Evaluation of the Program for Elders in Managed Care

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Authors

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## CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>i</td>
</tr>
<tr>
<td>I. INTRODUCTION AND BACKGROUND</td>
<td>1</td>
</tr>
<tr>
<td>A. OVERVIEW OF PEMC PROGRAM</td>
<td>1</td>
</tr>
<tr>
<td>B. EVALUATION OF PEMC</td>
<td>3</td>
</tr>
<tr>
<td>C. ORGANIZATION OF THIS REPORT</td>
<td>4</td>
</tr>
<tr>
<td>II. FINDINGS FROM THE EVALUATION OF IMPLEMENTATION GRANTS</td>
<td>6</td>
</tr>
<tr>
<td>A. GRANT STRUCTURE</td>
<td>6</td>
</tr>
<tr>
<td>B. MPR’S EVALUATION FINDINGS</td>
<td>13</td>
</tr>
<tr>
<td>1. What Motivated Grantees to Become Involved in PEMC?</td>
<td>14</td>
</tr>
<tr>
<td>2. Were Grantees Able to Implement the Interventions?</td>
<td>15</td>
</tr>
<tr>
<td>3. What Technical Problems Did Grantees Encounter, and How Did They Resolve Them?</td>
<td>16</td>
</tr>
<tr>
<td>4. What Did the Grants Accomplish, and How Sustainable and Replicable Are They?</td>
<td>20</td>
</tr>
<tr>
<td>C. DESIGN AND OUTCOMES FROM THE INDIVIDUAL GRANTEE EVALUATIONS</td>
<td>22</td>
</tr>
<tr>
<td>1. Methods Used for Evaluating the Interventions</td>
<td>23</td>
</tr>
<tr>
<td>2. Evaluation Findings—Outcomes Synthesis</td>
<td>24</td>
</tr>
<tr>
<td>3. Process Analysis and Explanation for Results</td>
<td>28</td>
</tr>
<tr>
<td>4. Program Office Analysis of Factors Important to Success</td>
<td>30</td>
</tr>
<tr>
<td>D. HOW PEMC FINDINGS COMPARE TO OTHERS</td>
<td>31</td>
</tr>
<tr>
<td>III. FINDINGS ON OTHER PROGRAM COMPONENTS</td>
<td>37</td>
</tr>
<tr>
<td>A. WHAT DID PEMC BUY WITH THE PLANNING GRANTS?</td>
<td>37</td>
</tr>
<tr>
<td>1. Description of Grantees and Outcomes</td>
<td>37</td>
</tr>
<tr>
<td>2. Evaluation of the Planning Grant Component</td>
<td>41</td>
</tr>
</tbody>
</table>
CONTENTS (continued)

Chapter  

III. (continued)

B. DID PEMC’S FLEXIBLE FUNDING FOR RELATED ACTIVITIES AND PROJECT AUGMENTATION PAY OFF? .................................................43

1. Use of Funds for Related Activities ...............................................................44
2. Use of Funds for Augmentation Grants to Implementation Grantees ...........45

C. WHAT WAS ACCOMPLISHED BY FUNDING RELATIVELY RIGOROUS INDIVIDUAL GRANTEE EVALUATIONS? ........................................47

1. Staffing and Role of the Individual Grantee Evaluator ..................................47
2. Assessment of the Individual Grantee Evaluation Requirement ...................49

D. WHAT WERE THE STRENGTHS AND WEAKNESSES OF THE WAY THE PROGRAM WAS ADMINISTERED? ........................................50

1. Effectiveness of the Grant Giving and Reach of the Solicitation ...............51
2. Role of Program Office and Program Infrastructure .....................................51
3. Grantees’ Sense of Community .....................................................................53
4. Grantees’ Views of CHCF in the Context of the Program ............................54
5. To What Extent Has PEMC Achieved Its Dissemination Goals? .................54

E. WHAT LESSONS CAN BE DRAWN FOR EFFECTIVE PROGRAM DEVELOPMENT FOR FRAIL ELDER? ...........................................................58

IV. CONCLUSIONS AND LESSONS ...............................................................................60

A. OVERALL CONCLUSIONS ON PEMC .............................................................60

B. LESSONS FOR CHCF AND CALIFORNIA PLANS/PROVIDERS ..............61

1. What PEMC Gives to Build On .................................................................61
2. Other Opportunities .....................................................................................61
3. Insight into the Use of Rigorous Individual Grantee Evaluations ..............62
4. Insight on Structuring Program Design and Oversight ............................63

C. NATIONAL RELEVANCE AND LESSONS ..................................................64

REFERENCES ............................................................................................................66
APPENDIX A: PROGRAM SYNTHESIS: PROGRAM FOR ELDERS IN MANAGED CARE
................................................................................................................. A-1

APPENDIX B: TABLE OF ALL PEMC-SPONSORED GRANTS ......................... B-1

APPENDIX C: IMPLEMENTATION AND RELATED-ACTIVITIES
GRANT SUMMARIES ............................................................................... C-1

APPENDIX D: PLANNING GRANT SUMMARIES ....................................... D-1

APPENDIX E: ANNOTATED BIBLIOGRAPHY ............................................. E-1

APPENDIX F: EVALUATION METHODS AND DATA SOURCES ............... F-1

APPENDIX G: ADDITIONAL INFORMATION ON THE PLANNING
GRANTS .............................................................................................. G-1
## TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.1</td>
<td>LIST OF PEMC IMPLEMENTATION GRANTEES AND OTHER OPERATIONAL GRANTEES BY TYPE</td>
</tr>
<tr>
<td>II.1</td>
<td>PROFILE OF IMPLEMENTATION GRANTS AND SIMILAR RELATED-ACTIVITIES GRANTS</td>
</tr>
<tr>
<td>II.2</td>
<td>GRANTEE EXPERIENCE WITH VARIOUS IMPLEMENTATION AND ENVIRONMENTAL CHALLENGES</td>
</tr>
<tr>
<td>II.3</td>
<td>SUMMARY OF ACCOMPLISHMENTS AND SUSTAINABILITY</td>
</tr>
<tr>
<td>II.4</td>
<td>OUTCOME RESULTS FOR FIVE GENERAL CARE MANAGEMENT PROJECTS FUNDED BY PEMC</td>
</tr>
<tr>
<td>III.1</td>
<td>PLANNING GRANTS BY SPONSOR, PURPOSE, PHASE, AND OUTCOME</td>
</tr>
<tr>
<td>III.2</td>
<td>PURPOSE OF AUGMENTATION MONIES</td>
</tr>
<tr>
<td>III.3</td>
<td>ROLE OF THE INDIVIDUAL GRANTEE EVALUATOR</td>
</tr>
<tr>
<td>III.4</td>
<td>GRANTEE PUBLICATIONS</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Elders who are frail because of disability, multiple chronic conditions, and other factors account for a growing share of the population, yet they are often poorly served by a health care system that is focused on acute care episodes.\(^1\) To improve care for these frail, at-risk elders, the California HealthCare Foundation (CHCF) funded the Program for Elders in Managed Care (PEMC)—a five-year, $15 million initiative begun in 1997 and the first of CHCF’s grant programs. The program aimed to encourage better linkages between plans, providers, and community organizations to improve care delivery. This overview summarizes the key findings from the evaluation of PEMC that was commissioned by CHCF and conducted by Mathematica Policy Research, Inc. (MPR). It complements the more detailed report on evaluation findings and provides an abbreviated description of the findings that are of general interest to stakeholders in both California and the nation who are concerned about providing care for frail, at-risk elders.\(^2\)

A. PROGRAM BACKGROUND

Health insurance tends to favor the delivery of acute care services—especially when care is paid for on a fee-for-service basis. Under such an arrangement, providers have few incentives to provide services that may not be well compensated, such as care management. These barriers to innovation are less prevalent in risk-based managed care organizations (MCOs) that are paid a set fee per member per month, regardless of the services provided. The Program for Elders in Managed Care sought to take advantage of California’s mature managed care market to encourage partnerships between managed care organizations, provider organizations, and community-based organizations to improve care delivery. In pursuing this goal, CHCF received encouragement from other foundations and groups that recognized the value in focusing on frail elders; plans and medical groups were already focused on disease management. It was also believed that the Foundation could play an important role both in bringing into focus the complex needs of frail elders with multiple conditions and in helping to forge links between medical groups and community-based organizations.

PEMC included two cycles of grants. Implementation grants for up to $1 million over a three-year period were awarded to test and evaluate specific interventions, and grantees were given substantial leeway to develop alternative interventions that involved all three partners (plans, providers, and community organizations). Grantees were required to conduct rigorous independent outcomes evaluations based on a randomized design. Planning grants of up to $75,000 for one year were intended to provide “seed money” to develop promising interventions


\(^2\) For the full report, see Marsha Gold, Tim Lake, and William Black “Evaluation of the Program for Elders in Managed Care” including Appendices submitted to the California Healthcare Foundation on August 20, 2004.
not yet ready for full implementation. In addition, the program made or oversaw grants on an ad hoc basis as opportunities arose for several related activities that involved complementary work to improve care to frail elders. In total, PEMC funded nine implementation grants, thirteen planning grants, and three related-activity grants, two of which involved direct delivery of services. After the first year or so, the UCLA Multicampus Program for Geriatrics and Gerontology took over the program administration from CHCF. In addition, since its inception, the program received guidance from an advisory committee that included local and national experts with diverse perspectives and expertise. Committee members were involved both in program design and applicant review.

B. EVALUATION DESIGN

CHCF commissioned MPR to evaluate PEMC after a competitive process in spring 2002, when the program was nearing its end. The evaluation was designed both to complement the grantees’ independent evaluations of project outcomes and to provide a programwide perspective. Specifically, MPR’s evaluation was intended to:

- Develop an understanding of which features of the project models could improve care delivery for frail elders;
- Discern how well the models performed and whether they could be sustained; and
- Assess what factors drove or impeded success.

At the Foundation’s request, the MPR evaluation was to build on secondary sources of information available through the program along with a limited amount of additional data collection. Data sources therefore included the following: (1) program/grantee reports; (2) results of the independent evaluations conducted by each implementation grantee; (3) independent and semistructured interviews conducted by MPR with each of the grantees and other program participants; and (4) a review of the literature on how to improve care for frail elders and similar subgroups using demonstrations as well as other means.

C. EVALUATION FINDINGS

Overview. CHCF funded eleven grants to test innovative case management and disease management interventions for frail elders. Two of the grants did not become operational. The other nine were subject to rigorous evaluations (independent of the MPR evaluation), with all but one involving a randomized clinical trial design. Most of the projects did not achieve statistically significant results on measured outcomes or lead to sustainable interventions. The lack of significant results is most likely attributable to a combination of factors, including ambitious outcomes goals for the case management interventions tested, shortcomings in design, and problems encountered in implementation. The instability in both the Medicare managed care market and among provider groups involved in the interventions also affected the results. Though lacking significant results, PEMC generated important insights relevant to the challenges likely to be associated with future efforts to coordinate care for frail elders.
1. What Kinds of Interventions Were Tested Under PEMC?

PEMC funded nine implementation grants, along with two related-activity grants that involved care delivery. (See Table 1 for a summary of the PEMC-funded and related-activity grants.) Of the nine implementation grants, seven focused on general care management for frail elders and the other two were specific to dementia. The two related-activity grants that involved care delivery supported disease-specific interventions for frail elders—one on depression, which was part of a national program, and one on diabetes.

**Implementation Grants for General Care Management.** PEMC’s implementation grants were structured to provide grantees with flexibility in designing strategies for improving care for frail elders. The lead sponsors of the nine PEMC implementation grants were a diverse group. Three were managed care plans (Kaiser TriCentral, Pacificare/Secure Horizons, and On Lok Senior Health Services Senior Health Services); three were community-based groups (Jewish Family and Children Services [JFCS], the Institute on Aging [IOA], and the California Institute for Rural Health Management [CIRHM]); one was a provider group (Sharp HealthCare); one was an academic group (UCLA Neuropsychiatric Institute [UCLA NPI]), and one was an organization consulting for CalPERS (Long-Term Care Group [LTCG]).

Of the seven implementation grants involving general care management, two were terminated before they became operational. One of the two grantees, On Lok Senior Health Services, was delayed in receiving a waiver from the Health Care Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services, or CMS). The waiver was needed to test refinement of a Program for All-inclusive Care for the Elderly (PACE) model intended to attract more beneficiaries to On Lok Senior Health Services’s system of support by incorporating a free-standing physician network. The model aimed to accommodate beneficiaries who were reluctant to enroll if it meant severing a relationship with their primary care provider. (The waiver has since been approved, and the program is operational.) The second terminated grant, CIRHM, targeted the City of Lompoc in rural Santa Barbara County and was ended when the participating managed care plan severed links with the independent practice association (IPA) participating in the project after the IPA encountered financial problems.

The remaining five implementation grantees—Kaiser TriCentral, Sharp HealthCare, Pacificare/Secure Horizons, LTCG, and JFCS—each used different algorithms to identify seniors at high risk, assess their needs, make referrals, and coordinate care. Two of these five grantees were particularly unique: (1) Kaiser TriCentral was unique in testing a benefit expansion for home- and community-based services; and (2) LTCG was distinctive in promoting exercise and lifestyle changes primarily for healthier seniors who were enrolled in a managed care plan and had purchased long-term care insurance from CalPERS and had at least one chronic condition.

