

Consumer Reactions to the Wisconsin Partnership Program and Its Parent, the Program for All-Inclusive Care of the Elderly (PACE)

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Purpose: To compare enrollees in the Wisconsin Partnership Program (WPP), a Program for All-inclusive Care of the Elderly (PACE) variant designed to allow clients to use their regular primary care physician, with PACE enrollees in two programs operated by the two Wisconsin agencies.

Design and Methods: All enrollees in both programs were included in the sample. Enrollees were interviewed in person. Family members were interviewed by telephone. Questions compared disability levels and satisfaction. **Results:** The WPP clients were generally less disabled than the PACE enrollees. The levels of satisfaction among both clients and family members were essentially comparable. The use of advance directives was higher than in the general population but did not differ across the programs. **Implications:** WPP may be a valuable alternative to the rigid PACE approach, which may make enrollment difficult. However, a problem may lie in the limited participation of physicians. On average, the primary care physicians had only about six clients each. This level of involvement is insufficient to motivate them to change their practice patterns to accommodate this more comprehensive and integrated approach of care of frail older persons.

Key Words: Managed care, Dual eligibles, Elderly, Medicare, Medicaid

The Program for All-inclusive Care of the Elderly (PACE) stands as a model for integrating care for frail older persons (Branch, Coulam, & Zimmerman,

1995; Eleazer & Fretwell, 1999; Eng, Pedulla, Eleazer, McCann, & Fox, 1997; Kane, 1999). It was designed specifically to serve the dual-eligible population, those eligible for coverage under both Medicare and Medicaid. The frail elderly target population is defined by two criteria. They must be (a) dually eligible for both Medicare and Medicaid and (b) considered to be eligible for admission to a nursing home but living in the community at the time of enrollment. As with all dual-eligible managed-care programs, its intention is to pool the resources of the two funding programs in order to gain better integration and avoid duplications and conflicts from different rules for eligibility and coverage. In addition, the flexibility afforded by a single payment pool allows more creative uses of the money to cover whatever services are deemed necessary.

Developed originally to serve an elderly frail Chinese population in San Francisco, PACE has become a federally certified Medicare managed-care program. It was designed to serve a niche market, persons eligible for both Medicare and Medicaid who were deemed eligible for nursing home care but still lived in the community. As might be expected, this is a very small target group of high-risk persons whose capitation rate is substantial. About two thirds of the money comes from Medicaid, but the Medicare rate is a generous multiple (almost 2.5 times) of the base rate. This pool of resources allowed for the establishment of an integrated approach to care, which featured physicians working on salary and a clinical base in adult day health care. A central part of the model was the active inclusion of all those involved in any aspect of the enrollees' care as part of the core team, with regular team meetings and active information sharing. Innovative efforts were made to avoid the use of either acute or long-term care institutions. Creative means were found to tap all available resources to permit housing support from other means and to integrate care into that housing. Because the medical care is provided by PACE physicians, enrollees must forsake their regular providers in order to join. This provision has proved a deterrent to enrollment.

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The evaluation of the original PACE demonstration project encountered logistical difficulties (Branch et al., 1995), but PACE did appear to have achieved its goal of reducing the use of institutions. Hospital days and admissions for PACE clients were lower than those for fee-for-service Medicare beneficiaries in general for the first 18 months of the evaluation, an impressive statistic when one considers the frailty of PACE clients. Likewise, PACE clients had fewer nursing home nights and admissions through the 1st year of the evaluation, but the difference dwindled over time. Perhaps commensurately, PACE clients had more ambulatory visits throughout the 24 months of the evaluation. Much less is known about the clinical outcomes of this care. There were few differences between PACE clients and controls in terms of functional status over time. Nor were there many patterns of differences in terms of self-rated health status, quality of life, or satisfaction (Chatterji, Burstein, Kidder, & White, 1998).

