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PACE*partners*

National Rural PACE Best Practices Report

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Introduction

In 2008, On Lok PACE*partners* developed and conducted leadership training to support the first PACE organizations operating in rural America. Out of this training a key finding emerged identifying marketing and enrollment as an important area for further examination and strategic focus. In 2009, a follow-up survey by On Lok PACE*partners* was conducted in conjunction with a SCAN Foundation-supported effort to stimulate the development of PACE in rural California. The survey found that marketing and enrollment continued to be a major area of interest. In March 2010, On Lok PACE*partners* revisited this issue with the intent of collecting and sharing best practices across rural sites, toward bolstering the success of rural PACE marketing strategies and results across the country.

For the 2010 National Rural PACE Best Marketing Practice Survey, On Lok PACE*partners* interviewed staff from 15 rural PACE organizations in March and April 2010. The goal was to identify trends and best marketing practices in rural PACE and disseminate valuable information and insights toward improving strategies and results. The rural PACE organizations participating in the survey listed in alphabetical order by program name, are Appalachian Agency (VA), Billings Clinic (MT), Cherokee Nation (OK), Hale Makua (HI), LIFE Geisinger (PA), LIFE Lutheran (PA), The Methodist Oaks (SC), Montrose VOA (CO), Mountain Empire (VA), Northland PACE (ND), PACE Vermont (VT), Piedmont Health (NC), Siouxland PACE (IA), Total Life HealthCare (AR), and Total Senior Care (NY).

We used telephone interviews and an internally developed questionnaire (Appendix A) to collect information, following up by email to obtain further details (such as program census). In some cases, we made follow-up calls to rural PACE organization leaders to collect additional information. The topics covered in the interviews included the organizations' sponsor relationship, census development history, community physician waiver decisions, State and County relationships, and marketing experience, challenges, successes and opportunities.

Background

Seniors residing in the nation's rural areas have a great need for PACE. According to the National Healthcare Disparities Report (U.S. Department of Health and Human Services, 2008), rural residents experience higher poverty rates, less education and more unemployment than their urban peers. The rural elderly tend to be in poorer health and face greater difficulty obtaining health services than urban seniors. Rural communities often lack access to essential health care services. Many rural seniors in declining health have limited community-based alternatives to nursing home care. Low-income and disabled seniors, precisely the group served by PACE, are among those who suffer the most in rural areas. With the budget

woes of many States likely to continue, securing access to health care services for frail seniors will remain a pressing need.

Congress authorized PACE development in rural communities in 2005 and CMS (Centers for Medicare and Medicaid Services) awarded 15 grants in 2006, conditional upon the rural organizations developing PACE by 2008. Fourteen of the grantees succeeded. Fourteen of the organizations we interviewed have received grants as part of this CMS Rural PACE initiative. The exception, Cherokee Nation (OK) is located in a rural area but did not receive a CMS grant.

Key Findings

The interviews provided rich information about the challenges rural PACE organizations face in conducting marketing activities and growing their enrollment. In this section we provide a snapshot of the enrollment situations of the participating organizations (Table 1), analyze the nature of the challenges being experienced related to marketing and put forth solutions being tried (Tables 2, 3 and 4), and look more closely at ways to address major challenges such as building relationships with referral sources (Table 5), addressing the crucial relationship with the medical community, including the role of community physician waivers, and improving the interface for State eligibility determination. Finally, we identify key rural PACE marketing success factors (Table 6) and best practices.

Census and Enrollment. Table 1 provides summary information on rural PACE enrollment and census for the organizations surveyed, arrayed by average enrollment per month (from low to high). As shown by this table, rural PACE organizations having a second PACE site in a non-rural area report the lowest rate of enrollment.

Table 1: Snapshot of Rural PACE Enrollment and Census

PACE Organization and Date Opened	Average New Enrollees Per Month	Clients Enrolled in Last 12 Months	Clients Enrolled Since Opening	Current Census	Target Census	% of Target to Date	Months Open
A* – 10/1/2008	0.5	8	8	7	30	23.3%	17.5
B* – 9/1/2008	1.2	23	23	19	50	38.0%	18.9
C* – 3/1/2008	1.8	16	45	33	125	26.4%	24.9
D – 10/1/2008	1.9	0	33	26	120	21.7%	17.7
E – 5/1/2008	2.0	24	45	35	125	28.0%	22.8
F – 8/1/2008	2.1	41	41	32	200	16.0%	19.5
G – 11/1/2008	2.4	42	42	35	110	31.8%	17.3
H – 3/1/2008	2.5	53	62	53	139	38.1%	25.1
I* – 1/1/08	3.0	27	83	59	110	53.6%	28.0
J – 4/1/2008	3.1	71	73	60	150	40.0%	23.8
K – 3/1/2009	3.1	39	39	33	240	13.8%	12.6
L – 8/1/2008	3.2	0	63	51	100	51.0%	19.7
M – 12/1/2008	3.6	57	57	52	150	34.7%	15.8
N[1] – 9/1/2008	4.5	79	87	67	150	44.7%	19.4
O – 8/1/2008	10.0	150	200	158	205	77.1%	20.0
Average	3.0	42	60	48	134	36.0%	20.0

*Information specific to PACE organization's **rural** center; organization also has a non-rural center

[1] PACE organization serves rural and urban areas from one rural center.