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3 A third grant (JFCS) became operational but the grantee was unable to test the intervention through a randomized design because physicians did not refer sufficient patients to the program to support it.
<table>
<thead>
<tr>
<th>Grantee</th>
<th>Lead Organization Type</th>
<th>Other Collaborators</th>
<th>Focus</th>
<th>Target Population</th>
<th>Intervention</th>
<th>Hypothesized Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jewish Family and Children’s Services</td>
<td>Community-based organization</td>
<td>Brown &amp; Toland Medical Group; provider groups</td>
<td>Frail elders</td>
<td>Those age 85+ or having at least one hospitalization, emergency room visit, or nine primary care physician visits</td>
<td>Assessment, referrals for supportive services (front office provider group staff trained to identify need for referral)</td>
<td>Targeted case management will reduce costs, utilization</td>
</tr>
<tr>
<td>Kaiser TriCentral</td>
<td>Managed care organization, integrated care system</td>
<td>Multiple community groups in Los Angeles County</td>
<td>Frail elders</td>
<td>Those age 65+ identified through a screening instrument; other referrals</td>
<td>Coordination of care; compared (1) mailed information and referral, (2) case management, (3) case management with $2,000 in additional benefits, and (4) limited telephonic case management</td>
<td>Coordinated care will reduce costs; those receiving extra benefits would later want to pay for them</td>
</tr>
<tr>
<td>Institute on Aging</td>
<td>Community-based organization</td>
<td>Kaiser Permanente, Brown &amp; Toland Medical Group, Sutter Health (which ultimately did not implement the intervention)</td>
<td>Dementia in frail elders</td>
<td>Those identified with dementia (some training and support in assessment); those who are part of national Chronic Care Network for Alzheimer’s Disease Initiative</td>
<td>Care management via physician, case manager, and Alzheimer’s Association (model varies by site)</td>
<td>Care management will reduce costs and use and will increase member satisfaction</td>
</tr>
<tr>
<td>Sharp HealthCare</td>
<td>Risk-bearing provider system</td>
<td>PacifiCare</td>
<td>Frail elders</td>
<td>Those age 80+ or age 65 with a chronic condition or functional limitation</td>
<td>Case management, including ongoing screening and follow-up</td>
<td>Intensive case management will reduce use and costs</td>
</tr>
<tr>
<td>Long-Term Care Group</td>
<td>Managed care organization (firm consulting with CalPERS for long-term care)</td>
<td>CalPERS, Eskaton, and three Managed care organizations</td>
<td>Frail elders</td>
<td>Those with long-term care insurance via CalPERS; also those with a chronic condition enrolled in a managed care organization</td>
<td>Care management; nurse coach encourages a plan for diet, exercise, disease management, and a referral to community services</td>
<td>Intervention will encourage healthy behaviors and reduce health care cost and use</td>
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**TABLE 1 (continued)**

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<tr>
<th>Grantee</th>
<th>Lead Organization Type</th>
<th>Other Collaborators</th>
<th>Focus</th>
<th>Target Population</th>
<th>Intervention</th>
<th>Hypothesized Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCLA Neuropsychiatric Institute</td>
<td>Provider (as coordinator)</td>
<td>Three managed care organization-associated medical groups and various community organizations</td>
<td>Dementia in frail elders</td>
<td>Those identified by providers as having dementia</td>
<td>Coordination of care based on guidelines developed through a collaborative process</td>
<td>Intervention will improve adherence to guidelines, increase caregiver satisfaction, improve provider knowledge, and reduce costs</td>
</tr>
<tr>
<td>Pacificare/Secure Horizons</td>
<td>Managed care organization</td>
<td>Multiple community groups and affiliated providers</td>
<td>Frail elders</td>
<td>Those age 85+ or age 65+ identified with a use-based algorithm scoring four or more</td>
<td>Care management via a community-based advocate with assessment and referral</td>
<td>Care management will reduce use of high-cost services</td>
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</tbody>
</table>

**Related-Activity Grants**

<table>
<thead>
<tr>
<th>Project IMPACT</th>
<th>UCLA Neuropsychiatric Institute</th>
<th>Kaiser Permanente Hayward, Desert Medical Group</th>
<th>Elders with depression</th>
<th>Those age 60+ with diagnosed depression</th>
<th>Specialized care management via a clinical depression specialist who coordinates between patient and physician</th>
<th>Better care management will improve care outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCLA General Internal Medicine</td>
<td>Provider group (as coordinator)</td>
<td>Pilot-site providers: Sharp HealthCare, West Los Angeles Veterans Affairs Medical Center; American Geriatrics Society as co-sponsor</td>
<td>Diabetes in geriatric population</td>
<td>No defined target population; materials support multiple interventions that can be diversely targeted and are still undergoing pilot testing</td>
<td>Development of guidelines and tool kit in collaboration with American Geriatric Society, including pilot testing</td>
<td>Effects of guidelines on care delivery</td>
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Note: Excludes the two implementation grants that never achieved operational status.

**Condition-Specific Implementation Grants and Related-Activities Grants.** Four of the PEMC grants focused on frail elders with specific conditions. Two were implementation grants addressing dementia (IOA, UCLA NPI). In addition, both related-activities grants involving patient care were condition specific. One involved depression (Project IMPACT) and the other, diabetes (UCLA General Internal Medicine [UCLA GIM]).\(^4\) Grants that focused on individuals

\(^4\) Part of eight-site, national effort funded by the Hartford Foundation.
with specific conditions were much more likely to rely on clinical guidelines than were those focused on general care management and links to home- and community-based services.

2. What Did the MPR Evaluation Find?

MPR’s evaluation focused on learning about the development of the implementation grants, grantees’ experiences, and the reasons for these experiences. Key findings are described below.

Impetus for Participation. For the most part, the impetus for grantees’ participation in PEMC seemed to reflect the convergence of three forces: (1) a local “champion” who had heard of the grant opportunity and who was interested in developing an initiative and ready to take the lead on it; (2) management’s perception that the kind of initiative envisioned would be to the advantage of the organization and consistent with its mission and business interests; and (3) broad awareness of the CHCF call for proposals for PEMC and applicant interest.

Extent of Implementation. All grantees appeared to have made a good-faith effort to implement the initiatives proposed. In a few cases, the design was modified in response to unanticipated problems or issues. During interviews and observations at program meetings, the enthusiasm and commitment of those participating in PEMC was obvious. However, in two cases, grants were terminated before implementation. One (On Lok Senior Health Services) appeared to have been caught in unavoidable regulatory delays. The other (CIRHM) was a riskier project because it was located in an area with less managed care experience. Both CIRHM and JFCS encountered problems in the stability of their participating organizations that stemmed from the Medicare+Choice (M+C) marketplace, which made progress on implementation difficult.

Implementation Challenges. Internal challenges delayed project implementation and probably limited the effectiveness of the interventions. The time required to gain approval from institutional review boards (IRBs) delayed the start of several projects. In addition, recruiting participants was a challenge for almost all of the projects. This made implementation not only more difficult but also more time-consuming than expected. In contrast, randomization went relatively well, and data problems were rare—perhaps reflecting the importance of including these elements in the initiatives from the start. Staff turnover and general instability in some of the affiliated organizations was common and made implementation more difficult or, in the extreme case, impossible. In contrast, most grantees were able to maintain the support of their physician groups; however, when they did not, the consequences were very disruptive. Similarly, medical, community-based, and largely social service agencies worked well together, despite the challenges involved.

Role of the External Environment in Project Outcomes. The M+C market in both California and the nation became very unstable after PEMC was implemented. This instability had an obvious effect on some projects—particularly the Brown and Toland Medical Group and the pressures it created for PacifiCare/Secure Horizons, a major managed care partner in several grants. The tight economic environment also probably reinforced concerns about the cost-effectiveness of the interventions and their business rationale, but these concerns were present at the start of the project. Yet while the adverse nature of the market put stress on the organizations that made resources scarce and success more difficult, it may be that the environment was less of a fundamental influence on project outcomes than were the internal challenges facing grantees in
developing operational large-impact projects that could be mounted quickly. With the benefit of hindsight, many grantees wondered whether their interventions could have been tweaked to perform better or if they could have better targeted individuals more likely to generate positive outcomes. This suggests that both the rapid movement to implementation without extensive planning and pilot testing and the overall challenges related to delivering better care to frail elders are fundamental reasons why grantees were not more successful.

**Accomplishments and Sustainability.** Because the grantees’ independent evaluations (discussed below) showed few detectable positive outcomes, many grantees now judge the costs of sustaining the interventions as too high. The two exceptions are Sharp HealthCare, which is maintaining its program despite the evaluation results, and Kaiser TriCentral, which, though not maintaining its intervention, is using what it learned from the three projects it implemented to change how it provides care management to frail elders and care for dementia. In addition, there is some potential for the activities undertaken through Project IMPACT and UCLA GIM to be sustained.

Despite the fact that most of the interventions have not been sustained, many have led to the development of promising tools, such as the diabetes guidelines created by UCLA GIM and the techniques developed as part of the national programs in which IOA and Project IMPACT participated. These tools may be of interest to others outside PEMC. Most grantees also perceived that there were less tangible benefits from their participation, including greater awareness of the needs of frail elders, contacts, and a better understanding of how to establish linkages between medical and community-based organizations.

3. What Did the Individual Grantee Evaluations Show to Be the Outcomes of the Interventions?

None of the five general care management interventions was shown to have statistically significant effects on the vast majority of outcomes, and the pattern of results does not otherwise indicate that the projects had a positive (or negative) effect on those outcomes. (See Table 2 for outcomes results for general care management projects.) However, there were some exceptions with respect to particular outcomes. Kaiser TriCentral’s project showed a significant decline in depression for one clinical group that the evaluators determined was not clinically relevant. Similarly, in LTCG’s project, there was a significant increase in aerobic activity and stretching for the intervention group; those who were depressed at the start of the intervention also experienced a decline in depression. In addition, at Sharp HealthCare, participants with three or more limitations in instrumental activities of daily living experienced a significant reduction in nursing home use through the intervention. However, because each project analyzed numerous outcomes, the few significant results that were found across all projects could be due solely to chance.

Of the three completed disease-management evaluations, only one (Project IMPACT) showed a reduction in depression as a result of the intervention, along with higher satisfaction with care, lower rates of functional impairment, and an increase in the quality of life. The other two projects (IOA and UCLA NPI) were either not designed to test intervention effects directly
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<thead>
<tr>
<th></th>
<th>LTCG</th>
<th>Pacificare/Secure Horizons</th>
<th>JFCS</th>
<th>Sharp HealthCare</th>
<th>Kaiser TriCentral</th>
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<td>Physician/outpatient</td>
<td></td>
<td></td>
<td>+c</td>
<td></td>
<td>n.s.</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td></td>
<td></td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
</tr>
<tr>
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<td></td>
<td>n.s.</td>
<td></td>
<td>n.s.</td>
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<td>Nursing home</td>
<td></td>
<td></td>
<td>n.s.</td>
<td></td>
<td>n.s.</td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>n.s.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Caregiver</td>
<td></td>
<td></td>
<td></td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Healthy behavior/exercise</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Use of community resources</td>
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<td></td>
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<td></td>
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<td>Member retention</td>
<td></td>
<td></td>
<td>n.s.</td>
<td></td>
<td>n.s.</td>
</tr>
</tbody>
</table>

Note: "n.s." indicates differences between treatment and control group were not statistically significant (p < 0.05). Blank cells indicate the outcome was not measured for that project.

^a Indicates a decrease in depression scores for two treatment groups relative to the control group.

^b Indicates an increase in utilization for the treatment group relative to the control group.

^c Indicates an increase in costs for the treatment group relative to the control group.

^d The evaluation for this project found significant baseline-to-follow-up declines in caregiver burden for all four comparison groups but concluded that these trends may be due to participation in the survey process, rather than to the intervention itself.

^e Indicates an increase in aerobic activity and stretching by the treatment group relative to the control group.

^f Indicates a decrease in mortality for the treatment group relative to the control group.

^g Indicates a decrease in hospital admissions for the treatment group relative to the control group.

^h Indicates an increase in both primary care physician and specialist utilization for the treatment group relative to the control group.
or had not reported primary outcome results by the time this report was written. However, some of the early findings from these three interventions suggest that one or more could have some promise.

4. What Explains the Lack of Positive Results?

There are three possible flaws that would explain why the interventions were not more effective. Interventions were flawed in (1) concept; (2) design and measurement; or (3) execution. Reports evaluating each individual grantee were reviewed and program and foundation staff were consulted to discern what role each of these three factors may have played in the outcomes of PEMC.

In the individual grantee evaluations, researchers gave some attention to the issues of concept, design and measurement, and execution, particularly with regard to general case management interventions, although not necessarily in a systematic or uniform fashion. Unfortunately, the fact that the nature and intensity of the interventions were not clearly specified by grantees in guidelines or in other detailed protocols makes it difficult to distinguish between design and execution. The evidence suggests that weaknesses in both may have contributed, at least in part, to the absence of more definitive outcomes and that the absence of explicit protocols used by grantees to support the intervention itself could reflect a weakness in design.

Program office and foundation staff reported a variety of factors to explain the lack of positive outcomes from the interventions. In terms of concept, it may have been unrealistic to expect change in the kinds of fundamental indicators examined. Program office staff noted that there was a lot of “noise” in the system. Because frailty has many dimensions, it may have been unrealistic to expect that case management and community-based services alone would be strong enough to “move” indicators in a way that would demonstrate to purchasers and plans that there could be a positive return on investment.

In terms of design, staff said that one issue may have come from the fact that the interventions did not incorporate elements that motivate frail patients to want to take advantage of services. In other words, it was presumptuous to believe that patients will automatically take advantage of new services. On the contrary, an intervention will attract the target population only if it is created to respond to their concerns and needs. For instance, focusing on those in crisis may target resources to those most likely to take advantage of the services. Furthermore, doing so through an intervention that draws in medical staff and takes advantage of the trust they develop with their patients over time may make those in crisis more willing to accept help once they realize they need it.

