

Contract No.: 500-00-0033 (01)  
MPR Reference No.: 8830-600

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**How Integrated Care  
Programs Use  
Community-Based,  
Primary Care  
Physicians**

*Final Report*

*May 8, 2006*

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Submitted to:

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## **A. BACKGROUND**

The Program of All-Inclusive Care for the Elderly (PACE) is designed to provide integrated health care and health-related support services to frail, elderly, nursing home eligible beneficiaries. Care is managed by an interdisciplinary team, and many program services are provided at a PACE day care center. PACE programs receive capitated payments from both the Medicaid and the Medicare programs to provide this all-inclusive care, and beneficiaries who are eligible for Medicare but not Medicaid can enroll if they pay the Medicaid capitated rate. When Congress made PACE a permanent part of the Medicare program and a Medicaid State Plan option as part of the Balanced Budget Act of 1997, it established the PACE model, but gave the Secretary the flexibility to modify or waive provisions of the PACE Protocol “as long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives and requirements” of the PACE legislation (*Federal Register*, vol. 67, no. 190, p. 61497).

In 1999, CMS issued a regulation that permitted rural or tribal PACE organizations to request flexibility to modify aspects of the PACE regulation such as utilization of community-based primary care physicians. This waiver authority was restricted to use in rural and tribal areas where CMS wanted to encourage the development of PACE programs. However, after the regulation was issued, CMS learned that some of the original PACE sites had used the flexibility clause in the Protocol to use community-based primary care physicians.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) modified PACE to grandfather the modifications that programs had implemented as of July 1, 2000, including the use community-based primary care physicians. Furthermore, it allowed for a waiver process so that established PACE organizations can receive CMS authorization to use community-based primary care physicians. This paper describes how

organizations that have the authority to use community-based primary care physicians are doing so.

### **1. What are community-based primary care physicians?**

The PACE regulation requires that the PACE interdisciplinary team include each participant's primary care physician. To qualify as a PACE primary care physician, a physician must be able to practice medicine in the state, must participate in the Medicare program, and must have one year of experience working with a frail or elderly population (Section 460.64). Primary care physicians are responsible for managing the participants' medical situations and overseeing the use of specialists and inpatient care (Section 460.102).

The PACE regulation also requires that this physician serve primarily PACE participants (and, thus, in most cases be employed by or contract primarily with PACE). By contrast, a community-based physician serving a PACE participant is responsible for managing the participant's medical care, but is not employed by the PACE program and has more than a few non-PACE patients in the community.

While the primary care physician is responsible for managing the participant's care, he or she is by no means the only physician caring for the participant. PACE programs routinely contract with physician specialists to care for their participants. PACE-employed physicians will care for each other's patients in circumstances when a PACE physician is unavailable. (For example, when a primary care physician is on vacation.) And the PACE Medical Director, who is responsible for delivery of all participant care and clinical outcomes, is ultimately responsible for the care provided.

## **2. Why allow PACE to use community-based primary care physicians?**

The PACE program, while it is growing, is still serving a very small number of beneficiaries. According to the National PACE Association, enrollment in January 2005 stood at 10,523 [[www.npaonline.org/website/article.asp?id=71](http://www.npaonline.org/website/article.asp?id=71)]. While a number of factors have contributed to the slow growth of the program, the fact that potential participants do not want to give up their own physicians in order to enroll in PACE is a hindrance to growth. Research has shown that the requirement that participants give up their own physician is very unattractive, and it is one of the major reasons beneficiaries opt not to enroll in the PACE program (Coulam and Dorsey 1996; Grosse et al. 2004). As one of the early advocates of allowing PACE to include community-based primary care physicians noted, “These are frail, sick people. To tell them that they have to give up their relationship with a doctor they know and trust, just so they can avail themselves of our services, seems cruel.” If beneficiaries are allowed to use their own community-based primary care physicians, they can both retain their physicians and enroll in PACE.

A second reason to allow PACE to include community-based primary care physicians is to make the model viable in rural areas, which typically do not have large numbers either of potential enrollees or of physicians. In rural areas, it may be infeasible to have a physician dedicated to just a small number of enrollees, or to expect that physician not to have a community-based practice, especially when there is a shortage of physicians in the area.