Appendix B provides information on rural PACE enrollment and program specifics. Respondents report variation (from eight to 200) in the gross number of seniors enrolling since opening. The average enrollment per month across the 15 sites is three enrollees and the overall average enrollment (current census at time of survey) is 48 participants.

Respondents report they enroll applicants in 34 days on average (with a range of 18 to 58 days). When asked to report the shortest and longest enrollment period they had experienced, respondents reported the shortest as 12 days on average, with a range of two to 28 days. The longest enrollment period reported on average was 98 days, with a range from 21 to 270 days.

Because rural PACE organizations cannot enroll a prospect until the State has determined the elder meets a nursing home facility level of care, we also looked at the length of time States take to process the eligibility screening. Respondents reported their State representatives take 11.5 days on average to process eligibility screening, with a range of two to 35 days.

Marketing Challenges. We performed a content analysis of respondents' comments about rural PACE marketing challenges. Building trust among physicians, elders and community agencies clearly is crucial to rural PACE organizations. Respondents' 46 comments about marketing challenges could be organized into four major categories and 16 types of issues. The four main categories are: 1) Referral Community; 2) Elders Reluctance; 3) Internal/Operational Barriers; and 4) Regulatory Environment. Chart 1 summarizes the category percentages and Table 2 shows the number of responses falling into each of these categories, as well as the several types within each category.

Chart 1

Table 2: Rural PACE Marketing Challenges

Challenges	Number	Total
Elders Reluctance:		
Cultural Issues	2	
Mistrust of PACE or New Program	7	
Won't Change MD	5	
Distance to Center	1	
Total Elders Reluctance		**15**
Internal/Operational Barriers:		
Staffing Challenges	6	
Lack Infrastructure	1	
Limited Budgets	1	
Understanding Best Marketing Strategies	4	
Total Internal/Operational Barriers		**12**
Referral Community:		
MD Resistance to PACE	2	
Lack of Awareness of PACE	4	
Lack of AAA Support	2	
Community Resistance (not AAA or MD)	2	
Total Referral Community		**10**
Regulatory Environment:		
Strict Medicaid Eligibility	4	
Strict PACE Eligibility	3	
State Responsiveness	1	
CMS Expectations	1	
Total Regulatory Environment		**9**

Table 3 provides specific examples of the marketing challenges as reported by survey respondents.

Table 3: Specific Examples of Rural PACE Marketing Challenge Anecdotes

Marketing Challenge	Survey Excerpt
Elders Reluctance	
Cultural Issues	• "Culture where they want to take care of their own parents. Don't want to ask for help. Don't want strangers coming in." • "Don't want to go through DSS because consider Medicaid to be a welfare program."
Mistrust of PACE or New Program	• "Feeling that it is 'too good to be true;' people are leery about an insurance product. All inclusive… people don't believe that."

Marketing Challenge	Survey Excerpt
	• "Fact that their Medicare and Medicaid cards go "dormant" is a scary thing for them." • "Community was burned by Windsor, an HMO that left them high and dry. Managed care a dirty word."
Distance to Center	• "Transportation to center can discourage people at first because the ride is often 40 minutes or more."
Internal/Operational Barriers	
Staffing Challenges	• "The volume the team has to deal with." • "Difficult to recruit (NP, OT, PT, Speech)." • "First year had a lot of turnover." • "At first I did not know the skill sets the staff needed."
Limited Budgets	• "Not having dedicated enrollment staff (had a hiring freeze)." • "Limited marketing budgets."
Understanding Best Marketing Strategies	• "Explaining what PACE is." • "Finding best way to market PACE in area."
Referral Community	
MD Resistance to PACE	• "Some of the local specialist refused to work with us. One office even said, 'We don't want those kinds of people in our office.'"
Lack of Awareness of PACE	• "Reaching people in this rural community. Isolation a big issue. Not going to churches, senior centers or even to see their doctor." • "The health care community doesn't get it. Doesn't see how beautiful the program is. When I go to the . . . County and tell them about PACE, they say, 'How come we don't have that here?' Why don't we get that response? Don't even get that response from Board members."
Lack of AAA Support	• "There is a lot of competition for individuals and State has had a waiver program for 30+ years. Hard to get to those people because State and AAA have to be the ones to get word out."
Community Resistance (not AAA or MD)	• "Private home care agencies have been wicked competitors—tell lies. Things like, 'They make you go there every day; they control every decision and you'll never be able to make a care decision again.'"

Marketing Challenge	Survey Excerpt
Regulatory Environment	
Strict Medicaid Eligibility	• "Finances—middle income people." • "Medicaid is 100% of poverty, which limits the eligible pool." • "Lack of retroactive payment limits when we can start serving."
Strict PACE Eligibility	• "State with budget deficit (2009 no deficit); now State is cutting back." • "Now have denials with LOC where didn't before. That started in December." • "People say it is like Ft. Knox to get in there—so many requirements."
State Responsiveness	• "Marketing materials approval process too cumbersome."
CMS Expectations	• "CMS has us under the same scrutiny as a bigger, established PACE site but we don't have any infrastructure."

