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Challenges to Cost-Effective Care of Older Adults with Multiple Chronic Conditions: Perspectives of PACE Medical Directors

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To the Editor,

In spite of growing interest in achieving cost reduction without compromising quality in the care of clinically complex older adults, little research has been done to evaluate how accountable payment systems operate at the level of the physician. To better understand these issues, we conducted and analyzed in-depth interviews with 16 medical directors from the Program of All-Inclusive Care for the Elderly (PACE), which serves as both payer and insurer for nursing home eligible older adults who wish to maintain residence in community settings.^{1,2} Our goal was to identify challenges and solutions that PACE providers have already faced in their efforts to provide financially accountable healthcare to high-need Medicare beneficiaries.

METHODS

From a list of all U.S. PACE programs operating for at least 18 months, we approached 41 sites randomly until 16 medical directors had completed the interview via telephone. Our structured interview guide asked general questions about challenging decision areas and experiences and inquired specifically about preventive services, consultations / referrals, laboratory and radiological tests, outpatient medications and therapies, hospital activities, and palliative care. Interviews were audiotaped and transcribed for analyses. Qualitative

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analyses were conducted by the research team, according to methods approved by the Institutional Review Board of the University of North Carolina at Chapel Hill.

RESULTS

Two general types of undesired consequences can occur from provision of health care services to frail older adults with complex medical issues: unintended adverse patient outcomes and cost without benefit. Interviewees reported that adverse medical outcomes were especially common when frail patients received certain supposedly routine invasive procedures, such a knee replacement or a cardiac catheterization. Concern about cost without clear benefit was especially common around certain preventive procedures (e.g., mammography) and outpatient therapies (e.g., hearing aids, dentures).

In spite of reservations that a medical intervention may have a high risk of negative consequences, such interventions can and do happen. Our respondents identified the following four factors as frequently contributing to such decisions: (1) pressure from families, often with unrealistic, unalterable expectations regarding the patient's potential for recovery or the benefit of a therapy; (2) a "cascade" of tests, additional consultations, and other procedures that can result from actions initiated by subspecialists who do not understand the PACE philosophy and yet to whom PACE, a small organization with a limited medical staff, must refer; (3) limited expertise of PACE primary care providers regarding the management of certain diseases, with concomitant reticence to question the recommendations of consultants, especially in subspecialty areas such as chemotherapy, ophthalmology, and vascular surgery; and (4) challenges estimating and communicating the degree to which multiple comorbid conditions alter risk. Figure 1 outlines how these factors can lead to services that are potentially futile or medically inappropriate.

Strategies implemented by PACE programs to reduce the use of services with a high risk of negative consequences include: (1) strengthening the role of primary care teams in decision-making (e.g., monitoring and approving all orders for tests and procedures by consulting physicians, minimizing emergency department visits and hospitalizations through same-day home visits and frequent follow-up of acute problems, and care coordination and discharge planning during hospitalizations); (2) developing strong, ongoing relationships with patients and families (including ongoing education about the program); (3) cultivating relationships with consultants who understand the PACE model (and avoiding those who are uncooperative); (4) substituting less costly alternatives when no evidence of added benefit is present (e.g. generic medications whenever appropriate; good shoes instead of "diabetic shoes"); and (5) development and use of guidelines and protocols.

DISCUSSION

A major goal of efforts to reform US health care is to reduce cost and improve quality by minimizing wasteful and inappropriate spending.^{3,4} Since geriatric patients with multiple chronic conditions are especially costly consumers of public resources, this group is being targeted by a number of initiatives.⁵⁻⁷ Though new accountable payment models will have some differences from PACE, the challenges identified in this study and the steps

recommended to address them are likely to be largely generalizable to programs that work with older adults with multiple comorbid conditions. Key among or interviewees' recommendations include: strong primary care; aggressive case management; relationship-building with patients and families by an interdisciplinary team; a shared vision for appropriate goals of care among primary care providers, consultants, and patients and families;⁸ and decision-making guidelines that offer less costly alternatives when appropriate.⁹ Development of such systems takes time, however.²

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Figure 1.
Model of the causes and pathways leading to potentially inappropriate service authorization decisions. PACE = Program of All-Inclusive Care for the Elderly.