On the other hand, CMS is concerned that community-based physicians, who may not embrace the PACE philosophy or may not want to work with the programs’ interdisciplinary teams, may compromise the quality of care that a PACE program provides. Without a dedicated physician, the PACE interdisciplinary team may not have access to the health care information it needs to deliver fully integrated, coordinated care.

### **3. Purpose of this report**

For an understanding of how community-based physicians might affect PACE programs, this report documents how these physicians participate in the only two PACE programs, On Lok in San Francisco and Comprehensive Care Management [CCM] in New York City, that used them at the time sites were selected. We also document how the Community Health Partnership in Eau Claire, Wisconsin—a member of the Wisconsin Partnership Program – uses community-based physicians. As detailed in the next section, the Wisconsin Partnership was designed from its inception to work with community-based physicians. Thus, we included the Partnership to demonstrate how community-based physicians may be implemented differently if it was considered an integral part of the model, instead of a variation of the model as it is in the two PACE sites.

We conducted one-day site visits to each of these three programs in fall 2005 and spoke with the site administrator, the medical director, the fiscal director, care team members, and staff members who play important roles in implementing the community-based physician model at their site. (For example, in CCM, we interviewed a nurse whose role is to recruit community-based physicians; at On Lok, we interviewed the physician who attends the center where the community-based physicians oversee patients.) We discussed with the administrative staff what the health care environment was like in their area, why they chose to use community-based physicians, and how they managed the physicians. With the staff, we discussed how patients received care from community-based physicians and how working with community-based physicians affected their jobs.

### **B. PROGRAM BACKGROUND AND STRUCTURE**

It is important to understand why these sites chose to use community-based physicians, since the factors contributing to their adoption are likely to affect how community-based

physicians are implemented. Community-based physicians were not specified in the original PACE protocol, so each of the sites we visited was thinking “outside the box” when it chose to incorporate this practice into its model. If they had adopted the model because of a unique set of circumstances that are unlikely to occur at other PACE sites, then aspects of the model that we observe here may not be relevant for adoption at future PACE sites.

### **1. Why these programs adopted community-based physicians**

CCM in New York, the largest PACE organization in the country with 1,500 patients enrolled as of January 2005, has worked with community-based physicians since the early 1990s, when it was a demonstration program. The program, which was the first to introduce the concept, did so because “it just never made sense to us not to have community-based physicians.” While the program does have its own physicians, staff felt that patients who had an established relationship with a physician should be allowed to keep that physician, and hence the program used the flexibility provision in the PACE demonstration protocol and adopted its model so it could work with community-based physicians.

On Lok, which is the third-largest PACE organization (with 907 patients as of January 2005) and the originator of the PACE model, first used community-based physicians in 2000 in an effort to diversify the ethnic groups that it served. The program wanted to expand into new neighborhoods and serve different communities, and felt that working with trusted physicians in those communities would be the best way to make that inroad. On Lok was unaware at that time that it could not make these arrangements without violating the PACE protocol. Once informed by CMS that it was in violation, it stopped using those physicians. However, a second opportunity arose when a religious order (the Sisters of the Holy Family) asked On Lok to develop a PACE program that would serve their community and another religious order (the Dominican Sisters of Mission San Jose). One stipulation, however, was that members of the

orders continue to use the two physician practices that had served their communities for many years. On Lok worked with CMS to obtain the waivers to use community-based physicians and implemented the new program site, which served the two religious orders exclusively.

The Community Health Partnership (CHP) program in Eau Claire was designed from its inception to work with community-based physicians. (Because it is not a PACE site, it is not bound by the PACE protocols and regulations.) The CHP program, which began in 1996 as a CMS demonstration for dual-eligible beneficiaries, was designed to test a model of integrated care that was based on the PACE model but differed in two important ways: first, it used community-based physicians, and second, care is centered at the home instead of at a PACE center (Wisconsin Department of Health and Family Services 2000). These model changes were key for implementing the program in Eau Claire, a rural area where physicians are in short supply and travel distances make a day care center infeasible. CHP does not employ any doctors to provide patient care, but it does have a medical director.