Not to be deterred by these significant challenges, respondents have come up with creative approaches to overcoming them. Table 4 below provides creative solutions to marketing challenges for each of the four major categories.

Table 4: Creative Solutions to Marketing Challenges

Marketing Challenge	Survey Excerpt
Elders Reluctance	• Marketing Coordinator brings guitar to outreach events at senior housing, which draws a crowd. • Run radio ad on gospel station during Sunday church radio services (listened to by homebound elders or caregivers not able to leave elders alone). • Get permission from PACE participants to give out number to skeptical prospects. • Allow new participants a certain number of visits with their existing Primary Care Physician (PCP) or specialist. • Run billboards that say, "PACE Keeps Me at Home" featuring current participants (who get positive comments from friends). • Use another agency's social day as an alternative site so seniors don't have to travel far. • Align with another respected senior service organization and the association gives automatic validity to PACE.
Internal/Operational Barriers	• A strong Intake Specialist is important; having a local person is critical because he or she is the "face" of the program. • Get free publicity as much as possible . . . Rotary, Kiwanis, community clubs and local newspapers are all resources.

Marketing Challenge	Survey Excerpt
Referral Community	• Every month send a photo of a PACE event to the newspaper. • Create a user-friendly referral form for discharge Social Workers and RN's to fax over (very basic info). • Bring lunch to physicians to get in front of them (like pharmaceutical reps do). • Set up contract with competitors so that if clients leave for PACE, contractors will still get the business (just a different payer). • CCRC has a wait list at SNF so market PACE to enable them to keep their SNF-level elders in lower level setting with support. • Meet with physician office managers individually and present to their monthly meetings. • Educate referral sources with materials that explain what a good referral is and success stories (for example, ability to keep a senior "frequent flyer" who had been admitted to hospital every three weeks out of hospital for six months). • Use PACE Center attractiveness as a tool and host as many events as possible (Mayor's task force, caregiver meetings, trainings, etc.) • Send a letter to every pastor saying that he or she can call on PACE Intake Coordinator if a church member needs help. • Send a friendly letter with request for medical record, thanking them for records and their time (nurture relationships at every opportunity). • Collaborate with assisted living facility with dementia care unit to help maintain residents living in assisted living rather than SNF. • Keep a database of inquiries about PACE. • Develop an "elevator message" about PACE and train staff to have it on the tip of the tongue. • Paint the vans with PACE organization logo. • Send out cards, e-mails or a newsletter to PACE contractors. • Educate the referral community by word-of-mouth, using testimonials.
Regulatory Environment	• Successfully advocate for the State to lower the share of cost (SOC). • Negotiate with State to have a Medicaid eligibility worker on site. • Negotiate with the State to have PACE Intake Coordinator (LPN) to conduct State eligibility assessment and review by phone with State RN. • Think of the State's single point of entry program as a customer. What problems are they having that you can solve?

Referral Sources. Respondents said they targeted a variety of organizations for referrals and encountered challenges in gaining the results they wanted. Organizations with the highest average enrollment per month generated referrals from their parent organization or "sister" agency programs while successfully reaching a ***variety*** of other organizations, suggesting that diversification is the key to building a healthy rate of enrollment. Most often mentioned as positive referral sources were these entities: 1) Hospitals; 2) Home health agencies (especially those of the sponsoring entity); 3) Short-stay SNFs; and 4) Senior housing (especially those with assisted living waiting lists and dementia care).

Less often mentioned, but likely just as important, were the following organizations, events and individuals: 1) Churches; 2) Seniors and caregivers through "word-of-mouth;" 3) Clinics; 4) Health fairs; 5) Department of Social Services; and 6) Hospice.

Sometimes mentioned were PACE contractors, information and referral (including a web-based program), community business associations/chamber of commerce, senior center nutrition programs, senior clubs, law enforcement and banks. Respondents identified Area Agencies on Aging (including an array of community-based programs) as a positive referral source in some cases and as a competitor in others. Table 5 provides a summary of common rural PACE referral sources.

Table 5: Rural PACE Referral Sources

Senior Service Entities	Sponsor Agency	Community	State	County	AAA	Medical Providers	Housing	Media
	Agency Board	Consumers	PACE State Administering Agency	APS	Meals on Wheels	Primary Care Offices	Custodial SNF	Newspapers
	Agency Leadership	Caregivers	SNF Eligibility Review Team	IHSS	HCBS Waiver Programs	Specialist Offices	Independent Housing	Radio
	Agency Providers	Local Officials	Medicaid Eligibility Office	Other County	I & R	Hospital Providers/ Discharge Staff	Assisted Living	Web
		Police and Fire	Eligibility Reviewers	Health Fairs		Clinics	CCRC's	Direct Mail
		Churches/ Clergy	Senior Resource Committees			SNFs -Short Stay and Rehab	Dementia Care	
		Chamber of Commerce				Home Health/ Hospice		
		Transportation Vendors						
		PACE Contractors				PACE Contractors	PACE Contractors	

Respondents frequently cited the following challenges in engaging referral sources:

- The physician community is unwilling to make referrals to PACE
- Home and community-based services waiver programs view PACE as a competitor
- State eligibility determination entities (level of care and financial) take too long
- “Single point of entry” for Medicaid long-term care entities don’t refer to or understand PACE
- Managed care organizations view PACE with suspicion
- Elders are very attached to their physician and don’t want to change physicians
- Adult children facing long-term care decisions are unaware of the PACE option.

