The program of All-inclusive Care for the Elderly (PACE) is a community-based, long-term care model designed for older adults that are nursing home eligible. Bound by original design and regulations, these programs have primarily utilized a center-based (“staff”) primary care physician model. However, some believe that this might hinder expansion of the PACE model.

In response to this concern, three PACE programs have explored the use of “community-based” primary care physicians (CBPCPs). In an attempt to evaluate the impact of this variation in the model, we surveyed the medical director, 2 community-based primary care physicians and 6 non-physician staff members at one of these sites.

Responders generally support the use of CBPCPs as a useful and productive alternative way to expand PACE services to a wider audience of eligible patients. Because some staff members perceive that CBPCPs utilize hospital and NH services at a higher rate, continued education of both CBPCPs and staff members regarding the expectations from this relationship is needed.

Keywords: Program of all-inclusive care for the elderly; primary care physicians

Over the past few decades, several innovations have been introduced to address the health and social concerns of the frail elderly. In an attempt to control costs while providing needed long-term care services to this population in the community, the Centers for Medicare and Medicaid Services (CMS) have supported nursing home alternatives such as the Program of All-inclusive Care for the Elderly (PACE). Like other community-based alternatives, PACE programs must comply with eligibility criteria to ensure that the highest-risk portion of the elderly, “nursing-home eligible” population is served. Although the Balanced Budget Act of 1997 mandated that expansion of such programs should be a priority, there has been slower growth in overall enrollment than anticipated.

By integrating all necessary aspects of patient care and financing, PACE programs strive to maintain nursing-home eligible older adults in the community. PACE provides medical, home care, and significant social support to frail older adults while empowering patients’ families to be successful caregivers. The goal of this program is to provide cost-effective and quality medical care while decreasing admission to hospitals and nursing homes. PACE centers are staffed by physicians, nurses, social workers, rehabilitation therapists, and other ancillary staff necessary to provide “all-inclusive” care. The importance of these interdisciplinary teams is underscored by the finding that PACE programs that have higher “team performance scores” have been shown to have significantly better functional outcomes among participants (both short and long term).

The PACE model received permanent provider status under the Balanced Budget Act of 1997. In the same legislation, Congress mandated that PACE services be extended to more frail elderly. There have been a number of barriers to expansion of PACE services, including start-up costs associated with opening new PACE sites as well as a limited supply of qualified physicians to provide care for medically complex and frail older adults. In addition, the reluctance of potential participants to change physicians has been identified as a barrier to enrollment in PACE.

Congress and the National PACE Association (NPA) have supported the expansion of PACE services by allowing for...
SIGNIFICANCE OF THE PROBLEM

There are no data that compare outcomes between PACE patients who receive care from staff physicians versus community-based physicians. Expansion of PACE services has been slow, with only 34 sites in operation (as of 2007) serving approximately 14,000 participants. It has also been suggested that some of the fundamental features of PACE programs may contribute to the slow expansion of the program. A specific example is that some potential participants may not be interested in giving up their personal physician in order to join the program.

Currently, 3 PACE programs use community-based primary care physicians (CBPCPs) to provide medical care to some of their PACE participants, or in a parallel, “PACE-variant.” One of the potential benefits of using CBPCPs is to serve patients who are reluctant to leave their primary care physician. Using the services of CBPCPs provides the potential benefit of increasing the number of PACE participants with-}

1. Compared to traditional PACE physicians, CBPCPs admit patients to the hospital:
   - Less often
   - Just as often
   - More often
   - N/A

2. Compared to traditional PACE physicians, CBPCPs admit patients to long-term care facilities:
   - Less often
   - Just as often
   - More often
   - N/A

3. Compared to traditional PACE physicians, CBPCPs are accessible to answer questions related to the care of their PACE patients:
   - Strongly Disagree
   - Agree
   - Neutral
   - Agree
   - Strongly Agree

METHODS

Tool

Surveys were created to evaluate the experience of various staff members who work within the 3 PACE sites that use traditional PACE staff physicians as well as CBPCPs. A survey was created for each of the following categories of staff members: PACE center director, PACE medical director, PACE staff members (nurses practitioners, nurses, social workers, therapists), and PACE community-based primary care physicians (CBPCPs).

The surveys allowed for general comments regarding the overall experience of CBPCPs working within PACE. Figure 1 shows 3 questions asked to specifically compare the perception of hospital and long-term care admission rates of CBPCPs relative to traditional PACE staff physicians, as well as the interdisciplinary team’s perception of CBPCPs’ accessibility relative to traditional PACE staff physicians.

Additional questions were posed regarding the PACE staff members’ experience working with CBPCPs. The CBPCPs themselves were asked questions regarding their experience working with the PACE model of care. They were also asked how their actual experience compared with their anticipated expectations of the experience.

Study Population

Although staff members from all 3 sites mentioned above were asked to participate in the survey, only staff members from 1 site were able to participate. Although the other 2 sites were unable to participate in the survey process, they were able to provide general descriptive information regarding their sites.
Human Subjects

This project was granted exemption from full review by the Institutional Review Board of Johns Hopkins Medical Institutions.

RESULTS

Nine of the 15 surveys were returned (response rate 60%). These included the medical director, 2 CBPCPs, and 6 non-physician staff members.

General Remarks

Medical Director (n = 1 Response)

The medical director has considerable experience working with the PACE model and was “very satisfied” with the overall experience. The medical director views the use of CBPCPs with “some concerns,” but would recommend continuing the use of CBPCPs at PACE programs. The strength of use of CBPCPs was attributed to the patients’ ability to retain their PCP. In addition, it was felt that the use of CBPCPs allows for greater “community awareness of PACE.”