## **2. How the care teams are structured**

All PACE programs are required to have an interdisciplinary team to comprehensively assess and meet the individual needs of each participant, consisting of a primary care physician, registered nurse, social worker, physical therapist, occupational therapist, recreation therapist or activity coordinator, dietitian, PACE center manager, home care coordinator, personal care attendant (or representative) and a driver (or representative) (Section 460.102). The two PACE sites, however, adopted different approaches to team formation, and the Partnership Program has a different team structure altogether. These differences may contribute to the ability of the team to work with a community-based physician.

The interdisciplinary care teams at CCM are formed around individual patients, with a nurse as the team coordinator. Unlike many other PACE programs that have one team that takes care

of a group of people, the CCM team changes for each patient, including the professionals who can best meet that particular patient's needs. On occasion, the best people include a staff member whose home PACE center may be in a location different from the one the patient attends, so it is not unusual for team members to work with a staff member from a different PACE site. Thus, interdisciplinary team members are used to working with staff—including physicians—who are not necessarily working at the same physical location.<sup>1</sup> Since the program is in New York City, some of the PACE sites are relatively close, and traveling between PACE sites is not as burdensome as elsewhere.

At the On Lok site that uses community-based physicians, one interdisciplinary team takes care of 65 nuns. This interdisciplinary team works exclusively with the two community-based physician groups to care for the participants. The community-based physicians serve as the PACE primary care physicians—managing the participants medical situations and overseeing the use of specialists and inpatient care. However, On Lok supplements these physicians by employing a physician who works at the center three days a week. This PACE staff physician plays two key roles. First, the physician provides clinical support to the PACE team, explaining clinical issues to the team that may affect care-giving decisions. Second, the physician provides urgent care to the participants when they attend the PACE Center.

In the CHP, the core patient care team (consisting of a registered nurse, a social worker, and a team assistant) is formed to work together to serve a panel of patients. For each patient they serve, a nurse practitioner works with the team on a patient-by-patient basis. The nurse practitioner, who is assigned based on the physician practice the patient uses, serves as the main liaison between the team and the physician. Each nurse practitioner works with 5 to 7 physician

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<sup>1</sup> Note that CCM has a number of sites, but when teams form across sites, the members are generally from neighboring sites.

practices. This is a recent change, however, as the nurse practitioner had been a part of a patient care team and cared for the same panel of patients that the care team did. However, in the past year CHP decided that having one nurse practitioner work with each physician office would improve communication between the care teams and the physicians. Thus, the nurse practitioner now works with multiple care teams.

### **C. HOW DO THE PROGRAMS WORK WITH COMMUNITY-BASED PRIMARY CARE PHYSICIANS?**

Before examining how the PACE programs work with community-based physicians, it is important to understand how PACE physicians work within the programs. This will allow us to understand how practices differ when community-based physicians are introduced.

At both On Lok and CCM, the PACE physicians practice out of the PACE centers. They attend team meetings, and informally interact with center staff. New physicians learn how to work with the teams in different, but similar, ways. At CCM, newly employed PACE physicians apprentice with a physician with more PACE experience to learn how to work with the interdisciplinary team, and in particular, how to encourage team participation and not always try to lead the meeting. At On Lok, the program works hard to hire PACE physicians who have the ability to work well with a team. Once these physicians are hired, the program immerses them in the practice and has senior physician staff teach them how to work with the team. Staff who work with PACE physicians acknowledge that some physicians communicate better than others, but in general, they are satisfied with the communication.

#### **1. How do the programs recruit community physicians and educate them about their program?**

The community-based physician model requires that the programs recruit primary care physicians and educate them about how the integrated care program works. However, we found

that none of the sites recruit physicians directly. At CCM and CHP they recruit patients, and then try to establish working relationships with those client's physicians. At On Lok, it was a joint decision to build the center to care for the religious orders and use the nun's physicians to oversee their health care.