Marketing Success Factors. We performed a content analysis of respondents’ comments about factors identified as critical to success in building census. Respondents’ 37 comments about marketing success factors could be organized into three major categories and 15 types of issues. The three main categories are: 1) Marketing Tactics (50%); 2) Strategic Alliances (32%); and 3) Organization Strengths (18%).

Table 6: Rural PACE Marketing Successes

Identified Successes	Number	Total
Marketing Tactics:		
Repetitive Outreach	4	
Billboard or Bus Wraps	2	
Train State Eligibility Workers	3	
Radio Ads	1	
Free Publicity Via Press	3	
Targeting Special Populations	2	
Auxiliary Program	2	
Doctor-to-Doctor Outreach	2	
Total Marketing Tactics		**19**
Strategic Alliances:		
State	3	
Housing	4	
Area Agency on Aging	3	
Sponsor Agency	2	
Total Strategic Alliance		**12**
Organization Strengths:		
Quality Staff Performance	1	
Well-reputed Marketing Staff	3	
Organization-wide Support for Marketing	2	
Total Organization Strengths		**6**

National Rural PACE Best Marketing Practice Survey

Best Practices. In comparing practices between "high enrollers" (the three respondents with the highest average enrollment per month) and "low enrollers" (the three organizations with the lowest average enrollment per month) certain themes emerge. The first is how similar both groups are in their marketing activities and approaches.

Both high and low enrolling respondents try to build mutual relationships with sponsoring entities, community providers, and seniors and caregivers. Both groups have a focused Marketing Coordinator or Intake Specialist. They get out and join community organizations and invite others to the PACE Center. Both high and low enrollers try to negotiate positive relationships, even in competitive situations, with community physicians, Area Agencies on Aging, the State and others. In fact, in many cases they win referrals by seeking to solve competitors' problems. Most importantly, both groups work to earn the trust of seniors and caregivers. All the organizations in both groups enjoy a relationship with a sponsoring entity or national affiliate. Sponsoring entities include rural health systems (three), a rural health care consortium (one) and a national affiliate (two).

Nuanced differences can be seen in the strategic alliances forged by the high enrollers. Interestingly, the national affiliate sponsors both a high and low enrolling program. For the high enroller, the national affiliate has local programs that also make referrals to PACE. For the low enroller, local programs of the affiliate are not a local referral source. Thus **sponsoring entities' *local* reputation and referral relationship** is likely an important factor in marketing and enrollment success.

None of the three low enrollers had community physician waivers, and two of the three high enrollers did. One moderate enroller, although not using a community physician waiver, reports significant physician referrals from a sponsoring entity's Federally Qualified Health Center (FQHC) clinic. A successful strategy to engage community physicians, either through an alliance for physician referrals or by securing a **community physician waiver** appears to be a best marketing practice among rural PACE organizations because when physicians understand the value of PACE, they influence elders to enroll. See below for additional information regarding community physician waivers.

The top three enrollers had contracts with an array of medical and non-medical services, even in one case with housing providers. Entities that might experience PACE as competition, **when under contract** (part of PACE network) have an interest in PACE success, which mitigates competitive relationships. These contracts can be with medical and non-medical providers such as nursing, hospice services, personal care and meals-on-wheels agencies. **Housing providers**, while only in rare instances under a contract, can be a substantial source of referrals. For housing providers, having PACE as a support to their residents can assist with keeping their census stable by enabling elders to age in place successfully, thus reducing turnover.

High enrollers report more cooperative relationships with the **Area Agency on Aging (AAA)**. All three low enrollers viewed the AAA as a competitor while two of the three high enrollers enjoyed cooperative referral relationships with the AAA.

High enrollers more often generate referrals from their parent organization or "sister" agency programs while successfully reaching a ***variety*** of other organizations; suggesting that **diversified marketing tactics** is a key to building a healthy rate of enrollment.

Low enrollers more often report challenges with referral sources—particularly generating an awareness and understanding of PACE—than high enrollers, suggesting that effective approaches to **creating community**

awareness of PACE through extensive, repetitive networking and word-of-mouth is a best marketing practice.

One high enroller has achieved enrollment success by targeting the younger frail senior, age 55-64 years, for rural PACE. Recently this high enroller developed plans to collaborate with the Veterans Administration to serve PACE-eligible seniors. **Reaching younger seniors or populations not traditionally served by PACE** is likely a best marketing practice.

Low enrollers report having a second PACE site in a non-rural area. The competing demands of marketing for two distinct centers, one rural and one non-rural, may diffuse the **quality of marketing staff focus** enjoyed by high enrollers. More information and analysis is needed to better understand the impact of having a second PACE site in a non-rural area.

Finally, low enrollers more often identify challenges with regulators—in some cases resulting from State budgetary constraints—than high enrollers. This likely translates into delays in eligibility determination. In fact, for low enrollers, the State average for processing level of care eligibility determinations is nearly double that of high enrollers (11 days vs. six days), suggesting that **constructive alliances with State eligibility determination entities** is a best marketing practice. See below for additional information.