The hallmarks of PACE have been an emphasis on interdisciplinary teamwork, a reliance on the day care center as a base of operations, and a commitment to keeping clients out of institutions. PACE employs physicians to provide primary care to its clients and to work as part of the integrated care teams. Persons enrolling in PACE must agree to accept PACE physicians as their primary care providers. The dual requirements of heavy use of day care and limited choice of physician have proven to be obstacles to marketing PACE (Kane, Illston, & Miller, 1992).

The Wisconsin Partnership Program (WPP) is a PACE variation that attempts to address aspects of that approach that have made it difficult to market; namely, WPP allows enrollees to remain with their own primary care physician and to make substantially less use of day care. To achieve the same level of benefit from use of an interdisciplinary care team that has been a PACE hallmark, WPP created an interdisciplinary care management team composed of a nurse, social worker, and nurse practitioner. The latter has as a major part of his or her responsibility the task of coordinating closely with the primary care provider in order to bring him or her into the care planning and implementation loop. The level of delegation from primary care provider to nurse practitioner varies with the rapport developed.

Two of the four WPP sites, ElderCare in Madison (Dane County) and Community Care for the Elderly in Milwaukee, offer both PACE and WPP options. As part of the federally mandated evaluation of WPP, we had the opportunity to compare aspects of the care received by PACE and WPP enrollees. This article describes the results of the survey of WPP and PACE enrollees from those two sites in the areas of functioning and satisfaction with the care received.

Methods

The study sample was limited to all WPP and PACE enrollees who were living in the community as of April 2000. Although both programs also cover

nursing home care, the number of enrollees in nursing homes made it impossible to achieve a sufficient sample size to include them. All enrollees were interviewed in person by trained interviewers whose interrater reliability had been established at the extensive training sessions. At the time of the interview, respondents were asked to identify a family member who had the closest caregiving relationship to them. This person was interviewed by phone. In the cases where the enrollee could not be interviewed, a proxy respondent was sought. The first choice for a proxy was a responsible family member who had enough contact with the beneficiary to provide valid answers. However, not all beneficiaries had family members who saw them regularly. For those who did not, a staff member was used as the proxy. These staff members were often caregivers in group homes or were care team members. Staff members were usually nurse practitioners, registered nurses, aides, case managers, or social workers. Staff members were not asked questions regarding patient satisfaction, quality of care, decision making, or unmet need.

The questionnaire was modeled after one used in a prior dual-eligible evaluation (Kane, Weiner, Homyak, & Bershadsky, 2001) but modified to emphasize elements the WPP staff felt were especially salient to their approach, namely attention to team care and respect for client autonomy. The survey instruments included demographic information; information regarding use of formal and informal care; satisfaction, including issues of access to services; advance medical directives; general health, functional status (activities of daily living [ADLs] and instrumental ADLs [IADL]); and informal caregiver burden (for family of community respondents). Wherever possible, previously tested measures were used. ADL items were derived from instruments developed by Finch and colleagues (Finch, Kane, & Philp, 1995). These questions focused on beneficiaries' ability to engage in basic daily activities (e.g., bathing, dressing, toileting, transferring, feeding, and walking). IADL items focused on the beneficiaries' ability to engage in a range of higher order daily activities from shopping to management of finances.

In addition to questions about ability to perform ADLs and IADLs, questions about unmet need for assistance with functional problems adapted from the work of Allen and Mor (1997) were used. For example, people who reported difficulties using the toilet were asked if they had needed help and did not receive it, if they had been wet or soiled because they did not receive this help, and if they had to wait more than 20 min before receiving help. To get at unmet need with regard to transferring, patients were asked if they had needed additional help getting in or out of a bed or chair and did not receive it and if they had fallen as a result of this lack of assistance. Satisfaction questions addressed receipt of services and the nature of the services they received (e.g., were services provided when needed, did personnel communicate effectively, did patients [or families] participate in decision making). Parallel versions of the satisfaction

items were used with enrollees and family respondents. The measure of burden was based on the Caregiver Reaction Assessment instrument developed by Given and colleagues (1992). Questions were asked about the extent to which advance directives were used and any pressures felt to adopt them.