When intake workers at CCM identify a potential client who wants to enroll but does not want to "give up" his or her own physician, the program will ask the patient's physician whether he or she is willing to work as a community-based primary care physician for CCM. The program has a designated nurse who contacts the physician, explains the CCM program, and provides literature about the program. The physician is invited to the PACE site to observe the program and learn more. Should the physician choose to join the PACE program as a community-based physician, he or she signs a contract with CCM, and the patient is enrolled in the PACE program. If the physician chooses not to sign a contract, then the client is again offered the option of enrolling in PACE and using a PACE-employed physician or not enrolling.

The CHP program, which does not employ any of its own physicians, must contract with and engage with the patients' community physicians. In the Eau Claire area, there are two major health systems that have a large number of physicians under contract, as well as a third group of "independent" physicians who have formed their own group practice. These three organizations do not allow individual physicians to sign independent contracts—the decision as to whether to participate is made by the organization. Since all three organizations have signed contracts with the CHP, virtually every physician in the area has agreed (if indirectly) to work as a CHP physician. Thus, when a patient chooses to enroll in CHP, that patient's physician automatically becomes a primary care physician for the program. At the time the patient enrolls in CHP, the nurse practitioner who is assigned to work with that physician group tries to meet with the physician to understand the physician's goals for managing the patient's care, to conduct a

medication review, and to explain the CHP program. However, as a result of their busy schedules, many physicians have chosen not to have this meeting; instead, they meet the nurse practitioner when the nurse practitioner accompanies the client on an office visit.

On Lok is not actively seeking new community-based physicians, as the same two group practices are still caring for the religious orders. Since the community-based physicians have been working with PACE for four years, participating in team meetings and working with the team, the staff felt that these physicians now understand the PACE model and program goals.

The two PACE sites both pay a premium (over regular Medicare) to the community-based primary care physicians for PACE patients—giving the physicians a financial incentive to contract with them. CCM pays a monthly stipend to community-based physicians for each patient they have, and pays the full Medicare fee for all visits and procedures. On Lok pays the community-based physicians a 20 percent premium over the Medicare fee. Both sites indicated that they wanted to ensure that physicians were compensated for any extra time they spent coordinating with the PACE interdisciplinary care team. CHP pays the Medicare fee to their physicians, but staff firmly believe that the program saves the physician time, and thus the Medicare fee is appropriate. None of the sites ask the physicians to share financial risks for any patients.

Finally, one important difference in the CCM model is that while many patients enroll in PACE with their own primary care physician, many, over time, choose to switch to the PACE physician. At any time, only 3 to 5 percent of CCM's patients have primary care community-based physicians, although many more entered the program with them. The site attributes the switching to two factors. First, when the clients see the PACE physicians at the centers and note how easy it is for other patients to visit with them, they understand the benefits of using a PACE physician, and their concerns about changing doctors are allayed. Second, some physicians who

initially agree to participate come to realize that they prefer not to care for these patients, and this encourages the patients to consider changing to the PACE physician.

## **2. How are routine physician visits arranged and results communicated?**

If the programs are to provide integrated care, they must have timely information about the physician's treatment plans and the patient's health status. Thus, communicating with the community-based physicians is critical. One key to ensuring that this communication occurs is to know when a physician is seeing the patient, so the team can follow up if the physician has recommended a change in treatment.

CCM arranges physician visits for patients using community physicians. Patients have the incentive to let CCM arrange those visits, since CCM will also arrange for transportation to and from the physician visit, and will arrange to have an aide accompany the patient if the team feels it is warranted. As a result, the PACE team always knows when a physician visit is scheduled. The team nurse is responsible for contacting the physician following the visit (if the physician doesn't make contact first) to see whether there are any changes in the patient's treatment plan. The nurse will act on verbal orders from the physician to change the treatment plan. At the same time, the CCM medical records group will automatically contact the physician's office to get the physician's notes and written documentation of any changes in the treatment plan. The physicians' offices, who are accustomed to providing information to managed care plans as a prerequisite to getting paid, are generally very good about faxing or sending the materials, and most of the information arrives the next day. However, for some physicians it will take a few weeks to obtain written information for the records.

