



Rural PACE Assessment Instrument Case Study: Sun and Snow Health Centers

This case study presents a completed Rural PACE Assessment Instrument for a fictional rural health organization - Sun and Snow Health Centers. The assessment describes and analyzes the factors that would shape this organization's efforts to develop PACE. At the end of the assessment, a self-rating section summarizes the organization's perceived strengths and weaknesses relative to developing PACE.

The assessment is completed for each of the following sections:

Section 1: Proposed Rural PACE Program and Service Area Description

This section describes the sponsoring organization, its community, proposed service area and proposed service population.

Section 2: Critical Factors

This section provides for detailed assessment of four critical factors, to be considered in sequence, affecting the development of a new PACE program:

- Critical Factor 1: Service Area's Potential Demand for Services
- Critical Factor 2: Community Relationships and Existing Services
- Critical Factor 3: State Environment
- Critical Factor 4: Organizational Capacity and Commitment

Section 3: Self-Rating

This section contains self-rating scales for each of the critical factors and the key areas within each factor.

Responses to the instrument's questions are in **bold** or in a response .

Section 1

Proposed Rural PACE Program and Service Area Description

General Information

- A. In one or two paragraphs, describe your organization, the services it provides, clients it serves and the project team that will be responsible for assessing the potential for rural PACE.

Sun and Snow Health Centers (SSHC) provides a range of health and aging services across 8 counties. Located in Lakedale, a town with a population of approximately 18,000 people, SSHC services extend into our neighboring areas, which are very rural. Our services include transportation, congregate meals, adult day care, case management and hospice care (entirely in the home, no inpatient). Our clients are the elderly in the community, across a range of health care and social service needs. The average age of an SSHC client is 58.

To develop a PACE program we have assembled a team consisting of our transportation coordinator, a representative of one of our congregate meal settings, the center director of our adult day care program, a nurse case manager and a home care nurse in our hospice program. This team brings extensive clinical and management experience to the project.

- B. Why does your organization want to develop a PACE program?

We want to do PACE because we see too many of our elderly clients suffer preventable declines associated with chronic illness and as a result reaching a point where their only alternative is a nursing home. Additionally, we have seen declining lengths of stay in our hospice program and believe PACE could help us continue to serve a broader segment of the community.

- C. In one or two paragraphs, describe your community. Specifically, address how where you provide service affects how you provide services.

Our community is located in an area that is mostly flat with some nearby mountain foothills. Many of the people we serve live alone and remotely. We have severe weather which is very hot in the summer and very cold, including significant snows of multiple feet on a regular basis, in the winter. The community was founded around the farming economy in the area. Presently, farming continues to be a large employer though it is rapidly shrinking. Our population is aging as younger people move to larger cities to seek employment. Recently the development of a high-tech call center in Lakedale has brought some jobs to the area. The remoteness of homes in our area and the weather conditions likely will make transportation to and from Lakedale a problem at times in the year. Our community has a long tradition of innovative health care solutions, founding the first rural hospice program in the state. We have partnered with a small assisted living residence in town to provide case management services.

Proposed Service Area Description

Summarize your service area in terms of its:

- A. State(s) **Mitexerado**
- B. Counties **Dorito, Potato, Cheetoh, Rind, Slim, Cola, Lemon, Pepper and Dew**
- C. Zip Codes **90001, 90002, 90003, 90004, 90005, 90006, 90007, 90008, 90009, 90010**
- D. Geographic Size
 - 1. Greatest distance from end to end **160 miles**
 - 2. Radius from proposed service area to center **60 miles**
- E. Road System and Impact on Transportation

Major state highways paved, multiple small towns with paved roads; mountain roads and home drive-ways often not paved

- F. Driving Times from Key Service Areas (e.g., hospital, potential service delivery sites)

From nearest hospital to service area border - 60 miles; from rural hospitals (2) in service area to part of service area they are in - 20 miles maximum and 15 miles maximum. We have 11 congregate meal centers across the service area. Everyone in the service area is within a 15 - minute drive to one of these centers.

- G. Topography Factors (mountains, rivers, etc.)

Mountains border our service area, limiting our ability to expand the area any further west. The Rainy River dissects the northwestern third of the service area. It is passable at two different bridge points.

- H. Seasonal Factors (e.g., snow, heat) **see above, Organizational Description**

- I. Population Centers - General

Lakedale is the largest town in the service area with a population of approximately 18,000 people. Other population centers include West Lakedale with a population of 2,200 and Sycamore, with a population of 2,000. The remaining population in our service area equals 13,800, disbursed evenly, with the exception of the area northwest of the river, which is more sparsely populated.