In evaluating execution, program office staff pointed out that there were major challenges in simultaneously satisfying the research need for a clear design and the practical needs of organizations delivering health care. For instance, clinicians and case managers trained to view each patient as unique may have trouble accepting a standard treatment protocol, especially for patients with complex needs. Therefore, developing support for an intervention may require methodological compromises that detract from its potential effectiveness. Those approving grants, like the PEMC grants, typically have only a limited pool of applicants from which to choose. Moreover, there may be strong incentives in the applicant selection process to take
advantage of sponsor interest and resources in ways that build upon applicant interest and provide awards to proposals with shortcomings, assuming problems can be dealt with later. The fact that PEMC focuses on frail elders, a group that many regard as being insufficiently served by the existing system, raises the level of interest in an intervention that would benefit this group, even if the evidence base for how to intervene effectively is lacking, as it was in a number of ways when PEMC was launched and as it remains today.

D. CONCLUSIONS AND LESSONS

1. Conclusions

PEMC was an ambitious program with a good rationale that produced modest results. It appears to have been well run and financed by a foundation with a strong, clear vision, and well supported by influential grantees, a program office, and an advisory committee that aimed to leverage the knowledge of the field.

Why then did so few of the projects not lead to more meaningful change in patient outcomes? In retrospect, the outcomes sought by PEMC were probably too lofty relative to the interventions tested, the speed with which they were developed, and the existing knowledge (when the program began) on how to both improve care for frail elders and finance those improvements. PEMC’s goal—improving care for frail elders—was a challenging, but important, task. CHCF pursued the program for this reason and was encouraged by others to do so. The form of the intervention—better communication that linked medical and social service providers, with limited change in medical practice—was well suited to the capitated environment in California. The decision to look at external returns, in terms of health outcomes and costs, was based on the market. In the planning process, CHCF found evidence to suggest that plans would have a hard time accepting the results of any intervention and taking the next step without a business case for improving care to frail elders. However, PEMC grantees generally could not achieve this ambitious goal.

In addition to the fact that the goals were very ambitious, CHCF was probably not well positioned to achieve them, since doing so would mean resolving weaknesses in delivery that others before had failed to overcome.\(^5\) For the most part, the implementation grants facilitated the testing of a diverse set of general, but limited, case management models overlaid on a medical care system in which participants were not asked to change very much in the way they practice. Furthermore, PEMC did not, for the most part, seek to reorganize the entire delivery system. Rather, the goal was to better link these medical systems to community-based social service providers and to introduce more limited, but affordable, change (what Thornton, et al. (2002) term “constrained innovation”).\(^6\)

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\(^5\) See, for example, David B. Reuben, “Organizational Interventions to Improve Health Outcomes of Older Persons” Medical Care 40(5): 416-428, 2002; and Boult Chad, Robert L. Kane, James T. Pacala, and Edward H. Wagner “Innovative Healthcare for Chronically Ill Older Persons: Results of a National Survey” The American Journal of Managed Care 5(9): 1162-1172, September 1999.

Further, at the outset of PEMC, CHCF was a new foundation that aimed to move quickly—probably more quickly than they were positioned to do effectively. CHCF’s decision to give grantees flexibility was an understandable response to grantees’ interests in more flexible strategies that left more room for innovation than did proscribed interventions. But flexibility also resulted in less emphasis than necessary or desirable in encouraging maximum use of evidence in both structuring the interventions and defining the outcomes. The absence of a program office at the start of PEMC limited the support available to grantees. And, having only two cycles of closely spaced grants limited the amount of learning that was available to improve the program over time. In retrospect, it may have been more effective to invest in developing models before entering a large-scale test of the models.

The PEMC experience is by no means atypical. Entities that fund interventions often want strong evidence of positive effects from their investment, and they want that evidence relatively rapidly. Achieving organizational change is difficult, however. Seen in this light, program experience is a telling example not only of how hard it is to establish interventions for frail elders in a way that seriously changes the care they receive but also of how much harder it is to do so while generating short-term savings.

2. Implications for Future Efforts to Improve Care to Frail Elders

Experience with PEMC suggests that generalized interventions focused on frail elders, if pursued, need to have realistic expectations of outcomes. For instance, it could be that improving health outcomes in the traditional ways are inappropriate, at least for some frail elders who are on an irreversible downward trajectory. In these cases, it may be that providing comfort in the way of caregiver and family support is the best one can achieve. Or, when so much is lacking in terms of systems integration, merely supporting efforts that improve communication between medical providers and community-based service providers may be valuable in itself, particularly if it provides the assurance that effective interventions were not overlooked just because the need was not identified. The fact that these kinds of outcomes probably do not provide an immediately measurable return on investment does not mean that they are not valuable in other meaningful ways. However it is unclear whether payers, in today’s environment, will support such “soft” interventions, which do not generate a hard measurable return on investment.

An alternative approach is to try to apply some of the lessons of disease-focused interventions to construct interventions for frail elders that work better. For instance, one could develop interventions directed to frail elders at particular points of vulnerability (for example, when they are in transition from one setting of care to another, or during hospitalization) or for particular events or conditions (such as falls, dementia, or depression). Such an approach may be focused enough so that evidence-based protocols can be developed and resources can be directed to the patients who are most ready to accept help and to the situations for which interventions could be most cost-effective. What appear to be promising results from Project IMPACT and the UCLA NPI interventions suggest that this strategy may have some potential.

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More fundamentally, it may be that meaningful changes in care outcomes require efforts to reorganize care systems so that they are more responsive to the needs of chronically ill patients, particularly those with multiple conditions and who are frail as well.\(^8\) This approach is essentially based on the conclusion that limited interventions yield limited results and that the emphasis, therefore, needs to be on more massive change. Unfortunately, while such major system redesign may be valuable, the environment is such that massive change in financial incentives and in how institutions relate to one another are not likely to be forthcoming in the immediate future, except perhaps in uniquely appropriate and auspicious circumstances.

3. Lessons for Efforts to Improve Care Coordination in Medicare

The Medicare Modernization Act of 2003 (MMA) requires chronic care to be a focus of private plans in Medicare Advantage and of the traditional Medicare program. A large pilot program concentrating on coordinated care has been authorized with ambitious goals with respect to both scope and outcomes.\(^9\) CMS is also likely to remain interested in demonstrations that address the needs of frail elders jointly eligible for Medicare and Medicaid, and such demonstrations could provide an opportunity to initiate more fundamental change in systems.

The experience of the Program for Elders in Managed Care underscores the importance of well-structured, evidence-based interventions to successful outcomes and the particular challenges associated with identifying and effectively implementing these interventions for frail elders. It is not clear from PEMC whether the interventions to be included in the federal pilots will be adequately scaled to the ambitious policy goals set for them, particularly given the speed with which they are likely to be pursued and the limited scope of their authority (especially for interventions outside provider systems). Like PEMC, the federal pilot may be expecting more than incremental change can deliver in improved outcomes of care.

It is unclear how much support for frail elders will be forthcoming from the federal pilots. Experience suggests that it is easier to develop interventions for relatively healthy people who can largely care for themselves but who have chronic care needs. Thus, it is possible that the pilots will have an incentive to focus less on elders with ill-defined conditions and larger care management needs than on other populations. If true, an important opportunity to improve care for frail elders may be lost. In addition, because frail elders account for a large proportion of

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\(^9\) The three-year pilots will involve contracts with private sector organizations that agree to develop coordinated care pilots involving either care management or disease management that target a population in a given region. CMS envisions contracting with organizations that agree to risk their fee on the results they achieve. Involved staff believe that a five percent savings over three years is realistic. Outcomes will be assessed based on the total population targeted, not just those reached by the intervention. See Foote, Sandra M. “Chronic Care Improvement for Medicare FFS: Cosmetic or Transforming.” Prepared for the Council on Health Care Economics and Policy (11th Princeton Conference) Washington DC: Health Insurance Reform Project, George Washington University, May 11, 2004.
Medicare spending, it will be hard to control expenditures if programs do not adequately focus on this population.
I. INTRODUCTION AND BACKGROUND

The Program for Elders in Managed Care was a five-year, $15 million program funded by the California HealthCare Foundation. Established in 1997, PEMC aimed to improve care delivery for frail, at-risk elders in Medicare managed care. The first of CHCF’s grant programs, PEMC encouraged partnerships between managed care organizations, provider organizations, and community-based organizations. The hope was that these integrated models of care would not only enhance access, but also improve care coordination for this vulnerable population. In pursuing these ends, foundation staff noted that they received encouragement from other foundations and groups who perceived the value of focusing on frail elders overall, not just the management of specific diseases. With interest growing nationwide on how best to improve care delivery for frail elders, both policymakers and clinicians, in California and nationwide, have great interest in PEMC and what lessons it may have for future efforts to improve care to frail elders.

To address this need, this report summarizes the results of the evaluation of PEMC that was commissioned by CHCF and conducted by Mathematica Policy Research, Inc. The initial chapter provides a brief background on the program. (See Appendix A for more information on the evaluation and program background.) This chapter also describes the MPR evaluation and outlines the organization and overall purpose of the report.

A. OVERVIEW OF PEMC PROGRAM

PEMC’s goal was to improve care for frail elders in Medicare managed care in California. California has always led the nation in its adoption of Medicare managed care (Gold and Lake 2002). In 1997, when PEMC was developed, it looked like managed care would become increasingly dominant in care for the elderly, not just in California, but also in the nation as a whole (Zaraboza, Taylor and Hicks 1996; Christensen 1998).

The Program for Elders in Managed Care aimed to influence the fragmented way in which frail elders receive care by forging links between MCOs, provider organizations, and community-based service providers. However, PEMC was more than just a communication program. Successful interventions would face the challenges associated with bridging the diverse outlooks of medical and social services providers and with the constraints of Medicare and its largely medically oriented benefits.

PEMC was based around two cycles of competitive grants. Grantees were required to represent a coalition of managed care organizations, health care providers, and community-based organizations. The PEMC solicitation was relatively broad to encourage diverse models, while also providing a mechanism for key constituencies to collaborate on effective ways of addressing program goals.

Several types of grants were funded—implementation, planning, and related activities. Implementation grants were designed to support efforts to develop new systems of care that aimed to improve care or service delivery for frail elders in managed care; those receiving such grants were awarded up to $1 million for a period of up to three years. They were required to
include an independent evaluation with, in most cases, a randomized design as a core part of the project. Planning grants were smaller and were intended to serve as “seed money” to further develop arrangements that were still at the formative stage. These grantees received up to $75,000 for a period of up to one year. Aside from the grants awarded during the two funding cycles, PEMC also made or served to oversee on an ad hoc basis a few “related-activity” grants for activities with similar objectives to PEMC; two of the grants funded under this initiative focused on disease management programs for those with depression and diabetes. In total, PEMC sponsored nine implementation grants, thirteen planning grants, and three related-activities grants; it also provided augmentation monies to three of the implementation grants to support additional analysis. (See Appendix B (Table B.1) for a complete list of grants; see Appendix C for summaries of each implementation and related-activities grant; and see Appendix D for summaries of planning grants.)

CHCF initially administered PEMC, but, in October 1999, the Foundation established a separate program office at the University of California at Los Angeles (UCLA) Multicampus Program for Geriatrics and Gerontology for this purpose. The program office was responsible for overseeing the grants, providing technical assistance to grantees, and disseminating the results from program activities. PEMC also had a 12-member advisory committee that was responsible for reviewing grant applications, attending the annual meetings, and offering guidance to the program office. The advisory committee consisted of experts in managed care and care for the elderly, both in California and nationally. Because the chair of the original advisory board was tapped to co-direct the program office, the office benefited from the early program experience.

PEMC’s goals were ambitious. The population it sought to target—frail elders—tend to have many chronic conditions that typically are not adequately addressed by a health care system focused on acute treatment and service (Anderson and Knickman 2001; Partnership for Solutions 2002). At the time PEMC was developed, most proposed innovations were “fairly cautious experiments” (Boult, Kane, Pacala, and Wagner 1999). By and large, their objectives were constrained—to “fix” one part of health care delivery (for example, using teams and redesigning primary care)—not the overall system. Articles highlighting the limitations of single intervention change and potential alternatives, like the chronic care model, were just starting to emerge (Wagner, Austin, and Von Korff 1996). Even now, few care providers use the kinds of comprehensive approaches believed to be important for improving care to frail elders and others with chronic illnesses (Casolino, et al. 2003). PEMC sought to address these problems, at least in part. It also sought to build an evidence base, through the rigorous individual grantee evaluations, that could inform future efforts.

The context in which PEMC was developed is important to keep in mind in judging the program. (See Appendix E for an annotated bibliography of selected research on this topic.) The task of reconfiguring care systems for frail elders with diverse disabilities, chronic illnesses, and cognitive impairments is substantially more challenging than that involved in improving care to relatively healthy people with particular conditions that are often targeted by disease management programs and quality improvement initiatives. Programs with proven effectiveness in intervening to improve care for frail elders are rare, even today. Furthermore, efforts at intervention are challenged by the expense of interventions, regulatory requirements, payer restrictions, and the attitudes of existing providers (Boult, Kane, Pacala, and Wagner 1999). While PEMC’s goals were not so lofty as to require all these challenges to be addressed, barriers were encountered. In addition, the program spanned the period during which the managed care
backlash developed, and Medicare managed care plans saw reductions in the rate at which their federal capitation payments increased. Plans and providers participating in PEMC were not immune to these influences, and their results created organizational instability that had a negative effect on some of the PEMC grantee coalitions.