CHP team members depend on patients to tell them about upcoming physician visits, and the majority of patients do so. In addition, the team nurse or social worker calls the patient every month and asks specifically about any upcoming appointments. If the appointment is something

other than a routine visit (for example, if it's the first visit with a new physician, if the patient's health status has changed, or if a team member has some concerns about the patient), the nurse practitioner will attend the visit with the patient. The nurse practitioner is then responsible for communicating the information from the doctor to the patient team. Doctors, however, often call the CHP team to discuss issues; the doctor usually calls the nurse practitioner (if he or she didn't attend the visit) but sometimes calls the social worker or other staff such as the physical therapist. Most physicians' offices fax over the notes the day after the appointment, but some do not send the paperwork for 4 to 6 weeks.

At On Lok, the nurse on the patient care team arranges the patient visits, which can take place at multiple locations. If the visit can be planned on a day when the physician is at the PACE center for a care-planning meeting, the staff will arrange for the participant to come to the PACE center when the doctor is there for the appointment. At other times, the PACE program will make an appointment at the physician's office and arrange transportation. (The religious orders themselves have assigned each frail member a "health care partner" who knows the patient's health history and accompanies the patient when she goes to the hospital or other outside health care appointment.) In these cases, the nurse will follow up with the doctor about any changes in treatment (although the doctor typically calls the nurses first). Physicians typically send visit notes in 24 to 48 hours. Sometimes, the physicians travel to the convents to see patients. When these visits are planned, the nurse routinely follows up with the physician; if the visit is unplanned, the program depends on the physician to contact the team nurse.

The PACE center that serves the two religious orders also has a PACE-employed physician who is at the center on a part-time basis. This physician sees patients at the center if the need arises while the client is at the center, and enters the visit notes directly into the patient's record. The PACE physician then calls the community-based physician to report on any changes in

health status and offers the community-based physician the opportunity either to see the patient or simply to discuss the issue and make decisions based upon that information.

### **3. How is information about emergency and in-patient hospital care communicated?**

In all life-threatening emergencies, patients at all three sites are told to call 911 to get immediate help. But short of such an emergency, PACE enrollees are supposed to call the PACE triage staff for after-hours urgent care. A patient who is using a community-based physician might instead call that physician directly, and the PACE team might thus be uninformed of the patient's health problems at a critical juncture.

Communication about emergency and inpatient care does not appear to be a significant problem for patients using community physicians at the PACE sites. In CCM, staff report that they focus on educating the patients to call the PACE triage staff, not their physician, in urgent care situations, and in most cases the clients do call the PACE triage staff. If the PACE triage staff recommend that the patient go to the hospital, they so inform the community-based physician. Staff noted that some of the community-based physicians give patients their cell phone numbers, and patients sometimes call the doctors directly instead of first calling the PACE triage staff. However, none of the staff recalled that any doctor had ever sent a patient to the hospital without contacting the PACE program either at the time or the next morning. Since PACE requires that the physician contact the plan within a short period of time after the commencement of emergency services in order to ensure payment, the physician has the financial incentive to notify the program of a patient's emergency care.

At On Lok, the religious orders usually do call PACE triage staff in urgent care situations. However, on occasion the order has contacted the community-based physicians directly and the patients were sent to the hospital. In those cases, the physician or the religious order (usually both) contacted the PACE team nurse the next morning. Furthermore, since the sisters live in

congregate, the PACE home care provider was notified the next day when he or she came to care for the patient. The team nurse noted that she typically received multiple notifications of a patient's being sent to the hospital and could not recall a case where the PACE team had not been informed.

In the CHP model, the local hospitals have an automated system that informs CHP each morning whether any of their patients were admitted during the evening or visited the emergency room. This information is given to the nurse practitioner each day.

Once a patient is admitted to the hospital, the physician who oversees care for that patient varies across the programs. In the New York area, many hospitals have "hospitalists"—physicians who care for patients only in the hospital. CCM staff believe that these physicians are the best providers of hospital care because they know the hospital and can get things done for the patient. So regardless of whether the patient's physician is PACE or community-based, in many cases, the hospitalist oversees the care. However, the PACE or community-based physician still oversees care provided by the hospitalist.