- J. Population Centers - Elderly Persons

In addition to Lakedale and the two towns, an order of retired Franciscan brothers lives 10 miles southwest of the city. There are 78 brothers currently living there and all are over the age of 70.

Note: Consider developing and attaching a map of the proposed service area with key location of health and human services providers, transportation routes, and transportation times identified. **Please see attached map.**

Rurality of Service Area

For your proposed service area:

A. What is the USDA rural-urban continuum code?

For Lakedale, the code is "7 - Urban population of 2,500 - 19,999, not adjacent to a metro area."
Beyond Lakedale, the two towns are "8 = completely rural or less than 2,500 urban population, adjacent to a metro (Lakedale in this case) area." The remainder of the service area is 9, or the most rural.

B. What is the USDA urban influences code?

We are an 8 - Micropolitan not adjacent to a metro area.

C. What is the USDA rural-urban commuting code?

5 - large town, high commuting

Service Area Disease Prevalence

In order to estimate the value of the PACE program to the service area, and begin planning for composition of the PACE program, it is helpful to identify the most prevalent disease in the proposed service area. Effective approaches to manage these diseases might inform the potential PACE sponsor about issues such as risk management, staffing patterns and contracts with other providers. It also might be helpful to be aware of diseases associated with special state or federal reimbursement opportunities, like black lung disease in certain coal mining areas. These considerations may be particularly important in ensuring an appropriate rate is set for PACE in the service area.

A. What are the most prevalent diseases in your service area?

Diabetes and congestive heart failure. Obesity is a significant issue for our population.

B. Are there diseases in your area associated with special state or federal reimbursement programs (e.g., black lung)? **No**

Additional Populations

As providers in a service area consider developing the necessary infrastructure to support a PACE program, their capacity to provide care and services to other underserved populations also may be expanded.

While PACE programs are limited to those aged 55 and older who need a nursing home level of care, organizations sponsoring a PACE program may wish to build on the expertise required for PACE to serve new populations and offer new services.

For example, an organization developing a PACE program may be able to integrate services for the younger disabled population, children with special health care needs, people with AIDS, or the chronically ill who require care management services. While these services would not be reimbursed as PACE services, they may help to spread some of the fixed costs associated with a PACE program and generate some economies of scale.

- A. Does the proposed PACE program's development call for the development of related services as part of its start-up?

We are interested eventually in serving the young disabled population with a model built around PACE. This would help offset some of the fixed costs of the PACE program.

- B. Would the organization seek to build on an operational PACE program in order to offer related services to an expanded population?

Yes, see above.

Section 2

Critical Factors

This section presents the critical factors that will shape a prospective PACE program's likelihood of success.

Critical Factor 1: Service Area's Potential Demand for Services

To estimate a service area's potential demand for services, the instrument looks at the number of people aged 65 and older, their clinical status and income status. Attachment A presents a detailed approach to assessing potential demand for services using Bureau of the Census data for the population in the rural PACE program's planned service area. This approach is described below. Additional state and local data sources also may be useful in estimating demand. Some examples of these sources are identified in the last section.

Key Area: Demographic Need

The demographic needs assessment used year 2000 Bureau of the Census data to estimate the potential population a PACE program could serve. This assessment uses the following factors:

- Aged 65 and older: While eligibility for PACE services begins at age 55, the available Bureau of the Census data is grouped for those aged 65 and older. In this sense the estimate of the potential population a PACE program would serve is conservative, since it does not include those aged 55-64 that could be served. Based on current PACE program experience, the substantial majority of PACE enrollees are over the age of 65, with an average age at enrollment of 80.
- Clinical Status: PACE enrollees must meet their state's clinical criteria for needing a nursing home level of care. To approximate state criteria, the instrument looks at the population's level of disability using three measures, ranging from least to most conservative:
 - o Inability to go outside the home;
 - o Self-care; and
 - o Disability in two or more activities of daily living, one of which is self-care.
- Income: Currently 9 in 10 PACE enrollees are financially eligible to receive Medicaid. While Medicaid financial eligibility consists of income and asset level tests, the instrument looks at income only. Each state's income level for Medicaid eligibility may be different. Most states set the level equal to 300% of Social Security Income. Others specify income levels based on unique formulations. It is not necessary to be financially eligible for Medicaid to enroll in PACE. The instrument presents the number of people both with and without Medicaid financial eligibility that might seek to use PACE services.