B. EVALUATION OF PEMC

In late 2002, CHCF commissioned MPR, based on a competitive process, to evaluate the overall program experience of PEMC. The MPR evaluation addresses six key questions:

1. What kinds of integrated models of care for frail elders were tested through PEMC?

2. What has been learned about grantees’ different models of care? What were the outcomes of the individual grants, and how did they vary?

3. Which demonstration efforts appeared most sustainable or applicable to other settings? What are the factors that lead to, or impede, the success of different models of care?

4. What are the nationwide implications of findings for care management, managed care practices, Medicare policy, or care for frail elders?

5. Generally, what has been learned about grant making in the area of integrated care for the elderly, or in general? What is the value and use of planning grants? How did the related-activities grants contribute to the program’s mission? Would these outcomes have come from the market without the benefit of foundation funding?

6. What can we learn about program office operations? Which program office activities have been perceived to be most useful and least useful, and why? What are the lessons for the management of other programs?

Given the resources available, and at the Foundation’s request, the evaluation built on information already available on PEMC, especially the evaluations built into each project grant. The MPR evaluation included four basic methods and sources of information:

1. A review of program/grantee applications, progress reports, and final reports.

2. A synthesis of findings from grantee reports of evaluations of outcomes, most of which included a randomized control design.

3. Independent semistructured interviews with grantees and other program participants using semistructured protocols.¹⁰

¹⁰ For implementation grants, MPR interviewed the lead organization for the grant, one staff member from another organizational participant (such as a community-based organization), and the internal evaluator. For planning grants, one interview was conducted per grant.
4. A review of the related literature on efforts to improve care for frail elders and others through demonstrations and other means.

To provide context, MPR also observed the PEMC grantee program meeting for the final year and the associated Leadership Summit and reviewed relevant literature on other applicable initiatives and findings nationwide. (See Appendix F for additional details on methods.)

C. ORGANIZATION OF THIS REPORT

This report provides the overall findings from MPR’s evaluation.

Chapter II focuses on the core of the program—the experience of the implementation grants. The chapter describes the different models of care funded by the grants, including the impetus behind their development. The chapter then describes MPR’s findings on implementation grants from reviewing documents and conducting interviews. These findings focus on the impetus for participation, problems encountered, and the accomplishments, sustainability, and replicability of the interventions tested. To enrich the findings, this analysis includes not only the experience of the nine implementation grants, but also that of the two related-activity grants that resulted in operational demonstrations. (See Table I.1 for a list of PEMC grantees by type.) Two of the nine implementation grants were terminated before they were operational; for these grants, the reasons for lack of success are reviewed, but obviously no data on operational outcomes are included. The chapter then summarizes what the grantees’ own evaluations found, including assessing the design of the studies that generated those outcomes. The chapter ends by assessing project findings in context of existing research in this area.

Chapter III presents evaluation results on other program components, including: (1) what was accomplished by including planning grants and flexible funds for related activities and augmented analysis; (2) MPR’s conclusions on the value of funding rigorous individual grantee evaluations as an integral part of the demonstration; (3) the findings on program administration and infrastructure; (4) the program’s success in meeting its dissemination objectives; and (5) the lessons for future programming.

Chapter IV builds on the findings and presents overall conclusions of the evaluation and lessons to be drawn from these findings/conclusions. The latter includes targeted lessons for CHCF and California health plans and providers, and more general lessons for improving care to frail elders.

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11 MPR’s findings in this area are separate from those of Randi S. Jones and others in the program office who also interviewed implementation grantees. Their analysis used computer-assisted qualitative analysis to generate ten themes relevant for others seeking lessons from PEMC. The resulting report includes valuable examples of how key processes work and complements the MPR approach, which focuses on more traditional research and evaluation techniques to assess change resulting under PEMC and the factors that contributed to that change.
# TABLE I.1. LIST OF PEMC IMPLEMENTATION AND OTHER OPERATIONAL GRANTEES BY TYPE

## Cycle 1—Implementation Grants

<table>
<thead>
<tr>
<th>Organization</th>
<th>Program Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jewish Family and Children’s Services</td>
<td>Expansion and Evaluation of the “Identification and Early Intervention Program.”</td>
<td>$750,157</td>
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<tr>
<td>Institute on Aging</td>
<td>“Northern California Chronic Care Network for Dementia Demonstration Project.”</td>
<td>$993,132</td>
</tr>
<tr>
<td>Kaiser-Permanente TriCentral Continuing Care and Partners in Care Foundation</td>
<td>“Implementation and Evaluation of the Community Partners Project.”</td>
<td>$1,048,260</td>
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<tr>
<td>(Includes a later $58,260 augmentation grant for additional analysis.)</td>
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## Cycle 2—Implementation Grants

<table>
<thead>
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<th>Organization</th>
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<tbody>
<tr>
<td>Long Term Care Group and LivHome</td>
<td>“Preventing Disability through Community-Based Health Coaching and Services Enhancement.”</td>
<td>$1,134,848</td>
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<tr>
<td>(Includes a Cycle 1 planning grant of $75,848 and a later augmentation grant of $60,000 for additional analysis.)</td>
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<td></td>
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<tr>
<td>PacifiCare/Secure Horizons and Greater Newport Physicians</td>
<td>“Secure Horizons ElderCare.”</td>
<td>$1,075,000</td>
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<td>(Includes a $75,000 Cycle 1 planning grant.)</td>
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<tr>
<td>Sharp HealthCare and West Los Angeles Veterans Affairs Medical Center</td>
<td>“Frail Elderly Care Management Program.”</td>
<td>$1,060,000</td>
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<td>(Includes $60,000 received later in augmentation funds to support additional analysis.)</td>
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<td></td>
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<tr>
<td>UCLA Neuropsychiatric Institute</td>
<td>“San Diego Alzheimer’s Disease Collaborative Care Initiative.”</td>
<td>$1,007,920</td>
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<tr>
<td>On Lok Senior Health Services</td>
<td>“Integrating Independent Medical Group Practices with On Lok’s Interdisciplinary Team Approach.”</td>
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<td>(Includes a $74,682 Cycle 1 planning grant.)</td>
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<tr>
<td>California Institute for Rural Health Management</td>
<td>“Lompoc Elders in Managed Care Program.”</td>
<td>$850,000b</td>
</tr>
<tr>
<td>(This grant was terminated early in January 2001 due to unanticipated instability in the managed care products in the Lompoc market that would have led to severe constraints on enrollment.)</td>
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<td></td>
</tr>
</tbody>
</table>

## Related-Activity Grants with Operational Focus

<table>
<thead>
<tr>
<th>Organization</th>
<th>Program Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Foundation Northern California, Desert Medical Group, and UCLA Neuropsychiatric Institute</td>
<td>“Project IMPACT.”</td>
<td>$2,939,521</td>
</tr>
<tr>
<td>UCLA General Internal Medicine.</td>
<td>“Improving Care for Older Persons with Diabetes in Managed Care in California.”</td>
<td>$469,075</td>
</tr>
</tbody>
</table>

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\*This grant was terminated early in April 2002 because On Lok Senior Health Services was not able to receive timely HCFA (now CMS) approval for PACE demonstration expansion needed for the intervention.

\^This grant was terminated early in January 2001 due to unanticipated instability in the managed care products in the Lompoc market that would have led to severe constraints on enrollment.
II. FINDINGS FROM THE EVALUATION OF IMPLEMENTATION GRANTS

This chapter presents the key findings from the evaluation of the implementation grants, the core of PEMC. The structure of each grant is described and MPR’s evaluation findings are presented in the following areas: (1) motivation for grantees to get involved in the demonstration; (2) grantees’ progress in implementing initiatives; (3) the technical and other problems encountered by grantees; and (4) grantee accomplishments under the program and whether they have been sustained. Next is a review of how grants were structured to support their independent evaluation of project outcomes and what these evaluation findings show. The chapter ends with a brief analysis of how these findings compare to those reported elsewhere in the literature for similar programs. (See Appendix C for a summary of each grant that includes information on grant design, implementation experience, structure of evaluation, and key findings.)

A. GRANT STRUCTURE

PEMC’s implementation grants were structured to provide grantees with flexibility in designing strategies for improving care for frail elders. (See Table II.1 for a summary of the PEMC-funded and related-activity grants.) The lead sponsors of the nine PEMC implementation grants were a diverse group. Three were managed care plans (Kaiser TriCentral, Pacificare/Secure Horizons, and On Lok Senior Health Services); three were community-based groups (JFCS, IOA, and CIRHM); one was a provider group (Sharp HealthCare); one was an academic group (UCLA NPI); and one was an organization (LTCG) consulting for CalPERS, a purchaser. Seven of the nine implementation grants focused on general care management for frail elders, although two of them never achieved operational status (CIRHM and On Lok Senior Health Services). The five that did achieve operational status include the following:

- **Jewish Family and Children’s Services.** The target population was high-risk seniors receiving care from physicians affiliated with the Brown and Toland Medical Group. Building on a 1993 pilot, physicians and front-office staff identified seniors who may have needed supportive services and referred them to a caseworker at JFCS for an in-home assessment, including appropriate subsequent referrals and services. Front-office staff at Brown and Toland received training to identify those appropriate for referral.

- **Kaiser TriCentral.** The target population was high-risk seniors in the Kaiser southern California system. This grantee tested whether high-risk seniors who received home and community-based services as a Kaiser benefit for three months would see the value of and be willing to pay for these services later. Using a randomized design with two rounds of randomization, Kaiser TriCentral tested four options: (1) usual care with mailed information and referral; (2) geriatric care management; (3) geriatric care management with $2,000 in additional benefits; and (4) limited telephonic case management.
<table>
<thead>
<tr>
<th>Grantee</th>
<th>Lead Organization Type</th>
<th>Other Collaborators</th>
<th>Focus</th>
<th>Target Population</th>
<th>Intervention</th>
<th>Hypothesized Outcomes</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jewish Family and Children’s Services</td>
<td>Community-based organization</td>
<td>Brown &amp; Toland Medical Group; provider groups</td>
<td>Frail elders</td>
<td>Those age 85+ or having at least one hospitalization, emergency room visit, or nine primary care physician visits</td>
<td>Assessment, referrals for supportive services (front office provider group staff trained to identify need for referral)</td>
<td>Targeted case management will reduce costs, utilization</td>
<td>Built on 1993 pilot</td>
</tr>
<tr>
<td>Kaiser TriCentral</td>
<td>Managed care organization, integrated care system</td>
<td>Multiple community groups in Los Angeles County</td>
<td>Frail elders</td>
<td>Those age 65+ identified through a screening instrument; other referrals</td>
<td>Coordination of care; compared (1) mailed information and referral, (2) case management, (3) case management with $2,000 in additional benefits, and (4) limited telephonic case management</td>
<td>Coordinated care will reduce costs; those receiving extra benefits would later want to pay for them</td>
<td>Two rounds of randomization moving from three to four interventions</td>
</tr>
<tr>
<td>Institute on Aging</td>
<td>Community-based organization</td>
<td>Kaiser Permanente, Brown &amp; Toland Medical Group, Sutter Health</td>
<td>Dementia in frail elders</td>
<td>Those identified with dementia (some training and support in assessment); those who are part of national Chronic Care Network for Alzheimer’s Disease Initiative</td>
<td>Care management via physician, case manager, and Alzheimer’s Association (model varies by site)</td>
<td>Care management will reduce costs and use and will increase member satisfaction</td>
<td>Part of national Chronic Care Network for Alzheimer’s Disease Initiative; Sutter Health never implemented</td>
</tr>
<tr>
<td>Sharp HealthCare</td>
<td>Risk-bearing provider system</td>
<td>PacifiCare</td>
<td>Frail elders</td>
<td>Those age 80+ or age 65 with a chronic condition or functional limitation</td>
<td>Case management, including ongoing screening and follow-up</td>
<td>Intensive case management will reduce use and costs</td>
<td>N/A</td>
</tr>
<tr>
<td>Long-Term Care Group</td>
<td>Managed care organization (firm consulting with CalPERS for long-term care)</td>
<td>CalPERS, Eskaton, and three managed care organizations</td>
<td>Frail elders</td>
<td>Those with long-term care insurance via CalPERS; also those with a chronic condition enrolled in a managed care</td>
<td>Care management; nurse coach encourages a plan for diet, exercise, disease management, and a referral</td>
<td>Intervention will encourage healthy behaviors and reduce health care cost and use</td>
<td>A typical intervention with minimal physician involvement; those served were healthier than those in other</td>
</tr>
<tr>
<td>Grantee</td>
<td>Lead Organization Type</td>
<td>Other Collaborators</td>
<td>Focus</td>
<td>Target Population</td>
<td>Intervention</td>
<td>Hypothesized Outcomes</td>
<td>Comment</td>
</tr>
<tr>
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<tr>
<td>UCLA Neuropsychiatric Institute</td>
<td>Provider (as coordinator)</td>
<td>Three managed care organization-associated medical groups and various community organizations</td>
<td>Dementia in frail elders</td>
<td>Those identified by providers as having dementia</td>
<td>Coordination of care based on guidelines developed through a collaborative process</td>
<td>Intervention will improve adherence to guidelines, increase caregiver satisfaction, improve provider knowledge, and reduce costs</td>
<td>NA</td>
</tr>
<tr>
<td>Pacificare/Secure Horizons</td>
<td>Managed care organization</td>
<td>Multiple community groups and affiliated providers</td>
<td>Frail elders</td>
<td>Those age 85+ or age 65+ identified with a use-based algorithm scoring four or more</td>
<td>Care management via a community-based advocate with assessment and referral</td>
<td>Care management will reduce use of high-cost services</td>
<td>N/A</td>
</tr>
<tr>
<td>California Institute for Rural Health Management</td>
<td>Community-based organization</td>
<td>Large independent practice association under contract with PacifiCare/Secure Horizons</td>
<td>Frail elders</td>
<td>Top 10 percent of users</td>
<td>Care management via nurse care coordinators</td>
<td>Care coordination will reduce costs and use and improve patient satisfaction</td>
<td>Terminated after PacifiCare dropped its risk contract with the major independent practice association</td>
</tr>
<tr>
<td>On Lok Senior Health Services</td>
<td>Managed care organization with staff model and focus on integrating medical and social services</td>
<td>Newly developed network of providers</td>
<td>Frail elders</td>
<td>Those aged 55+ and state-certified as nursing home-eligible</td>
<td>Coordinated medical and community services provided in collaboration with patient’s physician</td>
<td>Network will attract beneficiaries to coordinated care; coordinating medical and social costs will have positive outcomes</td>
<td>Basis of Program of All-Inclusive Care for the Elderly concept; terminated after CMS waiver approval delayed; waiver since received and patients are enrolled</td>
</tr>
<tr>
<td>Grantee</td>
<td>Lead Organization Type</td>
<td>Other Collaborators</td>
<td>Focus</td>
<td>Target Population</td>
<td>Intervention</td>
<td>Hypothesized Outcomes</td>
<td>Comment</td>
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<tr>
<td><strong>Related-Activity Grants</strong></td>
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<tr>
<td>Project IMPACT</td>
<td>UCLA Neuropsychiatric Institute</td>
<td>Kaiser Permanente Hayward, Desert Medical Group</td>
<td>Elders with depression</td>
<td>Those age 60+ with diagnosed depression</td>
<td>Specialized case management via a clinical depression specialist who coordinates between patient and physician</td>
<td>Better case management will improve care outcomes</td>
<td>Part of eight-cite national effort funded by the Hartford Foundation</td>
</tr>
<tr>
<td>UCLA General Internal Medicine</td>
<td>Provider group (as coordinator)</td>
<td>Pilot-site providers: Sharp HealthCare, West Los Angeles Veterans Affairs Medical Center</td>
<td>Diabetes in geriatric population</td>
<td>No defined target population; materials support multiple interventions that can be diversely targeted and are still undergoing pilot testing</td>
<td>Development of guidelines and tool kit in collaboration with American Geriatric Society, including pilot testing</td>
<td>Effects of guidelines on care delivery</td>
<td>American Geriatric Society is a cosponsor</td>
</tr>
</tbody>
</table>