The medical director identified specific areas for improving the use of services from CBPCPs, including greater emphasis on decreasing resource use and hospitalization and increasing the efforts of the interdisciplinary team for care coordination. The likelihood of nursing home admissions were viewed as equivalent for CBPCPs compared to traditional PACE physicians.

Of note, the quality of medical care at this site is assessed through peer review of charts. It was reported that the same method is used for CBPCPs and traditional PACE physicians. According to the medical director, the “quality of care provided by CBPCPs has been as good as [care provided by] staff physicians.”

Community-Based Primary Care Physicians (n = 2 Responses)

These practitioners reported a “positive experience” and feel that participating in the PACE model of care has allowed them to effectively use community resources to provide care that has prevented hospitalizations and nursing home admissions for some patients. They feel that they are receptive to the interdisciplinary team’s input. One CBCP commented that the current operational infrastructure of the interdisciplinary team could be better: “contact is too infrequent, sporadic . . . Suggestions for improvement/changes are considered but very slowly.” This same CBCP commented that the interdisciplinary team could work more effectively by “[streamlining] information or [allowing] Web-based access to all reports and assessments/recommendations of each part of [the] care team.”

PACE Staff Members (n = 6 Responses)

When comparing CBPCPs to traditional staff PACE physicians in evaluating the likelihood of admitting patients to hospitals, 2 responded that CBPCPs were more likely to admit patients, 2 felt that CBPCPs were just as likely to admit patients, and 2 were nonresponders. Four staff respondents viewed CBPCPs as not being as receptive to the interdisciplinary team’s input as staff physicians.

The responses regarding prevention of long-term care admissions were equivocal with approximately half agreeing and the other half disagreeing that the use of CBPCPs prevents long-term care admissions. Regarding nursing home (NH) admissions, 3 staff members responded that CBPCPs were just as likely to admit participants to NHs for long-term care, while 1 respondent felt that CBPCPs were more likely to admit to long-term facilities; there were 2 nonresponders.

When comparing CBPCPs and traditional staff PACE physicians with regard to accessibility to the interdisciplinary team for patient care questions, 5 responders reported that CBPCPs were less accessible, 1 responder felt that CBPCPs were accessible, and there was 1 nonresponder.

Specific remarks from team members included: “. . . understanding of team approach and communication of CBPCP (to) team . . . not effective to maintain participants in the community, limit hospitalization. Communication is limited when CBPCP takes the main role of communication with team and outside agencies, eg, nursing home, hospitals, on-call medical service.”

DISCUSSION

This survey, despite its limited sample of responses, indicates that a culture change may be necessary to open the PACE model to include CBPCPs. The culture change does not appear to involve concerns of effectiveness of medical quality of care or resource use; the medical director believed that the quality of medical care was equivalent and that the use of CBPCPs within PACE should be continued. Rather, the culture change concerns the building of effective communications between CBPCPs whose primary practice is not PACE and the PACE center–based interdisciplinary team.

Survey responses from nonphysician staff members did indicate that many felt staff physicians were more accessible to the team than CBPCPs, thereby enabling easier communications on day-to-day patient care. It would be expected that staff physicians who spend more time at the PACE center may be more familiar with the skills of the staff, making them more comfortable keeping patients under observation at facilities rather than admitting to acute-care hospitals. Indeed, it has previously been shown that patients receiving care within the PACE model had lower hospital and emergency room use than those patients participating in the Wisconsin Partnership Program, which uses community-based physicians.10 However, it is possible that as CBPCPs continue to participate in this care model, they become more familiar with using the resources available to them to prevent hospital and NH admissions.

From this information, it appears that optimizing the use of CBPCPs should focus on providing guidance and encouragement to these physicians on maximizing communication with the IDT to optimize the use of nonhospital and non-NH settings for care, when appropriate. The “infusion” of these important aspects of the PACE philosophy into a non-PACE office practice may be the primary challenge for the successful use of CBPCPs. This might ultimately be achieved by con-
continuously promoting the key aspects of the model, as well as intensive “seminar” approaches that have been used by 1 PACE site to educate professional students of all disciplines.11

In addition to addressing the skills and practice style of CBPCPs to conform to the PACE model, it may also be necessary for the PACE model and staff to adapt to CBPCPs. If using non–center-based physicians allows for more rapid expansion of PACE, which allows these services to reach more frail older adults, then such adaptations might be appropriate.

CONCLUSION

These survey findings provide important insight regarding the limited use of CBPCPs within the PACE model, particularly given the absence of other objective data. Although interpretation of these responses is hindered by the small sample size, it is reasonable to view the use of CBPCPs as one potentially effective mechanism to expand PACE services to a wider audience of eligible patients. Because some staff members perceive that CBPCPs use hospital and NH services at a higher rate, continued education of both CBPCPs and staff members regarding the expectations from this relationship is needed. Importantly, it is necessary to address the difference in how CBPCPs perceive their participation compared to the staff members’ perception of them.

Future studies will be needed that provide objective data such as actual hospital and NH admission rates for CBPCPs and traditional staff PACE physicians to compare the 2 groups and further explore the perceived trends noted above. It would also be informative to compare staff and community-based physicians with regard to patients’ and caregivers’ satisfaction with care. Such information would be useful to payers of care such as Medicare and Medicaid whose support is critical to future growth of PACE.

REFERENCES