To assist a prospective rural PACE program in considering the results of the demographic assessment, two additional sections present the estimated number of potential PACE participants in terms of:

- The market penetration rate needed to achieve a specified range of enrollment levels; and
- The estimated enrollment that would be achieved based on a specified range of market penetration rates.

1. What does the demographic needs assessment identify as the potential population that could be served by PACE in your service area based on age and clinical condition?

Range of 2,534 - 3,226 people.

2. What is the potential population that could be served by PACE based on age, clinical condition and income level that would indicate Medicaid eligibility?

Range of 912 - 1,161 people.

Supplemental Data Sources

Some potential additional sources of information might be available that can help an organization understand its market. These include:

- State projection of population growth. What projections does the state's eligibility agency use?
- Local health care councils (looks at health care service patterns in primary service areas - PSAs).
- State information on mentally retarded/developmentally disabled (MRDD) population 55-64 years old.

Critical Factor 2: Community Relationships and Existing Services

The development of a PACE program requires an understanding of existing community relationships and services. This understanding lays the foundation for adequate referral networks that will help the program build, census, contracted services to meet PACE participant needs, and public support for the program. Assessing community relationships and existing services is an opportunity to gather information about the resources in the proposed service area that may be used to implement a PACE program. In addition, the assessment is an opportunity to educate other stakeholders and/or referral sources in the service area about the PACE model so that they can be potential partners.

A. Key Area: Access To Long Term Care Services

1. How do people currently access long term care services (i.e., nursing home, home and community based services, adult day care or home care)?

The local Area Agency for Aging provides referral information. The AAA also determines clinical eligibility for a nursing home level of care. Because we are well known to the community, we also provide information and support services regarding accessing long term care.

2. Describe your community's referral processes.

See above. We also do presentations at our congregate meals on how to access care.

3. What is the process for Medicaid clinical eligibility determination? **See above.**

4. What is the process for Medicaid financial eligibility determination?

The AAA refers the determination to the state Medicaid agency for a determination of financial eligibility.

5. Describe the relationship of the proposed internal and external referral sources to the proposed PACE sponsor.

Referral Source	Relationship to Sponsor	Expected Impact on Enrollment
AAA	Community Organization	Services are scarce and we have a good relationship with the AAA. They also offer home care which may lead to a reluctance to refer to PACE.
Medicaid Financing Eligibility Office	We have a good relationship with the office.	Positive
Internal Hospice	Part of our organization	May refer those not eligible for hospice to PACE; need to coordinate when a PACE participant requires end of life and palliative care.
Internal Case Management	Part of our organization	Will alert potential enrollee in declining health status of the PACE option.

6. How will these relationships impact enrollment in PACE?

See above; generally a favorable enrollment impact.

7. Does your state have a single-entry point for determining clinical and financial eligibility for state-funded services?

No, other than by county. In each county, the clinical eligibility determination is done by one AAA for that county.

8. If yes, does the single-entry point also provide direct services?

N/A; AAA does provide home care directly.

B. Key Area: Existing Partnerships

Contractual relationships and other partnerships between providers in the community should be noted and understood. They can provide a foundation for possible partnerships and contractual relationships that may be necessary to provide the broad range of care and services required under PACE. It also is helpful to note what organizations have not worked together in the past or may view each other as potential competitors.

1. Describe any strategic alliances or partnerships between health care, housing or aging service providers in your area.

The largest hospital in Lakedale also operates one of the two rural hospitals (the one in Sycamore). We have partnered with an assisted living provider in Lakedale to do case management. The AAA owns and operates a home health agency serving the area we serve.

2. Describe any organizations that are not willing to work with other organizations.

The in-town adult day care center operated by another provider at one point worked with a local transportation contractor (ReadyWheels). After numerous conflicts, they dropped the transportation provider and now require center attendees to arrange for their own transportation.

C. Key Area: Existing Staffing

1. Nurse Aide Staffing

For PACE, as with many forms of long term care, an adequate number of nurse aides is key to providing effective care.

- a. Do other health care providers in the proposed service area have difficulty or success in attracting and retaining nurse aide staff? **Yes, all (hospital, home health, etc.)**
- b. Are other employment competitors present in the proposed service area that may affect nurse aide recruitment?

Generally no. Local fast food restaurants can pay close to a nurse aide wage and we do lose some potential employees to them. The new call center is starting to pull in some entry level people.

- c. Are there numbers of recently unemployed persons who might be interested in becoming trained as nurse aides?

For the most part, people leave for the city when they need a job, or before they lose a job.