Of the 392 elderly WPP enrollees identified, we were unable to locate 10, 24 had died, 3 had moved out of the area, 19 were living in a nursing home, 13 could not understand English and no proxy was available, another 2 had no proxy, 12 beneficiaries and 5 proxies refused interviews, and one interview was incomplete. Interviews were completed with 303 of 321 eligible enrollees or proxies (392 minus 71) for a response rate of 94%. Of these, 215 were beneficiaries, 82 were family proxies, and 6 were staff proxies. Among the 511 PACE enrollees targeted, 14 could not be located, 2 had moved out of the area, 57 had died, 92 had moved into nursing homes, 1 had no proxy, and 14 beneficiaries and 4 proxies refused interviews. Of the 326 interviews with the 345 persons eligible, 200 were with beneficiaries, 82 were with family proxies, and 44 were with proxies; the response rate was 94%.

Table 1. Characteristics of Sample

Patient's Characteristics	WPP Elders (N = 304)	PACE Elders (N = 322)	<i>p</i>
Female	74	82	.021
Mean age	77	80	.000
White	64	49	.000
Latino	5	3	<i>ns</i>
Education beyond high school diploma	25	22	<i>ns</i>
Married	26	14	.000
Self-rated health fair/poor ^a	13	9	<i>ns</i>
Mental status >3 errors ^a	12	17	<i>ns</i>
History of			
Hypertension	66	63	<i>ns</i>
Myocardial infarction	25	20	<i>ns</i>
Coronary heart disease	18	16	<i>ns</i>
Other heart disease	39	25	.000
Cancer (except skin)	14	11	<i>ns</i>
Diabetes	31	33	<i>ns</i>
Mental retardation	2	3	<i>ns</i>
Alzheimer's disease or dementia	18	29	.002
Other mental health	11	8	<i>ns</i>
Chronic obstructive pulmonary disease, asthma, or emphysema	25	16	.007
Vision problems	61	56	<i>ns</i>
Hearing loss	35	34	<i>ns</i>
Stroke	30	33	<i>ns</i>
Parkinson's disease	3	4	<i>ns</i>
Arthritis	65	64	<i>ns</i>
Hip fracture	10	9	<i>ns</i>
Lost arm or leg	3	2	<i>ns</i>
Neurological disorder	4	2	<i>ns</i>

Notes: Percentage of respondents and proxies unless otherwise indicated. WPP = Wisconsin Partnership Program; PACE = Program for All-inclusive Care of the Elderly.

^aBased on patients' reports only.

Results

The WPP sample differed from the PACE sample in a few demographic respects, as seen in Table 1. The PACE sample was more than 2 years older on average, was less likely to be married, and contained more people of color. PACE enrollees were more likely to suffer from dementia but were less likely to have other heart disease and chronic pulmonary disease.

As shown in Table 2, although there was no difference in the prevalence of pain or depression, the PACE sample was more disabled. They had significantly higher rates of dependency for all ADL measures, except walking. Likewise, they had significantly higher IADL dependency rates for all but one IADL category, using transportation.

Unmet needs were assessed by asking those respondents who reported dependency in a given area if they suffered untoward consequences because of lack of timely assistance with that problem. The pattern of responses is shown in Table 3. In general, the patterns were comparable. There were no significant differences.