Community Physician Waivers. CMS allows PACE organizations to apply for a waiver to use community physicians for participant medical care. Physician relationship issues took one of two forms: 1) Seniors unwilling to give up their community physician; and 2) Physicians unwilling to refer to PACE. In rural areas where there are very few doctors these issues can be serious. The community physician waiver helps PACE organizations to mitigate this limiting factor.

Issues related to the physician relationship were reported by 13 of 15 respondents (although the survey did not have a specific question about the topic). Only two programs (one with an extensive community physician waiver program and one without a waiver) did not recognize the physician relationship as an issue. The pervasiveness of the issue suggests that all rural PACE organizations—with or without a community physician waiver—must have a solid strategy to engender an understanding of the benefits of PACE among the medical community. With knowledge of elders' medical conditions, physicians (primary care, specialists and hospitalists) are in a position to make appropriate referrals and facilitate community acceptance of PACE. Community physicians may evolve into good referral sources when they understand the small number of seniors served by PACE relative to the age 55+ population and the benefits of PACE to frail seniors.

Four of the 15 respondents have implemented a community physician waiver program. Three others have applied for a community physician waiver and are awaiting approval. The seven respondents with, or applying for, a waiver said the primary reason for seeking the waiver is to increase the pool of enrollees. For example, one respondent found that the three local geriatricians in town were not referring to PACE, having a significant negative impact on the program's ability to grow census. Offering potential enrollees the option to see their primary care physician a few times during the year at this center did not sway seniors to enroll. Respondents also mentioned geography as a decision factor in seeking a waiver. They found elders are willing to make the trip through rugged terrain to come to the center for services but leery of having to travel

so far when they are not feeling well and need to be seen by a physician. Thus, involving physicians with a medical office closer to elders is appealing. All respondents using the community physician waiver have found it successful in increasing their census. One respondent with the fastest growing rural PACE nationally has said, "Our program is the fastest growing PACE in the United States because we have a waiver to use community physicians. We have found that every physician practice has a number of people they cannot effectively manage and in PACE they thrive."

We spoke with two respondents using waivers about how they integrated the community physicians into the Interdisciplinary Team (IDT) and the impact the program is having on health care utilization. Both have nurse practitioners involved in at least some participant care. Both described challenges integrating the community physician with the IDT. They said it took a year to work through the issues. One of the two respondents addressed the importance of involving the community physician in-person on the IDT during care planning and discussions related to a significant change in condition, noting that conference calls did not work well due to distractions. Incentives for participation included: paying for the doctors' time; scheduling physicians two to three weeks in advance; and involving them briefly for just 15 to 20 minutes. Both respondents addressed issues related to health care utilization, suggesting community physician oversight was difficult initially, but over time as the community physician entrusted IDT members with shared responsibility for managing utilization, the utilization improved.

Among those who did not have a waiver, there were strong feelings against it philosophically. Some respondents thought it undermined the integrity of the PACE model. Some did not have confidence that community physicians would have the same level of commitment as PACE physicians. Others feared that utilization would be unmanageable. One even said that when they discussed it at their organization, "it took on nightmare proportions." However, a frequent attitude even among those generally opposed was that they would eventually have to secure a community physician waiver in order to meet their census goals or, in one case, because they were having trouble recruiting enough primary care physicians.

Finally, we asked those who have applied for the waiver, and those who had not, what advice they had for others. Among those who had not applied, one recommended a practice of offering several physician visits to prospects, and added that once a senior met their well-liked PACE physician the senior felt less concerned about leaving their current community physician. Another recommended having the PACE Medical Director and Primary Care Physician network aggressively with community physicians so they will refer their frail elders. One of the interviewees also offered that it was essential to screen the potential community waiver doctors for their philosophy, willingness to invest the time necessary to make it work, and their reputation.

State Eligibility Determination. As described above, respondents report their State representatives take 11.5 days on average to process eligibility screening, with a range of two to 35 days. Financial eligibility can take considerably longer. Efficient level of care and financial eligibility determination by State entities plays an important role in successful marketing strategies. Respondents report considerable variation in State processes used to process eligibility, but several successful strategies emerge:

- An Intake Coordinator (LPN) got approval to use the State's eligibility assessment form to document the level of care screening information, and typically in a day or two, reviews it with the State RN. (Prior to negotiating this arrangement, the eligibility process was taking about 14 days).

- Two rural PACE organizations have negotiated arrangements with their respective States to locate the Medicaid eligibility worker on-site (one pays half the eligibility worker's salary) narrowing the time to process Medicaid eligibility to a few days. Both have also experienced a lower than average enrollment period, 18 and 21 days respectively vs. 34 days on average; the efficient Medicaid eligibility determination may partly explain the difference.

Respondents suggested two other yet unproven strategies: 1) Successfully advocating for a reduced cap on the number of days that States have to process eligibility determinations; and 2) Securing approval for PACE organizations to bill States retroactively once eligibility has been confirmed.

Recommendations: Strategic Alliance Building Framework

PACE, a complex, unfamiliar program (without name recognition like Hospice), requires elders to make what can feel like significant changes in their lives, such as changing a doctor or caregiver or "turning over" their Medicaid and Medicare cards. Many respondents said they face a challenge in explaining PACE. The most common theme among respondents is that elders say PACE is "too good to be true." PACE providers need support in introducing and marketing PACE to their communities.