2. Nurse Staffing

Recruiting nursing staff members is essential to providing home care, PACE center services, clinical assessment and care planning in the PACE model.

- a. Do other health care providers in the proposed service area have difficulty or success in attracting and retaining nursing staff?

Most have difficulty. The rural hospital in Sycamore received a grant to offer nurses financial assistance with a down payment on their house. This has helped them recruit.

- b. Are other employment competitors present in the proposed service area that may affect nursing recruitment?

Generally no; nurse pay is higher than most local competitors, with the exception of some management staff at the call center.

3. Primary Care, Geriatrics and Specialists

Physician relationships will affect the program in terms of the role physicians play as a referral source and the relationship of the physicians to the PACE program's interdisciplinary team.

- a. Will the PACE program have its own primary care physician or does it plan to incorporate community physicians (which will require a CMS waiver) into the program?

Initially, we would like to share our hospice physician with the PACE program. As our census builds, we will hire a full-time physician.

- b. Which physicians in the proposed service area currently are providing care for Medicare and Medicaid patients? (Note: These physicians might be the most willing to participate with PACE. They also may be the most resistant to PACE if they will no longer be able to be paid for treating their existing Medicare and Medicaid patients.)

All physicians, with the exception of one specialist practice in Lakedale, serve Medicare and Medicaid clients.

- c. Which primary care providers, particularly if community physicians are going to play a large role in the delivery of PACE services, will be looked to for expertise in geriatrics?

Dr. Goodheart (with our hospice) program has significant geriatrics expertise. We will look to her.

4. Informal Caregiving

One key to the success of the PACE model of care is the extent that it can support family and other informal caregivers to provide care and services in the community. It is important to understand, to the extent possible, the amount of informal caregiving that is present in the community. The Alzheimer's Association, home health agencies and hospitals, as well as a state's department of human services, area agencies on aging or office of adult services, may be able to help quantify to what extent informal caregiving is taking place in the proposed service area.

- a. To whom would the area agency on aging refer an interested family member for more information?

Themselves, us or the nursing home if the person is in an emergency.

- b. Does the state allow programs that pay family members as caregivers? (This could be both a possible source of caregiving staff and potential competition for potential PACE enrollees.)

Yes, our state has a systems change grant for paying family caregivers. This so far has been tried primarily in other areas of the state, mostly for people with disabilities.

D. Key Area: Telemedicine/Technology

Telemedicine and new technologies increasingly are being utilized in rural areas to overcome some of the challenges associated with greater distances and the common shortage of health care professionals. Telemedicine can be used for expert consultation, to enhance delivery in clinic settings, and deliver care and services in the home.

Some examples of the successful use of telemedicine include: reading X-rays, radiology, ultrasounds, telepharmacy (when the pharmacist is away), speech therapy, wound care, dermatology, psychology, diabetes monitoring, chronic disease management, case management, case team coordination, continuing education of health care staff, and potential administrative functions such as billing and coding. For more information, refer to NPA's "Technology in Rural PACE" issue brief.

1. What telemedicine/technology programs exist or could be developed in your service area?

We have done some teleconferencing for our hospice team meetings and our electronic medical record can be viewed by team members while out in the field.

2. Can specialist care be provided using existing telemedicine/technology programs to offset shortages of these providers in your service area?

We have not provided direct care using technology.

E. Key Area: Related Long Term Care Services

Existing health care and aging services providers should be identified in the proposed service area.

1. Publicly Funded Long Term Care Services: What long term care services that are publicly funded (i.e., Medicaid or state-only funded) are available to serve your target population?

- a. adult day care - **yes**
- b. home care - **yes**
- c. case management - **yes, just us**
- d. personal care - **some paid caregivers, not much**
- e. assisted living - **yes, in town and one in surrounding area**
- f. consumer-directed care - **consumers can choose who to get care from in the paid caregiver program**
- g. home and community based waivers (see #3 below) - **yes**
- h. skilled nursing facility - **yes**
- i. meals assistance - **yes, from us primarily**
- j. transportation - **emergency transportation only**
- k. other - **yes, small board and care home for six people**

2. Home and Community Based Programs: Using Attachment B, list the home and community-based waiver programs in your proposed service area. Please describe these programs.

We have a home and community-based waiver for home care in our area. Nursing home certifiable individuals are eligible for the program.

3. Home and Community-Based Long Term Care Providers: Using Attachment C, list the home and community-based long term care providers in your proposed service area. Please describe these providers.

In addition to our own home care services, the AAA operates home care in our service area.