The reported pattern of formal and informal service use differed across the groups. In general, this difference reflects the nature of the services provided. WPP used more care at home, and PACE relied on day care. As seen in Table 4, with regard to formal services, WPP respondents reported more nurse visits

Table 2. Evidence of Dependency and Discomfort

Dependency/Discomfort	WPP Elders (N = 304)	PACE Elders (N = 326)	<i>p</i>
Pain/discomfort moderate/severe ^a	49	44	<i>ns</i>
If pain, interferes with normal activity some/most of time ^a	59	50	<i>ns</i>
Very satisfied with pain control ^a	91	91	<i>ns</i>
Depression > 5 on GDS ^a	18	15	<i>ns</i>
Needs a little help or more with ADLs			
Bathing	44	64	.000
Dressing	29	47	.000
Toileting	15	32	.000
Transferring	17	28	.002
Feeding	5	15	.000
Able to walk between rooms	84	79	<i>ns</i>
Difficulty with IADLs			
Shopping	63	74	.003
Using phone	28	38	.014
Doing light housework	53	67	.000
Preparing meals	59	75	.000
Using transportation	35	42	<i>ns</i>
Taking medications	16	26	.002
Managing finances	53	75	.000
Arranging services	54	73	.000

Notes: Percentage of respondents and proxies unless otherwise indicated. WPP = Wisconsin Partnership Program; PACE = Program for All-inclusive Care of the Elderly; GDS = Geriatric Depression Scale; ADLs = activities of daily living; IADLs = instrumental ADLs.

^aBased on patients' reports only.

Table 3. Ratio of Unmet Needs (Persons With Unmet Need/ Respondents With Dependency)

Unmet Needs	WPP Elders		PACE Elders	
	%	Rate	%	Rate
Need help with bathing and did not get	9	12/133	8	17/209
Not able to bathe	15	20/133	15	32/209
Need help with dressing and did not get	16	14/89	9	13/151
Unable to put on clean clothes	10	9/89	5	7/151
Need help with toileting and did not get	10	2/20	27	7/26
Wet or soiled because no help available	30	6/20	54	14/25
Had to wait 20 min or more wet/soiled	19	9/47	18	14/76
Need help transferring and did not get	17	9/53	11	10/91
Fell because no help	6	3/53	6	5/91
Need help with eating and did not get	29	4/14	4	2/48
Hungry because no help	7	1/14	4	2/48
Thirsty because no help	14	2/14	6	3/48

Notes: All *ps* nonsignificant. Only respondents' self-reports are used. WPP = Wisconsin Partnership Program; PACE = Program for All-inclusive Care of the Elderly.

than did PACE, a finding consistent with the nature of the WPP service arrangement. Likewise, WPP beneficiaries used less day care and the special transportation associated with it. In a similar vein, they used less outpatient rehabilitation, a service provided at the day care centers. They also reported less speech therapy. Moreover, the WPP respondents used less infor-

mally provided help with dressing, toileting, and supervision than the PACE group.

Because both WPP and PACE are managed-care programs, there are subtle incentives to use less care or to avoid expensive, potentially futile care. As a result, one might expect that both sets of enrollees would be encouraged to complete advance directives. Table 5 compares the use of various types of advance medical directives. In general, the rate of advance directives was almost 50% for both groups. There was no difference in the content of these directives. Only one aspect of directive use showed a difference. More WPP enrollees reported that someone had suggested establishing an advance directive. Few in either group indicated any sense of being pressured to develop an advance directive.

Table 6 compares the level of satisfaction expressed for each of a series of elements for beneficiaries and families, respectively. The data are reported as unadjusted rates, but the statistical significance was calculated after adjusting for various attributes of the beneficiaries. For the beneficiary risk adjustment models, the variables used for risk adjustment included age (measured by years), race (measured by two dummy variables for Black and other races), education (measured by three dummy variables for high school diploma, some college, and college degree or above), marital status (measured by three dummy variables for widowed, separated or divorced, and never married), number of dependent ADLs, number of dependent IADLs, and number of medical conditions. For the family member risk adjustment models, the variables used for risk adjustment included beneficiary age, family member's age, gender, education, and race, number of beneficiary's IADL dependencies,