If a hospitalist is not used, the community-based primary care physician oversees the patient's care just as a PACE-employed physician would. Regardless of who oversees the care, the nurse from the patient's interdisciplinary team and the PACE physician who makes rounds at that hospital will visit the patient. These visits have two functions: (1) to obtain information about the patient's health status so the team can be ready upon discharge, and (2) to advocate for the patient and make sure the patient is getting high-quality care. One staff member noted that "a hospital is a great place to get treatment, but it's not a good place to get well." The PACE staff feel that if someone advocates on behalf of the patient, the patient will receive more timely care.

At On Lok, when members of the religious orders are admitted to the hospital, the community-based physician oversees the care. The nurse from the home care team is

responsible for seeing the patient in the hospital, obtaining information about changes in the patient's health care status, and identifying changes that will be needed in the patient's care plan after discharge.

In CHP, the community-based physician oversees the patient's care in the hospital. The nurse practitioner from the patient's care team visits the patient in the hospital to learn health status and to start the discharge planning process so the appropriate services can be available upon discharge.

#### **4. How is care rendered in the nursing home communicated?**

All three programs continue to serve patients who are admitted to a nursing home. PACE is still responsible for the care the patient receives, and communication with the patient's physician can still be important for overseeing that care.

PACE physicians care for patients in nursing homes, however, the PACE physician does not necessarily follow all of his or her patients once they enter a nursing home. Because CCM tries to offer a great deal of patient choice, and it is a large program, patients sometimes choose nursing homes that are quite a distance from their original PACE center. For example, a patient who is enrolled at the PACE center in Manhattan may choose a nursing home in Westchester County to be closer to a family member – a distance of over 30 miles. As a result, the same PACE physician cannot realistically continue to care for that patient.

Thus, a PACE participant who has a PACE-employed physician could, after entering a nursing home, have one of three different primary care physicians: (1) the same PACE-employed physician as he or she had before entering the home, (2) a different PACE-employed physician, or (3) a nursing home specialist physician. A nursing home specialist physician is akin to a "hospitalist"—a physician who specializes in taking care of the patients in that nursing home.

A PACE participant who has a community-based primary care physician essentially has the same set of possible primary care providers, except that he or she may be cared for by their community-based physician if that physician agrees to do so. At CCM, some community-based physicians do not care for patients in the nursing home. According to the CCM staff, many community-based physicians do not continue to care for their patients once they enter the nursing home because there are many nursing homes in the community, and it is difficult for a community-based physician to conduct rounds at all the different homes where their patients reside. In these cases, the care is either taken over by a PACE-employed physician, or a nursing home specialist physician.

Regardless of who the primary care physician was, a PACE physician who makes rounds at the nursing home, as well as the patient's interdisciplinary team nurse, will visit the patient in the nursing home. As with a hospitalization, the goal of the visits is not only to keep informed about the patient's health, but also to advocate for the patient.

In CHP, the community-based physician continues to oversee the patient's care when a patient is admitted to a nursing home. The team's social service worker may still have an active role to play in overseeing income benefits for the client, and the client is regularly visited by the nurse practitioner.

On Lok has had only one member of the religious order admitted to a nursing home. As a result, they didn't have any real experience to report. Given the living situation of the religious order and their commitment to try to care for their members at home regardless of their level of need, they don't anticipate that the community-based physicians will be overseeing care in nursing homes.

## **D. HOW DO PROGRAM STAFF PERCEIVE WORKING WITH COMMUNITY PHYSICIANS?**

One of the key features of the PACE program is the delivery of care by an interdisciplinary team, and the primary care physician is part of that team. If staff perceive that working with community-based physicians is more difficult or less fruitful, then care may not be as integrated with a community-based physician as it is with a PACE-employed physician.

### **1. How does the team work with a community-based physician?**

Using community-based physicians could alter the PACE program by changing the way the interdisciplinary team operates. In particular, one might wonder whether the community doctors will work as well with a team as committed PACE physicians, or whether there will be more conflicts with a doctor who is not as engaged in the PACE way of doing things. We asked program staff their perceptions of working with community physicians.