4. Nursing Facilities: Describe the nursing facilities that serve your market.

Provider Name	# of beds	Enrollment/ Occupancy	Waiting List?	Cost	Comment (re: quality, reputation, potential for partnership)
Happy Home	120	100	No	Medicaid= \$51,000/ year	Oldest in area; well regarded by people in town
Merry Manor	80	70	No	Medicaid= \$51,000/ year	Serves northwest area; unknown quality/ reputation
Elder Care Home	100	88	No	Medicaid= \$51,000/ year	Don't know

5. Assisted Living: Describe the assisted living facilities that serve your market.

Provider Name	# of beds	Enrollment/ Occupancy	Waiting List?	Cost	Comment (re: quality, reputation, potential for partnership)
Happy People Assisted Living	60	60	Yes	\$38,000	Still in the community (i.e., not in town) and viewed as more inde- pendent than the nursing homes
Just Like Home	100	65	No	\$45,000	We do case management for them; good reputa- tion, though some feel it is expensive. Located in Lakedale.

6. Housing: Describe the low income and affordable housing providers in your service area. What proportion of the residents is elderly? Are supportive services offered on site (specify what services)?

Provider Type	Capacity - Number of Housing Units	Proportion of Residents that are elderly - estimated	Services Provided	Comment
Senior Housing	100	All	Some chore services	
Low Income Housing	250	35%	None	

7. Primary, Acute and Specialist Care: Describe the primary, acute and specialist care providers in your service area, including any rural hospitals, federally qualified health centers or physician groups/practices that will be important to consider.

Provider Type	Services Provided	Comment
Primary Care Group Practice	Primary Care	Oldest and largest in town. Has an affiliated office in West Lakedale that serves the town and neighboring rural residents.
Dorito County Rural Hospital	Acute Care	Serves Dorito County in upper northwest section of our service area.
Lakedale Hospital	Acute Care	In town hospital
Sycamore Hospital	Acute Care	Serves southeast part of our service area; affiliated with Lakedale Hospital.
Healthy Heart Specialist Practice	Specialty Care	Specialists in caring for CHF, heart disease.
My Dialysis and Diabetes Center	Outpatient Dialysis	Provides outpatient dialysis services for ESRD patients; some diabetes management and counseling services as well.

Critical Factor 3: State Environment

The PACE provider agreement that allows providers to enroll participants and receive PACE capitated payments is a three-way agreement between the state, the provider and the Centers for Medicare and Medicaid Services (CMS). It is important that providers work with their states to ensure, to the greatest extent possible, that they are ready to support a PACE program. (NPA recently has developed many technical assistance resources to aid states.)

A. Key Area: State Long Term Care Programs

1. What is your sense of your state's commitment to home and community-based services relative to institutional care?

The state has indicated support for nursing home alternatives, with some concerns about the economic impact in small towns of a failing nursing home if use falls too low.

2. How is PACE consistent or inconsistent with the state's long term care goals?

The state's 2004 strategic plan calls for "a health care system that provides good choices and maximizes independence for all, regardless of location or disability." The strategic plan specifically identifies PACE as a "strategy of merit" for exploring.

3. Does the state have existing innovative programs that serve older persons with chronic care needs?

Not at present. The new head of our Department of Health came from Arcaflinia, a state that has pursued numerous innovative long term care programs. He has been in office for only six months.

4. Does the state currently have a PACE program or one under development elsewhere? **No**

5. Has the state ever explored PACE before? If so, with what result and why?

Once, about 10 years ago when the PACE demonstration was occurring. The AAA executive director at that time visited On Lok. Instead of PACE, they developed their home health service and the idea did not come back up.

6. What state agencies might need to be involved with supporting PACE (e.g., health, licensing, Medicaid, budget, aging, insurance, housing, governor's office staff).

Our Medicaid agency is taking the lead in discussions with us. We also would like to involve the Department on Aging in our initial discussions, and pull in other agencies once we get further along.

B. Key Area: State Financing

1. Does the state view money spent on PACE enrollees as a shift from another expenditure it otherwise would have to make or as new money it has to find? Do different departments view this question differently?

New money, because there is an assumption that the state will need to continue to support the fixed costs of nursing homes due to need and economic value in their community.

2. Does the state have resources it is ready to commit to funding new PACE services?

The state has set aside in its most recent budget funding to expand community-based alternatives to institutional care for people with disabilities, including the aged. The funding is capped at \$4 million in the first year. The funding can be used by the state to support start-up or services.