Table 4. Formal/Informal Care for Community Samples

Formal/Informal Care	WPP Elders (N = 303)	PACE Elders (N = 325)	<i>p</i>
Used homemaker in past 3 weeks	53	55	<i>ns</i>
Nurse visit in past 3 months	77	39	.000
Used home-delivered meals in past 3 months	38	41	<i>ns</i>
Used special transportation in past 3 months	76	91	.000
Used adult daycare in past 3 months	42	81	.000
Used outpatient rehabilitation in past 3 months	24	35	.003
Received physical therapy in past 3 months	15	18	<i>ns</i>
Received occupational therapy in past 3 months	5	7	<i>ns</i>
Received speech therapy in past 3 months	1	5	.002
Other services	18	9	.001
Currently using medical equipment in the home	25	24	<i>ns</i>
Own or rent medical equipment used in the home			
Own	17	29	<i>ns</i>
Rent	55	47	<i>ns</i>
Both rent and own	5	5	<i>ns</i>
Receive help from family or friends with			
Bathing	26	31	<i>ns</i>
Dressing	25	34	.022
Toileting	42	52	0.01
Transferring	15	19	<i>ns</i>
Making sure patient is safe	29	37	.049

Notes: Percentage of respondents and proxies. WPP = Wisconsin Partnership Program; PACE = Program for All-inclusive Care of the Elderly.

Table 5. Frequency of Advance Medical Directives (Percentage of Persons With Directive)

	WPP Elders (N = 278)	PACE Elders (N = 285)	<i>p</i>
Patient has put in writing . . .			
Advance medical directives established	47	52	<i>ns</i>
Does not want cardiopulmonary resuscitation	43	46	<i>ns</i>
Does not want to be put on ventilator	46	50	<i>ns</i>
Does not want tube feeding	39	39	<i>ns</i>
Does not want to have infections treated	16	14	<i>ns</i>
Does not want to be admitted to the hospital	14	11	<i>ns</i>
Does not want to have surgery	13	14	<i>ns</i>
Anyone ever suggest establishing an advance medical directive to patient?	62	52	.015
Patient felt pressured to establish an advance medical directive	8	9	<i>ns</i>
Recommended directive			
Patient physician	34	42	<i>ns</i>
Nurse	32	25	<i>ns</i>
Care team	49	24	.000
Family members	47	51	<i>ns</i>
Religious leader	3	4	<i>ns</i>
Lawyer	4	6	<i>ns</i>

Notes: Percentage of respondents and proxies. WPP = Wisconsin Partnership Program; PACE = Program for All-inclusive Care of the Elderly.

Table 6. Proportion of Beneficiaries and Family Members Responding Affirmatively to Satisfaction Items

Satisfaction Item	Beneficiaries (N = 391)			Family Members (N = 379)		
	PACE %	WPP %	<i>p</i>	PACE %	WPP %	<i>p</i>
You received PT, OT, or ST services when needed.	96	94	.359	94	89	.059
Hearing and eyesight checked regularly.	92	88	.258	93	91	.914
Your doctor or other health professional responds quickly if you get sick.	93	96	.366	94	96	.774
Your doctor or other health professional sees you often enough to treat your health problems.	96	93	.617	94	95	.762
One person is clearly in charge of your medical care.	79	81	.810	74	68.4	.907
Your doctor or other health professional spends enough time with you.	89	91	.336	94	91	.147
Your doctor or other health professional treats you with respect.	97	99	.275			
Your doctor or other health professional explains your health problems.	91	93	.607	95	93	.400
You are involved in making decisions about your medical care.	89	86	.361	82	90	.517
Your doctor or other health professional is responsive to your health problems.	96	96	.469	96	97	.544
Your doctor or other health professional will hospitalize you when your health problems require it.	98	99	.482	98	99	.893
Your doctor or other health professional knows how to manage your problems well.	94	97	.128	95	98	.263
Your doctor or other health professional is sensitive to your needs.	94	97	.280	96	97	.852
You can see a specialist whenever you need to.	93	94	.514	95	95	.895
Services are available at times that fit well with your home and personal life.	95	97	.193	97	97	.857
It takes a great deal of your energy to get the health care services you need.	26	35	.190	16	18	.573
You have difficulty communicating with your doctor or health professional.	14	19	.581	12	7	.229
Your doctor or other health professional does not take your needs and desires seriously.	13	12	.422	8	8	.499
Your care is not well coordinated.	29	27	.170	12	13	.972
People who provide care for you seem to rely on you to provide information they should have for each other.	31	40	.499	17	34	.000
When decisions about your care are made, your priorities count.	93	90	.244	85	86	.465