When asked if they formally collaborated with other organizations to market PACE, most respondents replied "no." However, when discussing marketing challenges and successes, respondents described collaborative relationships with stakeholders and stressed how critical these relationships can be to building awareness and generating appropriate referrals in their communities. For example, one respondent spoke eloquently about the substantial benefit PACE received in gaining the trust of seniors due to their sponsoring entity's well-established name. Another described the success of the State's nurse evaluator in getting the word out.

Also evident from the interviews is the variability across organizations in their community relationships. For example, some respondents described close and cooperative relationships with their local Area Agency on Aging and others noted competitive relationships that hindered access to elders. One respondent said the sponsoring organization generated 50 percent of their referrals while another described an unsupportive relationship with their sponsor agency. Several respondents are well-known by the medical provider community, while others encounter resistance or receive very few referrals from primary care or specialist physicians. Inevitably, opportunities for community relationships will differ from community to community. A rural PACE organization may not have a supportive sponsor, or may have little control over the AAA's initial view of PACE, for example, but ultimately each rural PACE must systematically evaluate their relationship opportunities and develop well-defined plans for maximizing relationships that ***are*** available.

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We consider relationships to be so important to the successful introduction and marketing of PACE in a rural community that we recommend the use of a systematic approach called "Strategic Alliance Building." The steps of the alliance building process are to identify all the available stakeholders, consider which has the greatest potential to generate referrals, and envision how the PACE organization would like stakeholders to regard and support rural PACE. From there, strategies and supporting tactics can be identified, implemented, evaluated and continuously refined. Once developed and shared within a rural PACE organization, the Strategic Alliance Building plan can be implemented by PACE staff.

Appendix C provides a Strategic Alliance Building Framework with examples of vision, strategy, and tactics that we gleaned from our rural PACE respondents nationally.

Appendix D provides a detailed PACE Marketing Tactics Checklist with tactics used by rural PACE organizations nationally as identified by the survey.

Appendix A

PACE Organization and Location: ____________________
Date of Interview: ____________________
Name and Title of Interviewee: ____________________

National Rural PACE Marketing Survey

Background

The National Rural PACE Marketing Survey will be administered by telephone to at least 10 organizations. In most cases, the individual being surveyed will be the PACE Marketing Director.

Here is what we know about growing census from the September 2009 National Rural PACE Survey administered by On Lok as part of the California Rural PACE Development Project:

- ✓ *In most rural programs census growth has been a challenge.*
- ✓ *100% of respondents view census development as "most important" or "very important."*
- ✓ *Programs had used a variety of strategies to overcome barriers, with varying success:*
    - *Life Geisinger: Focused on outreach, pounding the pavement.*
    - *VOA-SCC: Used community Primary Care Physicians (PCPs) and hired community homemakers as PACE PCAs.*
    - *Mountain Empire PACE: Obtained referrals from parent entity (an AAA and senior service provider) and hired staff with good community connections and reputation.*
    - *Billings Clinic: Used staff PCP model, but allowed new participants to visit community PCP.*
    - *PACE Vermont: Advocated, with difficulty, for changes to statewide clinical eligibility determination; struggled with a very competitive environment and without a parent entity.*
    - *Piedmont Health SeniorCare: Helped the local community understand the program with lots of presentations (had to be realistic about expectations for enrollment); made return outreach visits to successful referral sources; obtained referrals from community health centers; built trust through word-of-mouth by participants and employees.*

Introduction

"Thank you for agreeing to speak with us about best marketing practices for new rural PACE programs. We will be using your responses to develop a summary document of best marketing practices for rural PACE, which we will share with the 14 existing rural PACE programs nationwide."

"This survey builds on earlier work and if you participated in an earlier survey, you may feel you have already provided some of the information that we will request today. Because circumstances change, we are asking some of the same questions to be sure we capture the current situation for each program."

"This survey will take about 30 minutes and we greatly appreciate your time."

Rural PACE Census

1) When did your PACE begin serving participants?

   Month and year: ___________

2) How many different or unduplicated participants have you served in the past 12 months?

   Number of participants served: _____

3) What is your census and average daily attendance (ADA) today, {Date}?

   Census: ____
   ADA: _____

4) What is the maximum census and Center ADA you can accommodate with your current facilities?

   Census: ____
   Center ADA: ____

Organizational Auspices and Collaboration for Marketing

5) Is your PACE organization part of a larger sponsoring entity?

   Yes: ___ No: ___

6) If **yes**, has your sponsoring entity made referrals to your PACE?

   Yes: ___ No: ___ Not Sure: ___

   Comments:

7) Does your organization offer senior services other than PACE?

   Yes: ___ No: ___

   If **yes**,

   A. Describe:

   B. Do these other services generate referrals?

      Yes: ___ No: ___

C. If **yes**, what percentage of your total referrals come from your organization's other senior services? _____%

8) Has your organization sought a community physician waiver?