C. Key Area: Medicaid Eligibility

1. What state agency determines eligibility? Is it supportive?

AAAs determine clinical eligibility, with some review by Medicaid. Medicaid determines financial eligibility. They have been supportive of our programs in the past. They do not know much about PACE.

2. What are the state's requirements related to financial eligibility/clinical eligibility? Are one of these areas particularly stringent compared with other states?

We are a 300% SSI financial eligibility state. Our clinical eligibility is determined using our state's standardized assessment instrument. Clinical eligibility requirements are consistent with most other states.

3. Will PACE be an easy fit (from the state's perspective) with other programs requiring eligibility determination?

Yes, in the sense that the state already has a home and community-based waiver that has similar eligibility requirements.

4. How long does eligibility determination usually take?

Once the clinical assessment instrument is completed, clinical eligibility determination is immediate, based on the criteria established. The Medicaid agency receives the assessment from the designated AAA and confirms the determination within one week. Financial eligibility determination can take much longer, in some cases up to 3 months. Many people in our area have significant assets in their home/farm and property that they are reluctant to give up.

Critical Factor 4: Organizational Capacity and Commitment

How will your organization sustain the overall development of a PACE program? Who will lead this effort? Will a team be created to support planning and development of the program? From where will you recruit members of your team? With what services offered through PACE or care management strategies used by PACE does your organization have experience? Beyond service delivery and care management, consider what administrative and financial infrastructure will need to be developed.

A. Project Resources and Related Experience

1. Key Area: Leadership and Key Staff

- a. Who is the contact person for the PACE project? **Pat Dunkin**
- b. Is there a potential clinical leader (i.e., either nurse or physician) who can provide support for the program? Who is this? What is his/her background and interest in rural PACE?

Dr. Goodheart, and the nurse from our case management program provide clinical leadership.

- c. In exploring the development of a PACE program, who has agreed to serve on the leadership team? Where will the team be within your organizational structure?

Our team is: Pat Dunkin - Director, Home Care Services; Dr. Goodheart - Hospice Medical Director; Tom Tulane - Clinical Director for our care management program; Rita Roobeck - Transportation Coordinator; Don Berger - Director of Marketing; Cindy Loohee - Cheetoh Congregate Meal Center Coordinator; and Dora Flores - Center Director, Sun and Snow Adult Day Care.

- d. To what extent is your organization's chief financial officer aware of and supportive of PACE?

We have shared the PACE information available on the web site and our completed assessment with her.

- e. What experience and background will team members contribute to the team's effectiveness in developing a prospective PACE organization?

See above - team description; Additionally, Tom previously worked at the PACE program in Chatanooga, TN.

Note: In large organizations, PACE programs succeed when placed in a strong relationship with key administrative staff within the organization. Having direct links to key decision makers within the organization strengthens the program's ability to respond quickly to issues that occur during start-up phases of program development.

2. Key Area: Experience

In which of the following does the proposed organization, including all partners, have experience?

- a. direct provision of acute care - **no**
- b. direct provision of long term care - **no**
- c. transportation - **yes**
- d. providing community-based care (specify: **home care**)
- e. senior housing - **no**
- f. serving dual-eligible, frail population - **yes**
- g. use of interdisciplinary teams - **yes (hospice)**
- h. managing risk (specify: **hospice**)
- i. developing service networks - **no**
- j. medical care - **yes**
- k. adult day care - **yes**
- l. home care - **yes**
- m. telemedicine - **no**
- n. care management - **yes**
- o. other (specify: _____)

3. Key Area: Resources and Timelines

- a. Can the organization devote resources sufficient to develop a plan for the implementation of a PACE program?

We have a foundation with resources of \$200,000 and in the past we have been successful in fundraising to start up new services. We raised over \$400,000 to initiate our hospice program.

- b. What considerations regarding the sustainability of the program have you identified?

Adequate enrollment; state funding.

- c. What potential sources of capital and start-up funding are available (e.g., foundations, state funds)? How will these be accessed?

The local foundation of the Tom's Turkey Company provides grants to local health and environmental organizations. We have received grants from them in the past. We also are looking at USDA grant programs and economic development opportunities.

B. Organizational Support

1. Key Area: Priorities and Mission

- a. What is the organization's mission?

Our mission is "to serve elders well by keeping them well.

- b. How does the organization's mission relate to your community's goals and priorities?

Our community is an aging community and our mission reflects that.

- c. What other organizational priorities currently are being evaluated?

There is some interest in expanding our hospice program to include inpatient hospice services.

2. Key Area: Strategic Fit

- a. Has the organization considered how PACE fits into its strategic long range plan? If yes, describe the strategic plan as it relates to PACE.