Notes: For calculating the statistical significance of the beneficiary risk adjustment models, the variables used for risk adjustment included age (measured by years); race (measured by two dummy variables for Black and other races); education (measured by three dummy variables for high school diploma, some college, and college degree or above); marital status (measured by three dummy variables for widowed, separated or divorced, and never married); number of dependent activities of daily living (ADLs); number of dependent instrumental ADLs (IADLs); and number of medical conditions. For calculating the statistical significance of the family member risk adjustment models, the variables used for risk adjustment included beneficiary age, family member's age, gender, education, and race; number of beneficiary's IADL dependencies; number of beneficiary's ADL dependencies; and count of beneficiary's major medical diagnoses. WPP = Wisconsin Partnership Program; PACE = Program for All-inclusive Care of the Elderly.

number of beneficiary's ADL dependencies, and count of beneficiary's major medical diagnoses. None of the beneficiary satisfaction items showed a significant difference between WPP and PACE clients.

PACE family members were more likely to be female, non-White, and unmarried. There were no differences in the rate of contact with the beneficiaries. The only significant difference among family members' satisfaction after statistical adjustments were made addressed the issue of coordination within the care team. PACE families expressed less satisfaction than did WPP families. This difference was still significant after a Bonferroni correction was applied.

Table 7 displays the reports of caregiver burden among the two groups of families. Here again, the differences were modest. More PACE families felt they owed a great debt to their older relatives. They were less likely to feel they had enough physical strength to provide the care needed and that their health was adequate to the care tasks. However, these differences were not significant after a Bonferroni correction.

Discussion

The PACE programs in the same geographic area seem to be caring for a more disabled group of clients than the WPP, including a higher rate of dementia. PACE clients were more likely to receive informal care, but there were only modest differences in the satisfaction reported by beneficiaries or their families. Nor was there a dramatic difference in care burden. The added informal care provided by PACE families was reflected in a few items on burden.

The patterns of service use reflect the differences in

program design. One area where the two programs differ substantially is their relationship to physicians. PACE hires physicians who work full time caring for enrolled patients, whereas WPP relies on a wide variety of primary care providers, most of whom care for only a few WPP clients each. However, the WPP program operated by the Milwaukee PACE site, one of the two compared here, has made a deliberate effort to concentrate its primary care load among a limited number of physicians. Limiting the choice of physician has generally been viewed as a marketing problem for PACE. However, the Milwaukee site has been able to do this with both PACE and WPP because it deals largely with a hospital clinic population that has not historically experienced continuity of care.

The findings suggest that coordination of care can be achieved in different ways, but it is probably better achieved if the participating physicians have enough of a stake in the care program to capture their attention and motivate them to alter their practice styles to address the complex needs of dual-eligible patients. The WPP program has taken steps to encourage more active participation by a more constrained panel of primary care doctors.