Staff in all three sites agreed that physicians in general—regardless of whether they are employees or based in the community—are not trained in medical school to be part of a team. “Physicians are trained to be confident and to make their own decisions—and they all have to learn teamwork when they work here.” As a result, PACE staff felt that it took anywhere from six months to two years before a PACE-employed physician truly learned how to work with the interdisciplinary team. Put in this perspective, some staff believe that working with a community-based physician is really no different from working with any new PACE-employed physician. Staff at On Lok, who have worked with the same two physicians’ groups since 2002, believe that working with those physicians succeeds as well as it does with any of the PACE-employed physicians.

At all three sites, nurse managers lead the team meetings, so team meeting leadership is the same regardless of whether or not the doctor is community based. At On Lok, the physicians

attend the team meetings. However, at CCM and CHP, community doctors are invited to attend team meetings, but few choose to do so. The team nurse (CCM) or the nurse practitioner (CHP) conveys the information to and from the physician in these cases, and staff at these programs feel that they did have the medical information they needed to make decisions.

Staff at On Lok did not identify any significant conflicts with their community-based physicians, but CCM and CHP did indicate that conflicts have occurred. As one staff member at CHP stated, “The reality is there are no right answers. If you have three people, there can be three right answers—that is the value of what we do.” Staff at CCM did not feel that the conflicts arose with community-based physicians any more frequently than with PACE physicians.

When asked what kinds of conflicts usually arise with community-based physicians, a few staff gave examples where the doctor wanted to do something and “get it over with.” For example, one team member related how a patient had become recently unstable, and the physician wanted to admit her to the nursing home. The staff had to convince the physician that the patient could be safely cared for in the home. In another case, the physician wanted to approve a portable scooter that the patient wanted. But the team had been to the home and knew that the scooter would not function there and would not be safe for the patient. In the end, the physician was happy that the team had provided that information to him.

We asked staff who had worked with both a PACE and a community-based physician whether they perceived any differences in the flow of patient information between the physicians and the program. They responded that, in general, it was easier to walk down the hall to speak with a physician than to pick up a phone and call, and all else equal, they would prefer in-person contact. However, they noted that they did not always get information faster from a PACE physician than they would from a community-based one. Many of the same issues (such as

being too busy) can keep both a PACE and a community-based physician from completing paperwork or contacting the other members of the PACE team. But staff all agreed that they always had the information from both sources in time to make decisions about the patient's care plan. Furthermore, many staff noted that most of the issues the team has to address in the patient's care plan are not dependent on information from the physician—a lot of the issues being addressed involve issues of personal care and home environment. Finally, staff at CCM noted that they could have the PACE physician examine a patient at the PACE center if they were concerned, and the same was true on most days at On Lok. So from the staff's perspective, communication with community doctors was good enough for them to care for the patient.

Staff in both PACE sites, but in particular at On Lok, noted that changes in the way medical professionals communicate can further reduce the distinction between program-employed and community physicians. With the advent of electronic health records, team meetings—where the staff have to get together in the same room to discuss a patient—may become less and less necessary, and meetings could take place “virtually.” On Lok has recently instituted an electronic health record system, where staff can read about the latest changes in care and treatment plans for all the disciplines. The community-based physicians, at this point, can access this record only when the physician is on site. However, once it is accessible to the community-based physicians in their own offices, the entering of information into the patient's record could become as fast as with the entry by the PACE physician.

## **2. Does the PACE administration treat community physicians differently?**

One problem that could arise in a community-based physician model is that the PACE administration might treat community-based physicians differently from the PACE physicians. For example, the administration may require community-based physicians to preauthorize care

that PACE physicians do not, or subject them to different quality assurance checks, that could result in patient care differences.

In all three programs, however, we found very little administrative difference in how programs treated the community-based physicians. Both PACE-employed and community-based primary care physicians have to meet the same credentialing requirements to work for the PACE organizations, all are subject to the same quality assurance studies and utilization review studies, and the physician orders are generally not subject to prior authorization.<sup>2</sup> The medical directors at all the sites argued that physicians who treat program patients practice good medicine, and they see no reason to interfere with that process.