Note: A third related activities grant was funded but is not included here because it involved instrument development rather than testing a care intervention.

- **Sharp HealthCare.** The target population was chronically ill Medicare patients in the Sharp HealthCare system in San Diego who are enrolled in PacifiCare. These seniors were randomly assigned to receive intensive case management or standard medical management. In the former, case managers review screening results, receive referrals from primary care physicians, and monitor service-use data to identify at-risk cases for the primary care physician. Patients were eligible for, though not required to get, integrated medical/social case management including in-home visits as required. However, case management mainly involved telephone assessments, education and coaching, and referrals to community-based providers.

- **Long-Term Care Group.** The target population of this long-term care insurance provider was Sacramento seniors in CalPERS with long-term care insurance who have at least one chronic condition and who receive care through one of three managed care plans (Kaiser Permanente, Health Net, or PacifiCare). Those randomized to the intervention group met with a nurse health coach who worked with them to develop a plan that included diet and exercise, disease management, and referral to community services.

- **PacifiCare/Secure Horizons.** The target group was elders age 85 and older and other seniors identified as frail in three medical groups affiliated with PacifiCare. Those randomized to the intervention group were seen by a Care Advocate (a master’s-level
care manager) in a community care center who assessed need for eight types of services, made appropriate referrals, and did follow-up. The primary care provider was updated on the patient’s progress.

The other two implementation grants (IOA and UCLA NPI), described below, are specific to dementia.

- **Institute on Aging.** The target population was seniors with Alzheimer’s disease in three very different provider groups (Kaiser Permanente Northern California, Brown and Toland Medical Group, Sutter Health). This grant involved both the use of new instruments for assessing dementia and model treatment protocols for providing patient information and family caregiver support. The effort was part of a seven-site national initiative of the Alzheimer’s Association and the National Chronic Care Consortium.

- **UCLA Neuropsychiatric Institute.** The target population was seniors with Alzheimer’s disease (and their caregivers) receiving care through one of three medical groups in San Diego (Kaiser Permanente, Scripps Clinic, and UC San Diego HealthCare). The grantee tested guidelines for dementia care that were developed by a task force of providers and community agencies. Clinics within the provider groups were randomized to the intervention group (using guidelines) or control group.

Both related-activities grants supported disease-specific interventions, one on depression (Project IMPACT) and one on diabetes (UCLA GIM). These projects were funded on an ad hoc basis from available funds on an opportunistic basis when the Foundation received outside requests that they saw to be related to PEMC goals.

- **Project IMPACT.** The target population was elders age 60 and older diagnosed with depression and receiving care through the Kaiser Hayward medical site or the Desert Medical Group. Those randomized to the treatment group received specialized care management for depression from a clinical specialist in depression who coordinated care and acted as the interface between the patient and physician. CHCF funds allowed these two sites to be part of a national study that included five other sites and a coordinating center funded by the Hartford Foundation. (UCLA NPI received additional funds to coordinate the two California sites.)

- **UCLA General Internal Medicine.** This grant supported the development of a set of guidelines and a geriatric diabetes tool kit for care of older patients with diabetes. A national advisory committee participated in developing guidelines to enhance their

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12 A third related-activity grant was awarded to the National PACE Association to develop a consumer satisfaction measurement tool for frail elders participating in PACE. Two versions were prepared to provide measures for those with mild to moderate cognitive impairment, as well as those without such impairments. The instrument was used to assess satisfaction with PACE providers.
acceptance. The guidelines are now being pilot tested in two locations: Sharp HealthCare (San Diego) and West Los Angeles Veterans Affairs Medical Center. Related funding was provided to the RAND Corporation to develop a tool to predict risk of mortality and decline in order to help target support.

The implementation grants serving frail elders generally involved three types of activity: (1) identification and initial assessment; (2) development of a care plan; and (3) implementation of that care plan. Although each grantee used some form of identification, their methods varied, and some interventions focused on more frail elders than did others. Once identified, clients were assessed and care management was provided. The most atypical interventions targeting the general frail elder population were in Kaiser TriCentral and LTCG. The former emphasized the effects of benefit expansion for home and community services, while the latter sought to promote exercise and lifestyle change primarily for healthy seniors who had purchased long-term care insurance.

Disease-specific interventions used a similar sequence of activities but focused on assessment and care for specific conditions and placed more emphasis on adherence to medical practice guidelines. Although the type of organization acting as the lead differed across the grants, all of the implementation grants were structured to draw on the incentives of risk-based managed care. The interventions focused on those enrolled in risk-based managed care plans under the assumption that, by virtue of capitation, the plan and associated risk-based providers would have an interest in flexible delivery of care and in working with community-based organizations that offered potential cost savings and improved patient outcomes. The home- and community-based service organizations involved in the grants varied from project to project but generally offered such services as transportation, in-home services (including meals), and social-work counseling. In a few cases, community organizations were the lead entities in the grants, holding primary responsibility for establishing the care management approaches and linkages with MCOs. Examples of linkages or partnership arrangements include the following:

- Kaiser TriCentral partnered with Los Angeles County and the City of Los Angeles Area Agencies on Aging (AAAs), which provide home- and community-based services to the elderly.

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13 Four of the five grantees used administrative data, with two basing identification on use-based algorithms (Kaiser TriCentral and PacifiCare/Secure Horizons) and two on the number of chronic conditions (Sharp HealthCare and LTCG). The fifth, JFCS, did not use a formal set of criteria; the primary method of screening was by telephone.

14 Three of the four disease-specific projects (UCLA GIM, UCLA NPI, and IOA) involved general guidelines calling for the development and implementation of a treatment plan that included defined goals for the patient to attain. The UCLA GIM intervention, for instance, involved development and pilot testing of a set of evidence-based guidelines, which included specific care recommendations concerning health conditions associated with diabetes. Although the IOA intervention emphasized adherence to specific practice guidelines, it was similar to the general care management projects in that referrals to community-based services that addressed dementia played an important role. The Project IMPACT intervention, rather than using specific guidelines, attempted to standardize care by training clinical depression specialists, who performed the care management according to an intervention manual used for all intervention sites.
• IOA partnered with an operational risk-based MCO and provider (Kaiser and Brown and Toland Medical Group) and with local chapters of the Alzheimer’s Association.

• PacifiCare/Secure Horizons partnered with four medical groups (Cedars Sinai, Harriman Jones, HealthCare Partners, and Talbert), and two home- and community-based service organizations (Jewish Family Service of Los Angeles and JFCS of Long Beach/West Orange County).

• JFCS of San Francisco partnered with Brown and Toland Medical Group in order to identify frail elders who had been seen in primary practices in the group; Brown and Toland referred patients to JFCS for social services.

• LTCG partnered with CalPERS and Eskaton (a Sacramento-based agency providing assisted-living services) to identify CalPERS beneficiaries with long-term care insurance who could benefit from personal health coaching led by Eskaton.

As part of the goal of better coordinating medical and social services for frail elders, an important emphasis of the grant projects was to facilitate the relationships between medical and social service organizations. Partnerships and closer working relationships were intended to support the interventions tested in the demonstrations (as described in Section C of this chapter). Related-activity grants were not required to involve community-based organizations.

The intensity of the interventions varied among implementation grants. For example, some grantees conducted the initial assessment by telephone (Sharp HealthCare and Pacificare/Secure Horizons), while others did so in person (LTCG and JFCS).\(^{15}\) Kaiser TriCentral used both methods to test multiple interventions. The initial assessments for the disease-specific interventions were all conducted in person.

The extent of enrollee contact also varied. For example, care advocates in the Pacificare/Secure Horizons project contacted patients monthly for eleven months after the initial assessment; the geriatric case manager of the Kaiser TriCentral intervention devoted 20 hours, on average, to each case over an eight- to nine-month period. In the Sharp HealthCare project, care management began with “active” status patients being contacted monthly or weekly and transitioned to “monitoring” status (usually after the first 90 days), in which contacts were initiated every 60 to 90 days.

Staffing also varied. Three projects (Kaiser TriCentral, Pacificare/Secure Horizons, and Sharp HealthCare) employed either registered nurses or staff with a master’s degree in social work or family counseling. Staff in the other two care management projects typically had lower levels of training. Those with a bachelor’s degree were trained to be nurse health coaches in LTCG intervention, and physician office staff were trained to be geriatric resource persons in the JFCS project. Kaiser TriCentral also used bachelor’s level staffing in one form of its intervention. Project IMPACT, on the other hand, employed clinical depression specialists, who were either psychologists or psychiatric nurses.

\(^{15}\) If it was deemed necessary, an initial in-home assessment was conducted for the Sharp HealthCare and Pacificare/Secure Horizons interventions.
In accordance with the grant requirements, all of the implementation grants involved some type of partnership with community-based service providers. (See box below for an illustrative example of how this worked for one patient.) In some cases, the partnership took the form of referrals to community-based service providers, and in other cases, community providers were more closely involved in the overall design and management of the intervention. As part of the care management interventions, Kaiser TriCentral and Pacificare/Secure Horizons made referrals to a wide range of community-based services, such as food delivery, transportation services, adult day health services, or legal assistance. While Pacificare/Secure Horizons did this through only a few organizations, Kaiser TriCentral contracted with many. IOA and LTCG either partnered directly with or referred patients to community-based organizations for services related to the targeted outcome. The IOA grant, which targeted the needs of dementia patients, referred patients to the local chapter of the Alzheimer’s Association to support and educate patients and caregivers. LTCG—whose goals included encouraging health-promoting activity and teaching seniors to be more effective at chronic disease self-management—partnered directly with a community-based organization to provide services, such as fitness classes and chronic disease self-management.

An Example of Care Management

Mrs. M., an 85-year-old widow was physically frail, lived alone in a small apartment, used oxygen 24 hours a day, and walked with the aid of a walker. No longer able to drive, she felt “cooped up” and dependent. Her daughter, who lived 30 minutes away and worked full time, took her grocery shopping and helped with housekeeping chores on the weekend. Concerned that she was a burden to her daughter, Mrs. M. enrolled in the Care Advocate Program. After the initial assessment, Mrs. M decided to enroll in only the Dial-A-Lift transportation services. Mrs. M. used the service regularly for shopping, getting to her doctor’s appointments, and going to the bank. After nine months in the program, Mrs. M. was diagnosed with end-stage liver cancer. Because Mrs. M was not a candidate for cancer treatment, the care advocate discussed hospice options with Mrs. M. and her family and referred her back to their medical group. After the family discussed end-of-life options with Mrs. M’s physician, she was transferred from the hospital to a hospice-care center, where she died within a week. Soon after, the care advocate received a letter from Mrs. M.’s daughter thanking her for providing emotional support and for introducing Mrs. M. to transportation that offered her a “feeling of independence all the way until the end of her life.” (Wilber and Shannon 2003)

The extent of physician involvement also varied across grantees. For example, of the five general interventions, two appeared to have involved physicians on a limited basis, such as through a telephone discussion of the initial assessment results (JFCS) or a letter from the care advocate (Pacificare/Secure Horizons).

B. MPR’S EVALUATION FINDINGS

MPR’s evaluation was based on document review and interviews and thus complements the assessment of outcomes in the individual grantee evaluations. This section reviews what MPR learned about grantees’ motivations for becoming involved in the program, the ability of the grantees to move forward to implementation, the problems experienced in doing so, what the grants accomplished, and what is known about the sustainability of the interventions.
1. What Motivated Grantees to Become Involved in PEMC?