Our strategic plan calls for us to integrate the services we offer. We have tried to do this with our current services; however, funding requirements for each different program can make this difficult. PACE offers us the opportunity to more fully integrate our services.

- b. Is the organization interested in providing a full range of integrated services or is its focus on specializing in a particular health service/setting?

We are interested in being a comprehensive, integrated service for elders.

Section 3 Self-Rating

Rate your organization's strength with regard to each of the key areas on a scale of one to five, with five being the most favorable. In addition, rate the completeness of the information for each key area, with five being the most complete.

	Strength	Completeness
CF1, A Demographic Need	1 2 <u>3</u> 4 5	1 2 3 <u>4</u> 5
CF2, A Access to LTC Services	1 2 3 <u>4</u> 5	1 2 3 4 <u>5</u>
CF2, B Existing Partnerships	1 2 <u>3</u> 4 5	1 2 <u>3</u> 4 5
CF2, C Existing Staffing	1 2 3 <u>4</u> 5	1 <u>2</u> 3 4 5
CF2, D Telemedicine/Technology	1 <u>2</u> 3 4 5	1 <u>2</u> 3 4 5
CF2, E Related LTC Services	1 <u>2</u> 3 4 5	1 2 3 <u>4</u> 5
CF3, A State LTC Programs	1 <u>2</u> 3 4 5	1 2 <u>3</u> 4 5
CF3, B State Financing	1 2 3 <u>4</u> 5	1 2 <u>3</u> 4 5
CF3, C Medicaid Eligibility	1 2 3 <u>4</u> 5	1 2 3 4 <u>5</u>
CF4, A. 1 Leadership and Key Staff	1 2 3 4 <u>5</u>	1 2 3 4 <u>5</u>
CF4, A. 2 Experience	1 2 3 <u>4</u> 5	1 2 3 4 <u>5</u>
CF4, A. 3 Resources and Timeline	1 2 3 <u>4</u> 5	1 2 <u>3</u> 4 5
CF4, B. 1 Priorities and Mission	1 2 3 4 <u>5</u>	1 2 3 <u>4</u> 5
CF4, B. 2 Strategic Fit	1 2 3 4 <u>5</u>	1 2 3 4 <u>5</u>

Total Score (maximum of 70 possible) ___ 51 ___

___ 53 ___

Highest Scoring Key Area(s) for Strength:

1. **Leadership**
2. **Priorities and Mission**
3. **Strategic Fit**

Lowest Scoring Key Area(s) for Strength:

1. **Telemedicine/Technology**
2. **Related LTC programs**
3. **State LTC programs**

Areas Requiring More Information Before Proceeding:

1. **Staffing**
2. **Telemedicine**
3. **State support/funding**

Section 4

Next Steps

- A. Discuss the results of the self-assessment with your PACE development team.
- B. Contact the National PACE Association (at ruralpace@npaonline.org or 703/535-1517).

Attachment A: Potential PACE Population Estimate

The following section presents a detailed explanation of the sources used from the Senior Life Report in the calculation of the factors and the final estimate. Apply these calculations to the Estimated Market of Potential PACE Participants Summary Demographic Report to generate the answers for Critical Factor 1: Service Area's Potential Demand for Services, Key Area: Demographic Need.

1. Total Population, 2003 (estimated from 2000)
This number comes directly from the Senior Life Report under the "Population by Age" section, in the "Total Population" row. It includes all ages.
2. Total Population 65+
This number comes directly from the Senior Life Report under the "Population by Age" section, "Total Population" category in the "Age 65 and over" row.
3. Total Population 75+
This number is a sum of the age categories Age 75 and older (75 to 79, 80 to 84, 85+) under the "Population by Age" section, "Total Population" category.
4. Total Civilian Noninstitutionalized Persons 65+
This number is the sum of Males and Females Age 65 and older (65 to 74, 75+) under the "Mobility and Disability Civilian Noninstitutionalized Persons Age 16 and over" section, "Disability by Sex and Age" category, "Male" row and "Female" row.
5. Total Civilian Noninstitutionalized Persons 65+ with a disability or combination of disabilities (Self-Care Disability and Go-Outside-Home Disability)
These numbers come directly from the Senior Life Report under the "Mobility and Disability Civilian Noninstitutionalized Persons Age 16 and over" section, "Total Disability" category.
6. % of Civilian Noninstitutionalized Persons 65+ with a disability or combination of disabilities indicating clinical eligibility for PACE
These numbers are the product of the number of total civilian noninstitutionalized persons 65+ with a disability (#5) divided by total civilian noninstitutionalized persons 65+ (#4).
7. Estimated population 65+ that would be clinically eligible for PACE
This applies the disability rates calculated for the noninstitutionalized population aged 65+ to the total number of people 65+, both institutionalized and noninstitutionalized, from number 2 above.
8. Total 65+ Households, 2003 (estimated from 2000)
This number is a sum of the total householders for each of the categories "Householder Age 65-74" and "Householder Age 75 and over" under the "Household Income by Age of Householder" section.
9. 65+ Households with income < \$20,000
This number is a sum of the age categories Householder Age 65 and older that are less than or equal to an income of \$18,000. This can be done simply for each age category less than \$15,000. For the other income range of \$15,000 - \$24,999, 50% of the number of households is used as an estimate of the number of households with an income between \$15,000 and \$20,000. This is done because we are estimating the number of those households that fall within the Medicaid financial eligibility limit and \$20,000 is approximately one-half of the way between \$15,000 and \$24,999 for income.