While the qualifications of the physicians do have to be the same, it can't be said that the physicians themselves are "the same." Both programs, when hiring PACE physicians, try to identify those who can learn to work effectively with the team. To the extent that the programs are successful in this endeavor—and consequently successful at not hiring physicians who wouldn't work well—the PACE physicians might be better suited to serve this population in the PACE environment, and this could affect the quality of care.

### **3. Do community-based physicians take an active interest in the integrated care programs?**

All three sites have some community-based physicians that are actively engaged with the program. According to staff reports, the physicians at On Lok appear to be the most engaged. The physicians from the two practices make regular visits to the PACE center, go to the center for team meetings, and contact the care teams frequently about their patients. One community physician also sits on a PACE Quality Improvement Committee.

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<sup>2</sup> At both CCM and CHP, physicians do need authorization to refer a patient to an out-of-network specialist. However, such requests are rarely made, and when they are, they are rarely denied.

CCM and CHP have some community-based physicians who are very actively involved with the team, actively seek help from program staff in managing the patient's care, and recommend other patients from their practice for the program.

However, staff at CCM and CHP acknowledge that some community-based physicians are simply not interested in the programs. The physicians (and their office staff) supply patient information to the programs as they would any other managed care plan, and actively cooperate with the program staff when approached. But they do not initiate contact with the program team members. Program staff noted that physicians seem to be interested in caring for their patient's health care needs, but they are uninterested in getting involved with addressing the patient's other needs.

Finally, a small number of physicians have been actively hostile to the CHP approach. For example, one physician repeatedly refused to allow the nurse practitioner in the room for the patient's visit and repeatedly refused to speak with the nurse practitioner. A couple of other physicians have spoken with the nurse practitioner only during patient office visits. While this has happened on only two or three occasions, it likely occurred because the program does not contract with individual physicians prior to their involvement in the program, since it is the group practice, rather than the individual physicians, that has agreed to work with the program. When the program has encountered this issue, the CHP staff do not tell the patient to change physicians. During our interviews, a staff member noted that "just because a physician refuses to participate with us, it does not mean that they practice bad medicine." Furthermore, given the competition for patients in the area, CHP does not want to be viewed as "stealing" patients. Thus, it becomes the patient's decision as to whether they want to continue in the program or change physicians.

## **E. DISCUSSION**

Although the original PACE model includes only PACE-dedicated physicians, the use of community-based primary care physicians has developed out of practicality. PACE programs that are aggressively trying to increase enrollment—two of the three largest—are the ones that have experimented with integrating community-based physicians. The CHP has established a model that works in rural areas. None of the sites had a preference for working with community-based physicians; rather, they see this as a way to achieve an important goal: to get care to more people who need their services.

The concern is that the community-based physicians will not communicate with or work as well with the PACE team as PACE physicians do, and thus the program will not be able to care as effectively for its patients. In these three sites, they have all implemented models that, based on staff's perception, address these concerns. We have not tested whether the quality of care is the same for these patients as it would be with a PACE-employed physician, and can not say that it is the same. But staff feel that they have the communication they need, and that they work well enough with community physicians to provide good patient care.

Finally, note that none of these models is a clear blueprint for how community-based physicians will be implemented if CMS were to authorize the use of community-based physicians in additional PACE organizations. Key local factors limit the generalizability of this study's findings—the unique approach to team formation at CCM, the special commitment that the physicians have to religious orders at On Lok, and the concentrated physician practices in Eau Claire each create special benefits and challenges to implementing a community-based physician model—benefits and challenges that might not be found in other areas. Indeed the On Lok experience is so unique that one could argue that it really isn't a community-physician model; but instead is more of an organization-physician model – which is likely to be replicated

only if PACE programs continue to develop programs for organizations such as religious orders and retirement communities.

Electronic medical records or other improvements in communication could change the way PACE programs operate and make the physical location of the physicians less important. Furthermore, other areas are likely to have, in their local environments, unique challenges that any PACE program would have to address to make community-based physicians work at their sites. Best practices for working with community-based physicians in PACE is likely to evolve over a long time.

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