For the most part, the impetus for grantees’ participation in PEMC seemed to reflect the convergence of three forces: (1) a local “champion” who had heard of the grant opportunity and who was interested in developing an initiative and ready to take the lead on it; (2) management’s perception that the kind of initiative envisioned would be to the advantage of the organization and consistent with its mission and business interests; and (3) broad awareness of the CHCF call for proposals for PEMC and applicant interest.

In general, local champions had a three-pronged role: They created awareness of the potential to move forward with a particular initiative, served as communicators and negotiators across the diverse organizations and constituencies that had to be brought on board for a particular project, and moved the implementation process forward. Specifically, however, this role differed across grantees, and the decision to proceed with implementation appeared to have been more of an issue in some settings than in others. LTCG intervention would never have been developed without the active interest of a key consultant within LTCG who saw PEMC as an opportunity to propose a different kind of project. The consultant knew that launching this project would mean convincing CalPERS of its need and identifying an appropriate partner to mount the behavior-based intervention. In contrast, there was less convincing necessary at On Lok Senior Health Services where the champion was the CEO. Also, it was easier to champion projects that built on prior demonstrations (JFCS, for example) or on existing work in an area (such as Kaiser TriCentral’s work to identify frail elders).

A business rationale for proceeding was important for all grantees, regardless of type. For health plans, the rationale stemmed from recognition of the challenges involved in delivering care to a growing frail elderly population. This was variously expressed as a desire to improve links with community-based organizations, assess the potential for reaching out to those not served, or identify potential innovations and new services. Community groups leading grant development typically cited the value of the PEMC grant in providing a vehicle to further develop existing community-based initiatives. Provider groups cited the potential to improve care, though at least one noted that physicians would have to be persuaded that participation would not limit their ability to maintain clinical control over medical care.

Feedback from those successful in getting implementation grants suggests that knowledge of the opportunities presented by the solicitation was widespread. This may have been connected to the fact that there were many ways to learn about the solicitation, aside from mail. For instance, several grantees knew CHCF staff and heard about the call for proposals through them. Some potential grantees were active in the advisory board for the solicitation and heard of it that way. CHCF appears to have gone out of its way to inform dominant health care systems and providers about the opportunity. While MPR does not have a sense of the level of awareness among those who never applied or did not obtain grants, the explanations about awareness from those who did obtain grants suggest that knowledge of the opportunity presented by PEMC was widespread.

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16 Historically, program office staff say, getting resources from health plans has been a major issue for community-based organizations. Community organizations thus hoped PEMC would show positive outcomes valued by plans that would make plans more likely to pay community-based organizations in the future.
The process leading to related grant awards or awards for activity that was part of national demonstrations was different from the process for awarding PEMC-funded grants. California grantees receiving related-activity grants to participate in Project IMPACT learned about PEMC through their work with the Hartford Foundation on the national initiative. Including multiple California sites reflects CHCF’s interest in producing findings that could be generalized beyond the Kaiser model. UCLA GIM’s diabetes initiative was encouraged by fellow faculty at the PEMC program office, and CHCF encouraged UCLA to use a national advisory panel to build support for the findings. PEMC support for JFCS was enhanced by JFCS’s experience with a Robert Wood Johnson Foundation grant.

The decision to apply directly for an implementation grant versus a planning grant appears to have been a strategic one that was relevant only to Cycle 1 grantees, as it was well known that Cycle 2 would be the last of the grant cycles. Some grantees that were uncertain of their concept wanted or needed such a grant to explore the feasibility of their concept. Those going straight to an implementation grant sometimes did so because they were fearful that to do otherwise would mean that they would never progress to an implementation grant. (In Cycle 2, this was a high probability, since no additional grants were anticipated.) Others either felt they had done enough development work that they were ready for implementation or found the concept of planning grants not very useful. At least one grantee that went straight to an implementation grant learned later that its systems were not as developed as it had thought and said, in hindsight, that it would have benefited from additional time to plan. Another said a planning grant would have helped them to “hit the ground running.”

2. Were Grantees Able to Implement the Interventions?

All of the grantees appear to have made a good faith effort to implement the initiatives they proposed. In a few cases, they modified their design to address unanticipated problems or unexpected issues that arose. In interviews and through observations at program meetings, the enthusiasm and commitment of the PEMC participants was very obvious.

Of the nine implementation grants, seven became fully operational; however, one of the seven (JFCS) was able to recruit only six patients for its intervention group. JFCS attributes the failure to the instability in the market. Specifically, the intervention was based on a collaboration with medical groups affiliated with Brown and Toland Medical Group. Brown and Toland reportedly stopped accepting full-risk contracts, which meant that they no longer had an incentive to participate in the demonstration as they would not benefit from any savings that might result. Brown and Toland Medical Group sent patients a letter saying care management services were canceled. Despite its efforts, JFCS could not encourage physicians to refer. Since the intervention depended on physicians and their office staff referring patients, this meant that the intervention ultimately could not be tested. In the absence of a randomized trial, JFCS used both a retrospective analysis of health outcomes and costs for those voluntarily using services, versus those who did not use services, and a qualitative assessment of the effectiveness of the training for physician office staff.

External events appear to have been responsible for the inability of On Lok Senior Health Services and CIRHM to proceed to operational status. On Lok Senior Health Services, the nationally recognized impetus for the PACE program, hoped to use its grant to expand the reach of its program to those who preferred to keep their own primary care physicians while accessing
the extensive set of On Lok Senior Health Services support services. Unsure about whether this model would work, On Lok first sought a planning grant to explore with community physicians the feasibility of forming a network. With the implementation grant, On Lok Senior Health Services began patient recruitment, attracting 12 to 14 of the 40 or so individuals it sought to attract. Unfortunately, despite what appear to have been extensive discussions with state and federal agencies in its planning, On Lok Senior Health Services was asked by HCFA to stop recruitment based on the fact that there were new rules prohibiting PACE demonstrations from using contracted physicians. Given HCFA’s ruling, CHCF became concerned about the lengthy delay in implementation and officially terminated the grant in April 2002. (HCFA ultimately approved a waiver for On Lok Senior Health Services, and the program was relaunched in July 2002; 46 active enrollees were reported as of mid-August 2003.)

The reasons for the early termination of the CIRHM grant are more complex. In many ways, the grant faced challenges unique to a rural area, where managed care has historically had trouble thriving (MedPAC 2002). Under the grant, Lompoc Valley Community Healthcare Organization, a community health organization with 67 members, sought to introduce care management for seniors. The organization worked to create a managed care plan based around a major IPA group of physicians participating in PacifiCare’s Secure Horizons product. Unfortunately, PacifiCare decided that the risk-based model it used with the IPA did not work in this market. It was reported that care for two very sick patients cost the IPA $2 million, leaving it bankrupt. As an alternative, PacifiCare contracted with physicians individually and later developed a risk-based contract with providers in a nearby town. This move resulted in the loss of one-third of the anticipated participants for the demonstration. Concerned that it would not be able to meet its commitments, CIRHM notified CHCF about the change and the Foundation ultimately decided to terminate the contract.

3. What Technical Problems Did Grantees Encounter, and How Did They Resolve Them?

The grantees’ ability to move forward with their interventions was influenced by a number of factors—some more easily controlled than others. Each grantee encountered challenges, as would be expected given the types of interventions being introduced. The nature of the problem and the extent of its ultimate impact on implementation varied across grantees. (See Table II.2 for information on grantee experience with various implementation and environmental challenges.)

**Delays Resulting from Institutional Review Board Approval.** Four of the nine grantees said that gaining IRB approval for their work was a challenge that resulted in extensive delays and frustration, particularly in a few projects. Obtaining IRB approval was especially demanding for many grantees because the nature of the interventions and collaborations meant that approval was required from multiple institutional review boards. The Institute on Aging’s project, for example, required approval from four IRBs. Grantee staff characterized this requirement as a “nightmare.” The UCLA GIM diabetes project involved approval from three IRBs; approval took six months rather than the two anticipated. An insider who knew about ways to facilitate the process (such as sequencing the steps in the approval process in the order most likely to be effective) helped at least one grantee avoid delays. In a provider-based organization, a ruling that the project was a quality improvement project rather than a clinical trial also expedited the process. For another grantee, a prior planning grant helped the grantee “jump start” the approval process.
### TABLE II. GRANTEE EXPERIENCE WITH VARIOUS IMPLEMENTATION AND ENVIRONMENTAL CHALLENGES

<table>
<thead>
<tr>
<th>Grantee</th>
<th>IRB</th>
<th>Patient Recruitment</th>
<th>Randomization</th>
<th>Data</th>
<th>Physician Involvement</th>
<th>Community Involvement</th>
<th>Staff/Partner Stability</th>
<th>Changing M+C Market</th>
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<td>JFCS</td>
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</table>

Source: MPR assessments based on interviews and review of documents

**Participant Recruitment.** Recruiting patients for the intervention and control groups was a challenge in eight of the nine projects that became operational. Many relied heavily on administrative data. The grantees reporting the most success in this area sought to link their recruitment with individuals and organizations well respected by those they sought to recruit. Sharp HealthCare conducted focus groups and learned that physician support would be an important influence on patient participation; accordingly, solicitation was done through the medical director of each site. LTCG used the CalPERS connection for recruiting but still faced challenges in this area. As one interviewee observed, grantees had to be serious about recruitment since one could not assume that patients would automatically take advantage of new services. In some cases in which recruitment was a challenge, the grantee ultimately came close to its goals, so projects met their targets for participants in the randomized design. However, participation and attrition was an issue for some grantees, even when an adequate number of patients were recruited. Pacificare/Secure Horizons, for example, experienced a large drop in the number of individuals actually using their case management services. And, both LTCG and Kaiser TriCentral found that some services were not in demand, particularly classes (LTCG) and benefits for home- and community-based services (Kaiser TriCentral). This outcome was probably a function of a combination of lack of knowledge of the available benefit or perceived need for those services and case manager and client efforts to “hoard” services for later use. In some cases, the absence of significant outcomes could reflect the fact that those in the intervention group did not fully receive intervention services or that those in the control group were already making extensive use of services without the intervention.
Randomization. In general, grantees considered the randomization requirement in developing their projects, and most said that the process went smoothly. In retrospect, some sites (Pacificare/Secure Horizons) said they might have approached the process differently. Provider reluctance to deny a potentially valuable service to patients was a key challenge for some, especially if the design was developed closely with providers. Kaiser TriCentral, for example, responded to this challenge by offering control group members what was expected to be a minimal intervention consisting of brief case management by telephone, with information and referral. However, a diligent staff member carried out the intervention with such dedication that staff feared it would be impossible to ascertain the effects of the main intervention. The project was modified to include a second round of interventions that added a simple mailing of information as the least invasive intervention. Sharp HealthCare project staff also had to include a form of intervention for the control group in the random assignment design to get their buy-in.

Data. Data challenges appear to have been less formidable than is often the case. This is perhaps attributable to the fact that the use of a randomized design was made explicit up front, making it likely that grantees would review their data capabilities in advance. Still, data were a challenge to some grantees in ways that affected their operations. Kaiser TriCentral found it challenging to obtain data from community-based providers whose systems were not set up to generate reporting or billing for individual services, and this interfered with Kaiser’s ability to manage care or pay the providers. The Institute on Aging, which was part of a national evaluation, found it difficult to obtain the analysis of its project’s performance from the national program office. Pacificare/Secure Horizons sometimes struggled to get data from medical groups and was also concerned about the consistency of data across its sites. LTCG had difficulty obtaining outcome data from health plans after the nature of their relationship with CalPERS changed.

Physician Support. Most of the grantees did not find it difficult to involve physicians in their projects; however, for those who did, the problem was substantial. The refusal of physicians at the Sutter Medical Group to cooperate with the Institute on Aging’s project resulted in Sutter being dropped from the project. At JFCS, the refusal of Brown and Toland Medical Group to refer patients to the project after the medical group experienced financial difficulties and was no longer capitated was a crucial reason for a participation shortfall. Even projects with good physician support (such as Sharp HealthCare) had to work hard to gain physician support by overcoming the physicians’ concerns about how care management would affect their authority for referrals and their costs.

Partnership with Community-Based Providers. In general, grantees did not say that coordination with the community-based organizations was a problem—despite the inherent challenges created by the disparate cultures and orientations of these groups and the tensions that can arise from different perspectives. For example, community organizations sometimes view health plans as a source of revenue, and they may not understand why the plan will not pay them for important services. The plan, in contrast, wonders why the agency fails to recognize the limits of the plan’s contracted benefit package. Yet, while participants commented on such differences, the organizations appear to have moved beyond them. From the perspective of one plan, the most concrete problem involved getting data from community-based organizations, which are typically not set up to communicate with large insurance companies. Kaiser TriCentral had to work with community groups on this issue; Kaiser also found the process of developing contracts with numerous, small community organizations cumbersome. While other grantees did
not specifically mention problems, they did cite an awareness of and attempts to address the cultural differences between community-based organizations and the plans and providers delivering medical care.

**Staff/Partner Stability.** Turnover of staff was an issue in many of the projects. In very small organizations, turnover in even lower-level staff can disrupt day-to-day processes, and this type of turnover was noted by several grantees. Loss of key staff can jeopardize the ability to build on accomplishments. For example, UCLA NPI had turnover in a key community liaison with the local Alzheimer’s Association, added a new co-investigator midway through the project, and experienced a change in the Kaiser lead investigator when that person assumed a different job in the organization. Even more fundamentally, a number of the sites experienced attrition in some of their participating providers. Sutter Health contributed little, for example, to the Institute on Aging’s project, and the UCLA GIM pilot test went forward with only two of its anticipated three test sites. While Sharp HealthCare maintained its interventions, staff say that “lots of energy” in communication and planning was needed to work with PacifiCare, given the environmental stresses of the period and their impact on that organization. The most damaging loss to PEMC resulted from the instability of the Brown and Toland Medical Group, which was a key participant in two of the projects.