The two sites studied here face different market conditions. One site draws its clientele from poor people who rely heavily on university clinics, where there is an active turnover of physicians. Hence, these patients have no strong option for maintaining their continuity of care. Changing to a PACE physician is not a large transition. By contrast, the other site works largely with older individuals who have established relationships with local physicians and are less inclined to disrupt them. Not surprisingly,

Table 7. Rate of Caregiver Burden Among Families

Caregiver Burden	WPP (N = 179)	PACE (N = 177)	p
Family feels privileged to care for patient.	95	94	ns
Others have dumped caring for patient.	35	39	ns
Family finds financial resources adequate to pay for caregiving.	45	43	ns
Family activities centered around care.	55	64	ns
Family tired all the time since caring for patient.	32	42	ns
Difficulty in getting help from other family.	42	41	ns
Family resents taking care of patient.	7	6	ns
Family stops in the middle of work to care for patient.	34	35	ns
Family really wants to care for patient.	97	98	ns
Family feels health worse since caregiving for patient.	24	28	ns
Family visits friends and family less.	33	37	ns
Family feels can never do enough caregiving to repay patient.	67	78	.050
Family works together at caring for patient.	66	65	ns
Family eliminated things from schedule since caring for patient.	48	53	ns
Enough physical strength to care for patient.	83	73	.026
Since caring for patient family has abandoned me.	13	17	ns
Caring for patient makes family feel good.	98	98	ns
Interruptions make it difficult to relax.	35	38	ns
Family is healthy enough to care for patient.	90	81	.014
Family finds caring for patient important.	99	99	ns
Caring has put financial strain on family.	22	18	ns
Family left me alone to care for patient.	33	40	ns
Enjoy caring for patient.	96	98	ns
It is difficult to pay for patient's needs and services.	28	31	ns

Note: WPP = Wisconsin Partnership Program; PACE = Program for All-inclusive Care of the Elderly.

since the time of the study the two sites have gone in different directions. The Milwaukee site has kept both its PACE and WPP options operational, whereas the Madison site has merged all its services into the WPP option, which has proven easier to market. Even the continuing PACE site has changed its approach. For example, not all PACE users use the day care program.

Patient reports of satisfaction are often skewed positively (Hall, Feldstein, Fretwell, & Rowe, 1990; Owens & Batchelor, 1996; Stump, Dexter, Tierney, & Wolinsky, 1995). The responses reported here show more variation. Although the level of satisfaction with care is generally high for both groups, there are several areas with room for improvement. For example, a considerable proportion of respondents from both programs indicated dissatisfaction with the energy needed to get care, the coordination of that care, and communication with the health team. The family members identified problems with pain control, interaction with the team, coordination of care, and their overall rating of the medical care provided. The reports of satisfaction with pain control may well reflect some satisfaction bias among enrollees. Although a considerable number reported fairly active pain, most said they were satisfied with the level of pain control they experienced.

Although the proportion of clients with advance directives in both forms of managed care was considerably higher than average (both around 50%; DeLuca Havens, 2000; Gordin & Shade, 1999), there was no indication of any coercion to execute an advance directive from either plan. As part of their overall care management planning, representatives of both approaches were encouraged to offer advance directives to clients, but the recommendations were apparently low key.

The findings reported here are best interpreted in the context of a second study that compares the WPP experience to matched controls. That study found few differences (Kane, Homyak, & Bershadsky, in press). The prevalence of ADL and IADL dependency was lower for the WPP sample than for the PACE sample, but the extent of unmet needs was generally comparable. Overall, there were few areas of significant difference in beneficiaries' satisfaction. The WPP families were more satisfied than either control group that services were provided when needed and were better coordinated. There were no significant differences in the prevalence of any aspect of care burden. Although managed care seems potentially well suited as a vehicle to implement many of the goals of geriatric care, the overall results to date have been disappointing (Boult, Kane, & Brown, 2000; Kane, 1998).

Although PACE is widely cited as a model of well-integrated care, its effectiveness remains to be established. WPP may be a more marketable version of the PACE principles, but its effectiveness has not yet been demonstrated. It is important to recognize that WPP is still evolving as a program. It is trying to learn from its early experience to adapt its approaches as problems are uncovered.

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