may necessitate hiring multiple part-time people instead of a single full-time position to ensure timely service to participants in their homes. Doing so may make it difficult to attract qualified individuals looking for full-time work and benefits.

In addition, federal PACE regulations prescribe personnel qualifications for PACE staff, which may be difficult to obtain in a rural area (e.g., that a social worker have a Masters of Social Work degree).

Finally, the ongoing recruitment and training of new staff in rural areas is expensive. This administrative expense may not be accounted for in the methodologies used to establish capitated Medicare and Medicaid rates for PACE. Other expenses incurred by rural health care providers may not be reflected in the existing Medicare wage index, which is used in the calculation of other Medicare payment systems and generally reimburses rural providers at a lower rate than their metropolitan counterparts.

Strategy 1a: Provide grants and/or subsidies to informal caregivers. Due to a lack of health care personnel in rural areas (especially the broad range of personnel needed by a PACE program), rural PACE programs will likely rely on family members, neighbors, friends, church members, volunteers and senior centers to help deliver care. Indeed, participants and family members are considered important members of the interdisciplinary team in PACE. To help facilitate the involvement of these informal caregivers and offset their costs, some existing PACE programs provide them with subsidies or grants. Some states offer similar compensation to family and community caregivers. For example, the State of Colorado pays family caregivers \$400 per month to provide home health care. Similarly, the State of Wisconsin compensates family members and/or neighbors for providing direct care that is normally provided by a social worker.

Strategy 1b: Be flexible and innovative. Given the limited resources available in rural communities, prospective providers may need to contract for a wider range of PACE services than has historically occurred in metropolitan areas. Whether staffed directly or through contracts, flexibility will be important for PACE programs to serve rural communities. Section 460.102(f) previously required that the following interdisciplinary team members be employees of the PACE organization: primary care physician, registered nurse, social worker, recreational therapist or activity coordinator, PACE center manager, home care coordinator, and PACE center personal care attendants. However, with the passage of the October 1, 2002 interim federal regulation, the federal government no longer requires that the PACE organization directly employ the interdisciplinary team, the program director or the medical director.

While some states and PACE providers report that current federal regulations can make it difficult to contract for certain types of services, such as home care or adult day care, it is possible to file for a waiver to obtain more flexibility in these areas. For example, PACE Vermont is requesting waivers for the federal regulation requirement that members of the interdisciplinary team must serve primarily PACE participants and the requirement that the primary care physician must be an employee of the PACE organization. They plan to contract with other community health care providers to co-locate the PACE center with an existing successful adult day program to reduce facility costs and account for a small census. Rather than rely on a single physician, they plan to rely on a group practice, which they believe will give them the advantage of back-up, on call, and linkages with area hospitals that will ensure availability of physician expertise at all hours.

States also may want to ask the Centers for Medicare and Medicaid Services (CMS) to waive the Master's of Social Work or other similar requirements for staff or to include an equivalent but broader range of education and personnel qualifications required under 42 CRF § 460.64 to enlarge the pool of individuals who qualify for specific positions.

Strategy 1c: Dangle the big carrot. Rural health care providers are generally creative and quite generous when recruiting staff from other communities. For example, some

providers offer to make a down payment or pay closing costs on a home, help sell a home in the community the individual is leaving, absorb re-location expenses, or find employment for the spouses of new hires. In addition to flexible hours, adequate pay and educational opportunities, some existing PACE programs provide staff with company-owned vehicles to deliver home care. This practice not only helps offset the low salaries many of these workers receive, it also conveys respect for staff's personal property and helps ensure their safety while traveling for work.

Strategy 1d: Foster a new resource pool. Some rural health care providers create interest in nursing by educating students in junior high and high schools about the field, funding and recruiting students to participate in nursing summer camps and workshops, funding nursing education, and helping to repay employees' student loans.

Area Health Education Centers develop health careers recruitment programs in underserved rural areas. The centers also provide educational support and technical assistance to reduce professional isolation and increase retention.

Strategy 1e: Ensure Medicare and Medicaid rates adequately compensate rural providers. States and providers may want to explore with CMS opportunities to increase reimbursement rates to help rural PACE providers address recruitment and retention issues or help them compensate for the fact that they may require an increased number of staff to serve participants across larger distances. Some work may need to be done to improve the Medicare Wage Index Floor for rural areas to ensure providers can offer the salaries needed to draw staff from nearby metropolitan areas. Similarly, Medicaid rates should compensate rural providers for the recruitment, training and retention expenses that rural programs will incur on a continuing basis.

Strategy 1f: Cultivate community partnerships and share limited resources. Given the limited resource base of most rural areas, the lack of competition and the common challenges shared by all, partnerships often are more easily built in these communities. One way to overcome limited staffing resources in rural areas may be to share specialty or support staff with nearby PACE programs or other health care, transportation or social service providers. Such collaborations are common in community health centers and hospitals that share physicians in order to address liability issues. In addition, there may be opportunities for PACE providers to partner with universities or local colleges to utilize nursing, dental, social work, physical therapy or occupational therapy students with supervision.