**Changing M+C Market.** PEMC was conceived at the height of the managed care era, when Medicare managed care was growing rapidly. But its implementation spanned the period in which the market collapsed. While California avoided some of the massive withdrawals from the market experienced by other states, the shift in California’s environment had a critical influence on at least four the grantees (Gold and Lake 2002). PacifiCare, for example, found its ability to recruit participants compromised by decreases in its 2002 benefits package and the resulting inconsistency in benefits between Los Angeles and Orange counties, which had once shared the same benefit package. The instability in the M+C market was also a factor behind the Brown and Toland Medical Group instability that led to JCFS’s inability to recruit. However, it is noteworthy that the instability in the market at the time was not perceived by all grantees as having a large effect. The market had less of destabilizing effect on grantees with a more self-contained system (such as Kaiser TriCentral). Also, LTCG project staff felt “fortunate” in that they did not have to rely heavily on health maintenance organizations and were thus affected less by the turmoil in the managed care market. Some grantees (such as Sharp HealthCare) were able to compensate for the loss of expected financial or administrative support from managed care companies.

**Internal versus Environmental Challenges.** There is interest in understanding how much the instability in the M+C program limited the PEMC’s success, as some associated with the program over time perceive (Humensky and Gold 2003). This instability had an obvious effect on some projects, particularly as manifested in the instability of the Brown and Toland Medical Group and pressures created for PacifiCare, a major managed care partner in several grants. The tight economic environment also probably exacerbated concerns about the cost-effectiveness of the interventions and their business rationale, although these concerns were a factor from the start of the project.

Yet, even while the adverse nature of the market stressed the organizations, making resources scarce and success more difficult, it is not believed that the market environment was the primary influence on the difficulty grantees had in achieving positive outcomes. More
fundamental were the challenges faced in developing projects that could have a large impact and be mounted quickly. For many grantees, implementation was slowed by complex, unexpected IRB requirements, and almost all faced challenges in recruiting participants.

Targeting beneficiaries and intervention design were issues that several projects pondered with the benefit of hindsight and in light of subgroup findings. Sharp HealthCare, for example, said it would increase the eligibility cutoff for those without a specific diagnosis from age 80 to 85; include explicitly those with three or more instrumental activities of daily living and palliative needs; and incorporate a disease management component into its intervention design. These changes would result in a more defined intervention targeted to a higher-risk group. Similar population targeting was suggested by LTCG on the basis that its evaluation showed some evidence of success with depressed patients. This finding led grantees to speculate that focusing on a less healthy population might increase the success of the intervention. Similarly, more targeted interventions were of interest to Kaiser TriCentral. For example, some participants in the project said that, in retrospect, they might design their long-term care benefit to include fewer, more important services to reduce the administrative burden of negotiating provider contracts and to better match offerings to patient needs and priorities.

All of these issues related to targeting beneficiaries and intervention design suggest that the both the rapid movement to implementation without extensive planning and testing and the overall challenges related to delivering better care to frail elders are fundamental reasons why most grantees were not more successful.

4. What Did the Grants Accomplish, and How Sustainable and Replicable Are They?

The individual grantee evaluations provided little evidence that the interventions saved money or improved patient outcomes (as discussed in Section C of this chapter). Without evidence of financial or other gains, many grantees judged the costs of sustaining the interventions as being too high. Nevertheless, the grants have generated some useful tools, and most grantees believe that they have benefited from participating in PEMC. (See Table II.3 for a summary of grantees’ accomplishments and the likely sustainability of the grants.)

Among the implementation grantees, only one organization (Sharp HealthCare) is planning to sustain the intervention intact. One or more of the delivery sites associated with the UCLA NPI intervention for those with dementia are still considering whether to sustain activities. It seems likely that Kaiser, a large and dominant health care system in California that participated in two of the implementation grants, will use the results of its participation to change some aspects of education for and care delivery to frail elders generally and for those with dementia—even if it does not sustain the specific interventions. There seems to be more potential for sustainability from the related-activities grants than from the implementation grants, although, in general, it is too early to tell.

The PEMC grants have generated less-than-tangible but potentially long-lasting benefits for those organizations involved. In particular, many of the grants allowed individuals associated with the grants to establish new relationships (or build on existing ones) among health plans and medical, research, and community-based organizations in California. In addition, physicians and other providers who were exposed to or participated in the interventions generally responded
<table>
<thead>
<tr>
<th>Grantee</th>
<th>Accomplishments and Sustainability</th>
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<tbody>
<tr>
<td>Jewish Family and Children’s Services</td>
<td>While the grantee says that, in hindsight, it could have defined case management better, staff also say that the model used for the demonstration remains a “trademark program” that is self-sustaining. However, because the intervention was unable to be fully tested, the contributions of the project were limited.</td>
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<tr>
<td>Kaiser TriCentral</td>
<td>Based on the results of the evaluation, Kaiser has decided not to proceed with intensive case management, including benefits for home- and community-based services, because of the associated cost and complexity. However, the program has shown positive effects for low-cost telephone care management and has shifted care management staff away from geriatric care management to increase the number of telephone care managers. The organization has also increased its knowledge of existing community-based providers and appears to have integrated the knowledge from the evaluation into its ongoing operations.</td>
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<tr>
<td>Institute on Aging</td>
<td>As part of the national initiative, new instruments exist for assessing dementia and treatment protocols have been developed to provide patient information and family caregiver support. The project continues to have operational implications for Kaiser, which was the strongest site. Kaiser is integrating the care map and family questionnaire into their entire operations to better care for dementia patients. Participating Alzheimer’s Association grantees have also implemented components of the project, including referral forms and educational approaches.</td>
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<tr>
<td>Sharp HealthCare</td>
<td>Despite the disappointing results, Sharp HealthCare continues to perceive their intervention to be valuable. In particular, it says the Standardized Language for Case Management approach, with interventions for ten problem areas, has allowed the organization to move forward with program development. The activity will be sustained given the fact that it is inexpensive and well-structured.</td>
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<tr>
<td>LTCG</td>
<td>Results support the value of the intervention in increasing use of exercise even though no cost reduction was achieved. Sponsors perceive the project as unsustainable because of high costs and a lack of return on investment. They believe that findings support a more bare-bones intervention in which individuals are charged for exercise. They also recognize that their intervention could provide a better return on investment if it was targeted at less healthy populations, particularly those with depression.</td>
</tr>
<tr>
<td>Pacificare/Secure Horizons</td>
<td>The intervention is not being sustained, as it did not generate the anticipated savings. However, PacifiCare is continuing to use the risk index it developed here to support identification of frail elders.</td>
</tr>
<tr>
<td>UCLA NPI</td>
<td>The analysis of effects on recommended processes of care is promising. Staff believe that the model is easily replicable; however, the evaluation of health and health care outcomes is still underway. An assessment of cost-effectiveness would be a key factor in determining whether the interventions will be sustained by grantee organizations.</td>
</tr>
<tr>
<td>Project IMPACT</td>
<td>Both promising results and the development of tools suggest that aspects of this demonstration will be sustainable. One of the two participating California sites has expressed support for sustaining the model, but, so far, its mental health contractor has not adopted it. The other site is also supportive but is examining the resource requirements for paying to sustain the model or expand it to other areas. Both sites indicate that the approach should be easy to replicate in other settings.</td>
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<tr>
<td>UCLA GIM</td>
<td>Diabetes guidelines for older adults have been published and have gained wide interest and support among national advocacy organizations and associations. The newly developed tool kit should enhance the ability to use the approach in a wide variety of health care delivery organizations. Because the model is still being pilot tested, data on outcomes do not yet exist. These data will be important in determining whether the pilot test sites sustain the intervention and in generating interest in other locales.</td>
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positively to them. Grantee organizations say they have gained insight into the process of developing care management tools that may lead to improvements in care in their organization or elsewhere. Thus, while the outcomes of the interventions did not provide strong support for sustaining them, the implementation experience may have increased both the interest in and capacity for developing future efforts to improve care and outcomes for frail elders.

The issue of replicability is less a question of whether and the extent to which the interventions can be replicated than it is a question of whether it makes sense to do so. In fact, most grantees reported that they thought the interventions could be replicated outside their organizations and, indeed, quite broadly. Given the findings, however, wholesale adoption of the interventions is unlikely. Rather than an emphasis on models generated, PEMC’s most important legacy may rest in the examples it provides for helping stakeholders both to understand the challenges involved in improving care for frail elders and to shape a new generation of interventions.

C. Design and Outcomes From the Individual Grantee Evaluations

Final reports from the individual grantee evaluations are available for all but one of the operational projects, although there are some gaps—especially for the project that was part of a broader national evaluation. These reports cover all five of the general care management demonstrations and three of the four disease-specific demonstrations. This section reviews how the individual grantee evaluations were designed and describes findings. Readers should note that these evaluations were conducted independent of the evaluation by MPR. The evaluators for each project were selected by the grantee, and the methods and types of analyses varied across the studies. In particular, projects varied in terms of how comprehensively they addressed specific outcome areas (such as number of measures, what types of data were collected, and whether pre- and post-intervention data were collected). Most evaluations were able to address all of the outcomes that were originally targeted. Although some projects experienced delays or difficulties in implementation of the interventions, interviews with evaluator staff at each project indicated few methodological problems with data collection or analysis in implementing the evaluation designs.

Thus, the findings reported by the evaluations appear valid. Questions that remain include what explains the findings, whether the outcomes measured make sense, and what lessons exist for the future. These issues are discussed in Section D following a description of the evaluation results. Chapter III contains a more extensive discussion of the value of including such rigorous evaluations as a core program strategy in grant making.

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17 For one of the three available disease-specific grantee final reports (submitted by UCLA NPI), primary study outcomes (dementia care processes) and some secondary study outcomes (such as provider perceptions of care quality) were reported. Other secondary outcome data (for example, patient health status or caregiver perceptions of quality) were not yet available at the time of report publication. The evaluation for another of the four disease-specific projects (a related-activity grant to UCLA GIM) is ongoing, and a final report has not been submitted; however, preliminary baseline results and selected survey results at a three-month follow-up for the intervention group were provided.
1. Methods Used for Evaluating the Interventions

**Use of Random Assignment.** All but one of the individual grantee evaluations used random assignment designs to evaluate the effects of the interventions on outcomes.\(^{18,19}\) While this form of evaluation was mandated by CHCF, each project developed its own design and the outcome measures that were used varied.\(^{20}\) Final reports on the outcomes for each project were submitted to the UCLA program office and to CHCF at the conclusion of each grant.

**Measures and Data Collection.** The projects attempted to measure a range of outcomes, using both survey and administrative data. All of the projects collected measures of health status and health care utilization.\(^{21}\) Other outcomes measured by selected projects included health care costs, enrollee/caregiver satisfaction, enrollee behavior modification (for example, exercise), health plan member retention, and use of home- or community-based social services. In some cases, outcome measures were calculated as the difference in post-intervention (follow-up) outcomes between the treatment and control groups. In other cases, outcomes were calculated as the difference in trends from baseline to follow-up between the treatment and control groups—often referred to as “difference-in-differences” designs.

The projects also collected and analyzed baseline data on socioeconomic and demographic characteristics of enrollees in the treatment and control groups. These data were used primarily to describe the study samples and to assess the success of the randomization. For all of the projects that used randomization, there were few statistically significant baseline differences, indicating that randomization was successful.

Eight of the nine PEMC projects collected follow-up outcome measures after an intervention of at least 12 months.\(^{22}\) Data sources typically included an enrollee survey after the first year to

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\(^{18}\) Randomization was at the patient level for six of the grantees (LTCG, Kaiser TriCentral, Sharp HealthCare, Pacificare/Secure Horizons, Project IMPACT, and UCLA GIM). Of the remaining four grantees, two (UCLA NPI and JFCS) involved the randomization of physician practices, and two (IOA and On Lok Senior Health Services) did not have randomized designs.

\(^{19}\) The one implementation project that did not use a random assignment design was the Northern California Chronic Care Network for Dementia project, led by IOA. This project was not designed to test the effectiveness of a specific intervention. Rather, as part of a larger national study of the Chronic Care Network for Alzheimer’s Disease, the evaluation for this project examined outcomes and implementation experiences associated with the application of a set of tools and procedures within a chronic care model that tailored the specific interventions to meet the needs of two of the three California sites that became operational.

\(^{20}\) Randomized assignment was chosen because it is the most powerful design, allowing evaluators to attribute statistically significant outcome differences to the intervention itself and minimizing concerns about potential sources of bias, such as self-selection and the influence of secular trends.

\(^{21}\) The Pacificare/Secure Horizons program collected information on one health-related outcome: mortality following the intervention.

\(^{22}\) The UCLA GIM intervention was a pilot test that lasted less than 12 months with follow-up data collected at 3 and 6 months post intervention. Project IMPACT’s intervention period lasted 12 months, but the project collected follow-up data for up to 24 months from the time the intervention was initiated. Two projects evaluated interventions for periods longer than 12 months (Kaiser TriCentral and UCLA NPI), each capturing data for up to 18 months.
measure self-reported health status and use of services, as well as administrative data (including enrollment, claims, or encounter data) to track utilization and cost. Baseline measures were also developed from both survey and administrative data, and they were collected immediately prior to the intervention.

