NATIONAL ASSOCIATION OF
Community Health Centers

Important Content Note:

This technical assistance resource was developed prior to the August 2017 release of the Health Center Compliance Manual by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). The BPHC Compliance Manual, issued August 2017, indicates where PINS, PALs and other program guidance are now superseded or subsumed by the BPHC Compliance Manual.

See: https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf

Successful Practices in Accountable Care: Piedmont Health Services, Inc.'s PACE Program

Health Center Profile

Health Center: Piedmont Health Services, Inc.

Location: Alamance, Caswell, Chatham, Lee, Orange, Person, and Randolph counties in North Carolina

Number of unique patients served: 42,000

Number of sites: 10 + 2 SeniorCare locations

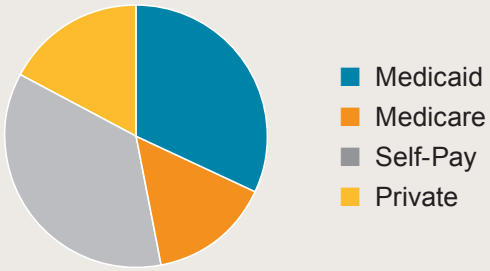
Services offered: Primary Care including prenatal, pediatric, adult, 6 dental locations, nutritional and behavioral health, case management/community care link, substance abuse pilot program, 7 pharmacies, 3 WIC offices; PACE sites offer additional services such as therapy, rehabilitation, and transportation.

Source: Toomey, B. and De Vries, A. (2016 December 20). Telephone Interview. Ratcliffe, M. (2017 January 17). Telephone Interview.

Certifications: The Joint Commission Accredited, AAAHC Accredited, PCMH Level II

Unique Feature: Second PACE program in NC; Serves a large refugee resettlement program.

Payer mix (approximate): 32% Medicaid, 15% Medicare, 36% Self-Pay, 17% Private



Medicare's Program of All-Inclusive Care for the Elderly ("PACE")

The PACE program is a partnership between CMS, State Medicaid agencies, and providers that delivers in-home, comprehensive and intensive primary care services to the elderly and frail populations on a level with the care generally provided at nursing homes. Enabling these patients to remain in their homes and communities for as long as possible offers qualitative, cost-effective care and a vastly improved quality of life. Eligible patients are over 55, require the level of care required under the State Medicaid plan for coverage of nursing facility services, reside in the service area of the PACE organization, and must be able to live in a community setting without jeopardizing his or her health or safety (42 CFR 460.150(b)(c)).

As a comprehensive care plan, all aspects of patient health are provided through the PACE providers, including the addition of home safety measures (such as building a ramp) and medical transportation. The PACE program is reimbursed for provided care through a capitated fee from Medicare, Medicaid or both when the patient is dually eligible. For the purposes of efficiency and collaboration, PACE programs have a limited approved service area, minimizing the travel time and efforts participants have to expend on care while living at home and allowing providers to work with defined population bases and partnership opportunities.

Piedmont Health Services

Piedmont Health Services (PHS) is a Community Health Center in North Carolina with twelve locations across the state, two of which are designated as PACE service sites. PHS serves over 42,000 unique patients annually and has served 500 PACE patients cumulatively since the program's inception in 2008. Piedmont opened its first separate SeniorCare facility in Burlington, NC to serve the PACE program in 2008, and following its success, opened its second SeniorCare location in Pittsboro in 2014. The

program continues to grow at a rate of five to six patients per month on top of the program's 275 current enrollees. As the program continues to grow, PHS is focused on provider utilization, managing their relationships with specialists, educating the community, and looking to utilize a similar model of service delivery for their patients not enrolled in the PACE program.

Why Did PHS Join the PACE Program?

The main reason why PHS began exploring the PACE program was its organizational mission. The aging population in rural NC was growing more isolated due to decreasing family growth rates and the departure of younger members to urban areas. The community's age 65+ population far outnumbered it's smaller under 18 population. Brian Toomey, PHS' Chief Executive Officer, saw the PACE program as a way to keep community members living in the community rather than in nursing homes. Toomey saw this as a natural extension of the role of a Community Health Center: to be there and care for the community, regardless of a patient's age.