Challenge 2: Coordinating an Interdisciplinary Team, Multiple Partners and Various Contractors in Various Locations

At least some members of a rural PACE program's interdisciplinary team are likely to be contracted rather than employed. Interdisciplinary team members may work in different areas or communities, especially in the event that a rural PACE program is designed with alternative care sites and/or home care. All of this can hinder coordination and communication among staff.

Strategy 2a: Use technology. Advanced information technologies enable many rural health care providers to deliver and coordinate care across long distances and can do the same for rural PACE programs. For example, video, computer or phone line teleconferencing can enable the interdisciplinary team, field staff and contracted staff to meet and coordinate care across miles. It also can help with oversight and monitoring.

Though such technologies are not available in every rural community, by being flexible and innovative, rural PACE programs can access and use them. Programs may need to seek out partners such as community colleges or other institutions outside the health care field in order to gain access to these technologies. (See *Challenges and Strategies for Rural PACE: Using Information Technologies.*)

Strategy 2b: Cross-train staff. Staff working in a rural PACE program may require more cross-training given the limited resources available and in order to ensure that those providing care in the field are sensitive and aware of symptoms or conditions that should be reported to other interdisciplinary team members and to limit the number of people intruding in a participant's home.

Challenge 3: Obtaining Access to Training

Training for staff can be difficult to obtain in rural areas. Few rural areas have training resources locally, and travel budgets and backup personnel to allow staff to attend training events elsewhere can be hard to come by for professional, paraprofessional and administrative staff.

Strategy 3a: Utilize existing PACE programs to train staff. PACE providers report that most training for PACE is conducted on the job, particularly with respect to the interdisciplinary team. Many existing PACE providers offer programs to train new staff on the interdisciplinary team. They also provide one-to-one training for PACE specialists. In addition, PACE providers often offer cultural and demographic education and training. Consequently, opportunities exist for new PACE providers in rural communities to partner with established PACE providers to meet their training needs.

Strategy 3b: Draw on community resources. Some rural hospitals, nursing homes and social service programs utilize lay people and volunteers to help offset staffing shortages. In many cases, these providers offer to others their training programs, which may not be as extensive as state-certified training, but do build the necessary skills for a lay person to perform a specific function and qualify that individual to work in a very limited capacity. In addition, other community resources such as economic development agencies, grade schools, community colleges and university programs offer various training opportunities. These training programs could be utilized and/or used as templates to develop in-house training programs for PACE providers.

Strategy 3c: Use technology. Advanced information technologies can give rural providers remote access to training programs held elsewhere—eliminating the need to have the training locally or travel to it.

Challenge 4: Overcoming Bias Against Outsiders

People are more likely to prefer health care providers who share their culture and are established in the community over those perceived as “outsiders.” Because rural PACE providers likely will need to draw upon staff from outside the local community, problems with trust may arise—especially with respect to home care, when providers come into a participant’s house.

Strategy 4a: Ensure staff is sensitive to the local, rural context. When staff from outside the community is used, the PACE program will need to build trust among the staff and participants by ensuring that the staff understands the local, rural context (including the cultural values and faith practices of tribal communities) and acts accordingly. This is especially important given all the staff likely to enter participants’ homes.

Staffing Resources

Several federal and state programs help increase and maintain the health care workforce in rural areas:

- The National Health Service Corps (NHSC) provides scholarships and loan repayment to physicians and other health professionals who agree to serve in rural and urban underserved areas. The NHSC State Loan Repayment program provides funds to the states for their own loan repayment programs (<http://nhsc.bhpr.hrsa.gov>).
- Area Health Education Centers extend the resources of academic health centers into rural areas by recruiting students to health care careers and providing clinical training opportunities to health professionals and nursing students (www.aamc.org/advocacy/hpniec).
- The Quentin Burdick Rural Interdisciplinary Training Program provides grants to improve access to health care services in rural areas by increasing the recruitment and retention of health professionals in these areas. The program funds projects to develop new and innovative methods to train health care practitioners to provide services in rural areas (www.aamc.org/advocacy/hpniec).
- The Nurse Reinvestment Act of 2002 establishes scholarships in exchange for commitment to serve in a public or private non-profit health facility determined to have a critical shortage of nurses. It assists health care facilities in retaining nurses and improving patient care through increased collaboration among nurses and other health care professionals, and by increasing the involvement of nurses in the

decision-making process. The Act provides for programs to train and educate individuals in providing geriatric care for the elderly and establishes partnerships between health care providers and schools of nursing for advanced training. It also helps nurses obtain more education (<http://bhpr.hrsa.gov/nursing/reinvestmentact.htm>).

Conclusion

While rural PACE programs face many challenges, many strategies are available to help them overcome those challenges. Using the strategies described above, along with others, rural PACE programs can acquire and maintain the staffing needed to succeed.