10. % of 65+ Households with income < \$20,000
This number is the product of the number of 65+ households with income less than \$20,000 (#9) divided by the total 65+ households (#8).
11. Estimated population 65+ that would be financially eligible for Medicaid coverage of PACE (those w/ income <\$20,000)
This number is the product of % of 65+ households with income less than \$20,000 (#10) multiplied by the total population 65+ (#2).
12. Estimated clinically eligible population for whom Medicaid would pay for PACE
This number is the product of the estimated population 65+ with income less than \$20,000 (#11) multiplied by the percentage of people aged 65 and older who would be clinically eligible for PACE (#6).

Estimated Market of Potential PACE Participants

POPULATION			
1. Total Population, 2003 (estimated from 2000)	36,000		
2. Total Population, 65+	11,520		
3. Total Population, 75+	8,640		
CLINICALLY ELIGIBLE POPULATION			
4. Total Civilian Noninstitutionalized Persons 65+	7,158		
	Self-Care Disability	Go-Outside-Home Disability	2+ ADLs (one of which is self-care)
5. Total Civilian Noninstitutionalized Persons 65+ with a disability indicating clinical eligibility for PACE	2,004	1,718	1,575
6. % of Civilian Noninstitutionalized Persons 65+ with a disability indicating clinical eligibility for PACE	28%	24%	22%
7. Estimated population 65+ that would be clinically eligible for	3,226	2,765	2,534
CLINICALLY AND MEDICAID ELIGIBLE POPULATION			
8. Total 65+ Households, 2003 (estimated from 2000)	16,857		
9. 65+ Households with income < \$20,000	2,529		
10. % of 65+ Households with income < \$20,000	36%		
11. Estimated population 65+ that would be financially eligible for Medicaid coverage of PACE (those w/ income < \$20,000)	4,147		
	Self-Care Disability	Go-Outside-Home Disability	2+ ADLs (one of which is self-care)
12. Estimated clinically eligible population 65+ for whom Medicaid would pay for PACE	1,161	995	912
MARKET PENETRATION MEASURES			
If you set a PACE Participant enrollment target of:	You would need an estimated market penetration rate of:		
100	9%	10%	11%
150	13%	15%	16%
200	17%	20%	22%
If the Assumed Estimated Market Penetration Rate is:	The expected PACE participant enrollment would be:		
5%	58	50	46
10%	116	100	91
15%	174	149	137

Attachment B: Home and Community-Based Waiver Programs in Your Service Area

Program Name	Target Population	Services Provided	Financial Eligibility	Limits on Number of People the Program Serves	Waiting List for Program - If yes, how many people?
Home Care Options	Nursing home certifiable population	Skilled home care	300% SSI	Yes - currently set at 1000	Yes - approximately 120

Attachment C: Home and Community-Based Long Term Care Providers

Provider Type/Name	Range of Services Provided	Quality and Reputation	Referral Potential	Rural PACE Partner Potential
Adult Day Care				
Lakedale Adult Care	Adult day care; some meals	Good, expensive	Possibly; if the person would otherwise enter the nursing home	They serve the west side of town and we serve the east side. Might reduce travel time to use them as an alternative care site.
Personal Care				
None				
Home Care				
AAA	Home care, skilled	Good	Possibly, if Medicare home care benefit is exhausted and person requires care in order not to enter a nursing home	Yes - their home care services are more extensive in the surrounding rural areas; also, as the clinical eligibility determination organization they can affect enrollment
Hospice				
None				
Other				
None				