Yes: ___ No: ___

If **yes**,

A. What prompted you to apply for the waiver?

B. Where are you in the process?

C. What methods do you use to integrate the community physicians into your Interdisciplinary Team process?

D. In your opinion, is your community physician waiver helping you to meet your marketing and enrollment goals?

Yes: ___ No: ___

If **no** (your organization does <u>not</u> have a community physician waiver),

A. What led you to use a staff physician model?

B. Please identify any clear advantages or serious challenges you have met in working with community physicians.

C. What are you doing in your work with community physicians to reduce real or perceived barriers to participant enrollment in PACE?

9) Do you have other tips to help rural PACE providers coordinate with community physicians?

10) If collaboration is defined as "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals," have you collaborated with an organization other than your sponsoring entity to market PACE?

Yes: ___ No: ___ N/A: ___

A. Describe:

B. Please indicate two benefits and two challenges you have experienced related to **collaboration** for marketing your PACE

Benefits	Challenges
1.	1.
2.	2.

Comments:

Marketing and Enrollment: Challenges and Opportunities

11) What have been the main two or three **general** challenges your PACE organization has faced in developing census in a rural area?

Challenge 1:____
Challenge 2:____
Challenge 3:____

Comments:

12) What has worked best in addressing the challenges you have just identified (in question 10)?

Response: ____

____
____

13) In building your PACE organization census, could you identify one or two areas that have been critical to your success?

Area 1:____

Area 2:____

Comments:

14) What have been the main two opportunities your PACE organization has discovered in marketing PACE in a rural area?

Opportunity 1:____
Opportunity 2:____

Comments:

15) Does your State have a "single point of entry" for referring Medicaid-eligible seniors to long-term care services, including PACE?

Yes: ___ No: ___ Not sure: ___

If **yes**,

A. Is your PACE program receiving referrals from the State's single point of entry?

Yes: ___ No: ___

If **yes**, what tips would you offer to rural PACE providers about coordinating with the State's single point of entry?

B. If your State has a single point of entry, have you used other methods to market to seniors outside the single point of entry system?

Yes: ___ No: ___

If **yes**, what marketing techniques have you used and have your methods worked?

16) Is your local AAA an active competitor for PACE referrals?

Yes: ___ No: ___

If **yes**, what have you done that has proven successful in generating AAA referrals to PACE?

17) Are there other comments you would like to make about marketing rural PACE?

"Thank you for taking time to complete this survey interview. If you have thoughts after we are done, please e-mail them to me at. . ."

Appendix B: Rural PACE Enrollment and Rural PACE Program Specifics

Enrollment		Rural PACE Program Specifics	
Average Enrollment per Month		**Community Physician Waiver**	
Mean	2.98	In Place	4
Median	2.45	Applied	3
Range	.46 - 9.98	Don't Have	8
		Percent with Waiver	26.7%
Participants Since Opening		**Waiver Helped Reach Goals**	
Mean	60.07	Yes	4
Median	45.00	No	0
Range	8 - 200	Percent	100%
Average Days: Call to Enrollment		**MD Barrier Mentioned**	
Mean	34.00	Yes	13
Median	35.00	No	2
Range	18 - 58	Percent Yes	86.7%
		Part of Local Sponsoring Agency	
Shortest # Days: Agency Process		Yes	14
Mean	12.13	No*	1
Median	13.00	Percent Yes	93.3%
Range	2 - 28	*National sponsoring agency	
Longest # of Days: Agency Process		**Sponsoring Agency Type**	
		Hospital or Medical System	5
Mean	97.57	Area Agency on Aging	2
Median	84.00	Community Services (SNF, Hospice, HHA or Other)	6
Range	21 - 270	Not Applicable	1
		Tribe	1
Average Days: State Process			
Mean	11.47	**Sponsoring Agency Referrals**	
Median	10.00	Yes	13
Range	2 - 35	No	2
Shortest # Days: State Process		**% Sponsoring/Sister Agency Referrals**	
Mean	3.87	Number Organizations Reporting	8
Median	2.00	Mean %	21.5%
Range	1 - 14	Median %	10.0%
		Range %	5 - 50%
Longest # of Days: State Process			
Mean	23.40		
Median	18.00		
Range	5 - 90		

Appendix C: Strategic Alliance Building Framework[2]

	Sponsor Agency	Elder and Caregiver Community	State	Community and County Elder Care Providers	AAA	Medical Providers	Housing	Media
Vision	Sponsoring agency members with influence are enthusiastic about PACE and promote it.	Elder and caregiver community is aware of PACE and views it as a positive option for elders.	State supports and nurtures new PACE program.	Elder care providers understand the value of PACE for frail seniors and welcome addition of PACE to continuum.	AAA know s value of PACE for frail and embraces PACE as part of the service system.	MD's offer PACE when SNF placement being considered and feel PACE benefits elders and their practice.	Housing providers understand opportunity PACE provides in helping people age-in-place and stay in community.	Media embraces the opportunity for human interest stories and helps to build awareness of PACE.
Strategies	Ensure that all levels of sponsoring agency are educated on PACE.	Give the community multiple, and varied means to learn about PACE.	Proactively develop positive rapport at all levels and make requests as needed.	Educate continuously so that all agencies understand PACE value.	Join an AAA-sponsored initiative.	Nurture relationships with all levels of staff; engage PACE medical staff.	Educate continuously so staff and residents think of PACE when residents' needs change.	Find interested reporters and communicate with them regularly to maximize opportunities; maximize free press.
Tactics	Presentation and tours to sponsor agency board.	Send a letter to religious leaders explaining the PACE option and inviting to PACE tour.	Weekly conference calls while planning.	Invite staff for luncheon and tours.	Attend meetings.	Bring lunches to providers to present (as Rx reps do).	Host luncheon and tour for housing providers.	Host opening and anniversary events inviting media.
	Identify joint marketing opportunities.	Billboards in high traffic areas with photo of PACE MD.	Face-to-face meetings to resolve issues.	Whenever new staff hired, invite for a tour.	Invite to meet at PACE Center.	Meet with office managers.	Make presentations to elders at housing sites.	Send a day center photo monthly.
	Identify mutual benefits between PACE and sister agencies.	Newspaper feature stories.	Study response times and bring them a report.		Provide training to AAA staff.	Provide nurse-to-nurse trainings to office RN's.	Invite elders for group tours.	
	Make referrals from other senior serving programs easy.	Host events at the PACE Center to generate familiarity.	Request dedicated Medicaid worker.			Develop and distribute an easy referral form to fax.		