Additionally, the program has several practical benefits. The typical enrollee in the PACE program is 77 years old, with ten medical diagnoses, six daily activity assistance requirements, and ten medications. During their time on the program, which averages about 42 months, patients average one hospitalization and one nursing home visit per year. Patient satisfaction for PACE is extremely high and scores in the areas of infections, falls, wound care, dementia and depression improve almost immediately because the patient is at home. The program structure of home care and capitated payments aligns the patients, family members and caregivers in a way that encourages patient and family engagement. In North Carolina, the cost of care for the PACE program is at least 5% lower, as the reimbursement rate is 95% of the Nursing Home rate. The 95% reimbursement is spent more efficiently as well, wholly invested into primary and preventative care activities. PHS strongly believes that the PACE program is a great way to move towards the Triple Aim, providing better quality care for satisfied patients at a lower cost.

Program Integration

One of the most important differences between the PACE program and Health Center care is the reimbursement structure. The PACE program pays the health center a capitated rate per patient, and PHS quickly found that maintaining fee-for-service and PACE care in one location is nearly impossible because of the different mindsets they require. The PACE provider must maintain patient's health and safety in the community, providing comprehensive primary, preventative, home safety, DME, social and quality of life services, many of which need to be contracted out. As a result, for many services, the PACE provider takes on the role of an MCO, contracting with and paying the claims of local hospitals and organizations for services not provided in-house. This model raises the risk level PHS has had to take on through the program, but PHS maintains that this is a benefit rather than a drawback. PHS is in a strong position going forward by being well versed in a risk-based environment.

Participating in the PACE Program

The suggested first step towards participating in the PACE program is to join the National PACE Association (NPA) as an exploratory member, which costs $3,000 a year. Due to the wide range of services it is expected to provide to participants, the PACE program requires a significant outlay of capital upfront and can take between 18 and 30 months to become profitable. As a result, it is essential for a health center to make sure it has the capabilities to operate successfully within the program requirements. PHS applied for and received a grant from a local organization to carry out a $25,000 feasibility study to educate PHS' choice to pursue the PACE program.

Following an intense, nearly two-year education period for Board Members, Executive Leadership and staff, PHS' Board of Directors formally approved the launch of the program. To build the first location and maintain operations for the time it took to break even, PHS partnered with CMS, local organizations and foundations, and sought lenders open to partnering with the program. In all, it took about $3.5 million to set up the first site and break-even, and PHS began seeing profits in 13 months on the program. Since then the program has opened a second location, and regional assignments ensure that PHS can continue to develop the program's capacity over time.

Piedmont's Recommendations:

Pre-Education:

In building the program from scratch, PHS learned some lessons about implementation. One lesson learned was the value of pre-program education. Joining the National PACE Association as an exploratory member was a huge help for PHS, giving the leadership access to education, examples, and experts to help their decision-making. Brian emphasized the importance of engaging in the feasibility study prior to opening the first site, as it showed PHS the prospective service area and the potentially eligible population. PHS made the strategic decision to educate the entire organization so that the program would not be an unpleasant surprise for anyone; when the Board decided to launch the program, it was an educated decision.

State Landscape and Risk Assessment:

It is very important to take into account the state landscape, the capital outlay, and the staffing requirements. The PACE program is a partnership with the State Medicaid Agency and each PACE program works with a specific region, so state landscapes matter. The capital outlay is significant, and finding partners for the funding is important. Program staffing is significant as well: if the average provider ratio is one provider per 1,200 to 2,000 patients, in the PACE program it is one provider to 85 patients. Staffing is also incredibly important in terms of risk management. PHS maintains a re-insurance plan to balance the PACE program's risk level and generally aims for a 3% operating margin, but from its initial experience, PHS learned that a leaner staff could raise risk factors and lead to caregiver burnout.

Partnerships:

Partnerships are a crucial factor in a successful PACE program and seeking regional foundations and organizations for funding, consulting and collaboration is very important. In addition to serving as contractors for services, resources like Senior Centers, Hospitals, Rehab facilities, and other organizations are very helpful for the all-encompassing, comprehensive level of service required under the PACE program. Not to be forgotten, internal referrals and services are a significant help to the program as well. Community Health Centers are very well placed to have a PACE program; they are already in a primary care model and can draw on internal patients and services as the programs is established.

Commitment:

Finally, making the commitment to do the program right is vital. Health Centers are often the first responders in healthcare issues, and tackling the cost and quality of care for aging populations is today's issue. The PACE program tackles that challenge, excites providers and raises satisfaction. PHS hired a full-time employee to oversee the development of the PACE program, educated its leadership and took steps to balance the risk of the program. The result of PHS' commitment to doing it right is a strong, qualitative and cost-effective program serving a growing number of patients in five North Carolina counties.

This document was produced by the National Association of Community Health Centers.

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