[2] Marketing vision statements, strategies and tactics are samples only and should be used and adapted as circumstances dictate.

Appendix D: PACE Marketing Tactics Checklist

To bring PACE awareness to the level of other provider types such as Hospice or Nursing Homes requires multiple avenues and repeated education efforts. A number of tactics have been used at PACE programs around the country.

Medical Community – Hospitals, Doctor's Offices and Clinics

- ☐ Reach out to non-medical staff such as office managers in doctor's offices and administrators in clinics hospitals and SNFs
- ☐ Meet briefly with MD's in the a.m. before patient visits begin, if more convenient
- ☐ Include PACE MD in outreach with marketing staff
- ☐ Host lunch and tour for MD and their office staff
- ☐ Communicate successful outcomes to referring MD's (such as reduced re-admits)
- ☐ Reach out to hospital discharge planners
- ☐ Create and distribute simple fax referral form for hospital discharge planners
- ☐ Provide simple faxable referral form on a clipboard to simplify referrals

Area Agency on Aging

- ☐ Include AAA in PACE planning from outset
- ☐ Tour AAA staff and new staff as hired
- ☐ Attend AAA meetings regularly
- ☐ Cultivate PACE Executive and AAA Director relationship
- ☐ Participate in AAA-sponsored initiatives

Housing – Low-Income, Assisted Living and SNFs

- ☐ Host lunch and tours for housing staff
- ☐ Host lunch and tours for <u>residents</u>
- ☐ Have brochures on site

All Eldercare Providers (including above and other community care providers)

- ☐ Schedule ongoing face-to-face outreach and tours
- ☐ Maintain current database and send:
  - Newsletters by mail
  - E-mail news between newsletters
- ☐ Host community events at center (mayor's task force, fairs, etc.)
- ☐ Develop a program serving eldercare professionals and paraprofessionals such as a speaker's bureau that offers CEUs
- ☐ Develop contracts for services (home health, hospice, meals, etc.)

Sponsor Agency

- ☐ Conduct internal marketing at all levels (board, sister agency staff, etc.)
- ☐ Engage PACE MD in education from the outset
- ☐ Partner with sponsor agency in marketing

National Rural PACE Best Marketing Practice Survey

State

- ☐ Convene regularly scheduled meetings with high-level state officials to update on PACE and advocate for State support and expansion of PACE
- ☐ Meet face-to-face to resolve issues when necessary
- ☐ Track and present medical and or financial eligibility determination turnaround times to State officials if it is inconsistent or slow (more than 10 days)
- ☐ Host tours for State staff
- ☐ Exchange information on PACE requirements and Medicaid requirements
- ☐ Request dedicated Medicaid eligibility worker on site or in their office
- ☐ Advocate for faster eligibility determinations
- ☐ Advocate for faster marketing materials review

Elder and Caregiver Community

- ☐ Offer a number of visits to their prior primary care MD
- ☐ Consider contracting with the elder's specialist
- ☐ Apply for a community physician waiver from CMS
- ☐ Use newspaper ads
- ☐ Run radio ads at times when elders and caregiver may be listening (example: before or after radio church services)
- ☐ Educate religious leaders about PACE option
- ☐ Use billboards in high-traffic locations
- ☐ Use bus wraps
- ☐ Maintain database of prospects that declined and check-in later
- ☐ Assess community need and target underserved populations (younger elders, mentally ill, cancer patients, etc.)
- ☐ Identify underserved populations and build in-house capacity to serve them (for example people with psychiatric disabilities or younger seniors 55-64)
- ☐ Develop alternative care sites for day center activities to maintain continuity or reduce travel time for PACE clients
- ☐ Reach out to community leaders - banks, chamber of commerce and law enforcement
- ☐ Conduct direct mail campaign

Media

- ☐ Invite reporters for tour
- ☐ Invite media to significant events
- ☐ Send a day center photo to newspaper monthly
- ☐ Reach out to TV and radio show hosts for interview opportunities

PACE Organization

- ☐ Assure executive leadership engages staff in understanding importance of marketing
- ☐ Provide clear expectations to staff on how they can support marketing and enrollment