Several projects also collected additional data on project implementation experiences to provide a context for interpreting the outcome results. JFCS interviewed care managers about their experiences with the project and physicians to assess their satisfaction with the intervention. The Kaiser TriCentral project interviewed treatment group enrollees about the reasons they did not purchase coverage for home- and community-based services. The project also involved a process analysis including site visits and chart review to understand how the care management intervention was implemented; descriptive statistics were also collected on the use of community services by treatment group enrollees. Both the Pacificare/Secure Horizons and Sharp HealthCare projects collected descriptive statistics on the use of community services by treatment group enrollees, but not for comparison groups. The IOA project surveyed, in three waves, all types of providers who received instruction and orientation to the intervention model or who were involved with implementing the case model. The survey focused on characteristics of providers and their perceptions of various aspects of the care model and its impact on their ability to care for dementia patients and family caregivers.

2. Evaluation Findings—Outcomes Synthesis

Any assessment of the outcomes of PEMC would be incomplete without an analysis of the individual grantees evaluations that were an integral part of each project. MPR synthesized the information on outcomes reported in the final reports from the eight projects; these were written as part of each project’s evaluation. Rather than provide individual report citations for the results given below, only the relevant project is indicated. (See Appendix C for full report citations; refer to project reports and publications listed at the end of each project summary.)

General Care Management Project Outcomes. As shown in Table II.4, the five general care management projects did not show statistically significant effects for the vast majority of outcomes that were measured. For example, all five of the projects measured effects on inpatient hospital and emergency room (ER) use during the first year of the interventions and found no significant effects. Four of the five projects also collected data on health status outcomes after the first year and found no significant effects associated with the interventions. Other outcomes reported less consistently across projects, but findings for these outcomes were also not statistically significant, with a few exceptions noted below. More detail on project-specific outcome findings is included in the project summaries in Appendix C.

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23 MPR did not conduct any primary data collection or individual-level data analysis for the outcomes synthesis because each project conducted data collection and analysis; thus, additional efforts would have been duplicative, and the Foundation did not wish to fund it. At one point, the UCLA program office tried to do a meta-analysis by collecting patient level data on specific outcomes common to many sites. However, they stopped when the complexity of merging such diverse data became apparent, and individual sites resisted sharing data because of the burden of unanticipated requests, concerns about patient privacy, and interests in publishing their own analyses.
TABLE II.4. OUTCOME RESULTS FOR FIVE PEMC-FUNDED GENERAL CARE MANAGEMENT PROJECTS

<table>
<thead>
<tr>
<th></th>
<th>LTCG</th>
<th>Pacificare/Secure Horizons</th>
<th>JFCS</th>
<th>Sharp HealthCare</th>
<th>Kaiser TriCentral</th>
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<tbody>
<tr>
<td>Health status/quality of life</td>
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<tr>
<td>Health status rating</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
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<tr>
<td>Functioning</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
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<tr>
<td>Mental health status</td>
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<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
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<tr>
<td>Mortality</td>
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<td>n.s.</td>
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<tr>
<td>Quality of life</td>
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<td>n.s.</td>
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<tr>
<td>Utilization</td>
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<tr>
<td>Inpatient hospital</td>
<td>n.s.</td>
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<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
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<tr>
<td>Physician/outpatient</td>
<td>n.s.</td>
<td></td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
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<tr>
<td>Emergency room</td>
<td>n.s.</td>
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<td>n.s.</td>
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<td>n.s.</td>
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<tr>
<td>Nursing home/home health</td>
<td>n.s.</td>
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<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
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<tr>
<td>Costs</td>
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<td>Total</td>
<td>n.s.</td>
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<tr>
<td>Physician/outpatient</td>
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<td>Inpatient hospital</td>
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<td>Emergency room</td>
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<td>Nursing home</td>
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<tr>
<td>Satisfaction</td>
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<tr>
<td>Patient</td>
<td>n.s.</td>
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<tr>
<td>Caregiver</td>
<td></td>
<td></td>
<td>n.s.</td>
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<tr>
<td>Healthy behavior/exercise</td>
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<tr>
<td>Use of community resources</td>
<td>n.s.</td>
<td></td>
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<tr>
<td>Member retention</td>
<td>n.s.</td>
<td>n.s.</td>
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</table>

Note: "n.s." indicates differences between treatment and control group were not statistically significant (p < 0.05). Blank cells indicate the outcome was not measured for that project.

a Indicates a decrease in depression scores for two treatment groups relative to the control group.
b Indicates a decrease in mortality for the treatment group relative to the control group.
c Indicates a decrease in hospital admissions for the treatment group relative to the control group.
d Indicates an increase in both primary care physician and specialist utilization for the treatment group relative to the control group.
e Indicates an increase in utilization for the treatment group relative to the control group.
f Indicates an increase in costs for the treatment group relative to the control group.
g The evaluation for this project found significant baseline-to-follow-up declines in caregiver burden for all four comparison groups but concluded that these trends may be due to participation in the survey process, rather than to the intervention itself.
h Indicates an increase in aerobic activity and stretching by the treatment group relative to the control group.
There were some statistically significant findings for selected outcomes of a few projects. In particular, the Pacificare/Secure Horizons project found a significant decrease in mortality among intent to treat (ITT) group members. This project also found significant changes in different measures of utilization, although the overall impact on utilization was unclear—ITT group members had both a decrease in hospitalizations and an increase in physician care use. The Kaiser TriCentral project showed a significant decline in average depression scores for one of the three treatment groups, while the control group showed no significant change; however, the authors of the final report concluded that these differences were not clinically meaningful. The LTCG project showed significant increases in aerobic activity and stretching for the treatment group—increases of 19 and 23 minutes per week, respectively—compared to declines in these activities for the control group. The JFCS project also showed a significant increase in primary care physician visits and expenditures from baseline to follow-up for the treatment group relative to the control group, an outcome that runs counter to current interests in cost containment.

Given the overall lack of significant findings (with the few exceptions noted above) attempts were made to assess whether there were discernable patterns among the statistically non-significant results that might indicate an overall effect not captured by any individual project. However, MPR was not able to identify consistent or strongly apparent patterns. For instance, three of the projects presented point estimates indicating a decrease in hospital use for the treatment group relative to the control group, while estimates for two of the projects indicated increased hospital use. As noted above, all results were not significant, and most estimated differences were small in magnitude.

Several of the projects conducted sensitivity analyses or additional analyses that looked beyond the main effects of the interventions measured in the random assignment designs. The JFCS project conducted a follow-up retrospective analysis to compare outcomes for a group of enrollees who received social services to several matched comparison groups who did not receive these services. The evaluation for this project found that those who received the services were less likely to have primary care visits and were more likely to have ER visits in the follow-up period; most other differences were not significant. However, the authors note that, because of substantial differences in the characteristics of the two retrospectively drawn samples (despite attempts to match on age, sex, and self-reported functioning), it was not possible to draw firm conclusions from the analysis.

Two projects assessed whether there were intervention effects for specific subgroups. The project led by LTCG reported that among participants with depression at baseline, treatment group members experienced a statistically significant decrease in the level of depression, relative to the control group. The project led by Sharp HealthCare reported that for those in the treatment group with three or more limitations in instrumental activities of daily living, there was a significant reduction in the likelihood of nursing home use for the treatment group relative to the control group. Given the large number of comparisons that were made when looking at subgroups for these analyses, it is possible that some of the significant differences reported for these projects were the result of statistical chance alone.24

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24 That is, with statistical testing performed at the conventional p < 0.05 level, 5 percent of the comparisons would show statistically significant differences based on chance alone.
**Disease-Specific Project Outcomes.** Of the four disease-specific projects, one showed significant effects from the care management/practice guideline interventions on key outcomes; results are limited or not available for the other three for the reasons noted below, though some show promising effects on process and intermediate measures.

Project IMPACT, which tested the effects of a care management intervention on elderly enrollees with depression in seven sites around the nation, found that 45 percent of enrollees in the treatment group had at least a 50 percent reduction in depressive symptoms from baseline to 12-month follow-up, compared to 19 percent of enrollees in the control group. Some 25 percent of the treatment group was free of depression at follow-up, compared to 8 percent of the control group. The treatment group also experienced higher rates of satisfaction with care, lower rates of functional impairment, and increased quality of life compared to the control group.

Among a subgroup of enrollees with arthritis in the Project IMPACT study, the treatment subgroup reported lower pain intensity, fewer limitations on activities of daily living, and greater overall health and quality of life relative to the control subgroup after 12 months of intervention.

As noted earlier, the project led by IOA did not directly test the effects of a specific intervention using a comparison group or a random assignment design. Instead, it examined baseline and follow-up differences in outcomes for older patients with Alzheimer’s disease who were enrolled in care management programs implemented in two different managed care settings (Kaiser Permanente San Francisco and Brown and Toland Medical Group). The project found that the two sites were significantly different in terms of baseline and follow-up measures of health care utilization, likely due to differences in the severity of illness of the two enrolled populations. At the same time, there were several significant reductions in utilization from baseline to follow-up within organizations, occurring primarily at Kaiser Permanente and particularly among patients who were not placed in a long-term care facility during the follow-up period. The two sites also did not show significant differences in use of services from Alzheimer’s Association chapters, indicating that chapter services were offered equally in both settings, and that the level of interest by families of enrollees was similar. The use of chapter services was high (70 to 79 percent of enrollees had some chapter service use) compared to evidence from previous research.

The UCLA NPI evaluation involved analysis of both primary and secondary outcomes. Primary outcomes measure the degree of adherence to the dementia care guidelines. Secondary outcomes indicate caregiver satisfaction, caregiver strain, patient health outcomes, provider knowledge and perceptions of care quality, extent of implementation of the intervention, and cost-effectiveness. Preliminary analyses conducted found that intervention group caregivers were more likely to have adhered to 21 of the 29 dementia care processes, suggesting that the intervention had beneficial impacts on dementia care quality. In addition, the intervention appeared to have had little impact on provider knowledge or attitudes favorable to dementia care; however, the evaluation stated that “intervention clinic providers perceived that there was better

25 Kaiser Permanente San Francisco enrollees experienced a significant decrease in ER, primary care, and specialty physician visits, and Brown and Toland Medical Group reported a significant reduction in specialty physician visits.
availability of resources and care coordination for dementia patients compared to perceptions of usual care clinic providers (p < 0.01).”

Early results from the UCLA GIM evaluation were primarily from a patient survey, which collected data on the 106 participants in the baseline sample (52 control group and 54 intervention group) and on the first 62 of 82 participants (30 control group and 32 intervention group) at three months. The intervention and control groups were similar at baseline. Based on these three-month follow-up results, most participants responded favorably to the intervention and reported improvements, such as better confidence in their understanding and skills related to diabetes (93 percent), aging (70 percent), and medication management (74 percent).

3. Process Analysis and Explanation for Results

**Explanations for Intervention Outcomes.** There were three possible flaws that would explain why the interventions were not more effective. Interventions were flawed in (1) concept; (2) design and measurement; or (3) execution.

In the first case, the theory behind the intervention was flawed. That is, the intervention was not the appropriate “lever” for generating the outcome of interest, even under the best of circumstances. Interventions that were conceptually flawed may be ineffective in and of themselves, or they were effective in some ways but not in introducing change in the outcome(s) of interest.

In the second case, the theory behind the intervention may have been sound, but the experiment was not designed well enough to test the theory. For example, an intervention would be flawed in its design if it was not appropriately targeted to those most likely to benefit, or the intervention and control groups may have been selected or structured in ways such that there was little practical difference in the treatment received by each. Flaws in measurement include, for example, a sample that was too small, in which case the design would not have enough power to identify outcomes. Another measurement flaw is an inappropriately short observation period.

In the third case, both the theory behind and intervention and its design were sound, but the implementation was flawed. That is, the intervention may have been incompletely implemented or implemented in a way that was not “faithful” to the design. This could occur, for example, if certain parts of the intervention were not implemented at all or if patient recruitment targets were not met or protocols were not followed.

Determining which type of flaw, or flaws, led to outcomes different than those hoped for typically involves working backwards to see how completely and accurately the design was implemented, the extent to which the design itself was well suited to test the theory, and whether the design was appropriately implemented. To the extent that there were weaknesses in design or execution, the theory behind an intervention cannot be said to have been tested fairly.

**Evidence from Independent Grantee Evaluations.** In grantee evaluations, researchers give some attention to outcomes issues (flaws in concept, design/measurement, or execution),
though not necessarily in a systematic or uniform fashion. The focus of grantee evaluations, as well as the MPR evaluation, was on implementation grants (not related-activity grants) and on general care management interventions, as these were the main thrust of the program. Unfortunately, lack of clear specification of the nature and intensity level of the interventions (such as through guidelines or other detailed protocols) made it difficult to distinguish between execution and design. The evidence suggests that weaknesses in both may have contributed at least in part to the absence of more definitive outcomes and that the absence of more formal protocols to support the intervention itself could reflect a weakness in design.

Of the five implementation grants that involved general case management models, there is some evidence that weaknesses in execution could have contributed to the null findings in at least three of the five cases. Referral rates were very low in JFCS, in which only six individuals were referred from Brown and Toland Medical Group and for which physician support was lacking. In both the Kaiser TriCentral and Pacificare/Secure Horizons projects, service use was relatively low in the intervention group. In Kaiser TriCentral, less than half of eligible enrollees (54 of 124) used the $2,000 purchase of community services benefit. Although enrollees who responded to the survey often said they did not need the benefit, they were not always clear on the purpose of the benefit or on whether they were eligible for it. Others wanted to wait “until a rainy day.” In Pacificare/Secure Horizons, the rate of service use varied from 21 percent for in-home care and psychosocial support services to 30 percent for home safety services, 36 percent for transportation services, and 38 percent for nutrition counseling. The Kaiser TriCentral focus groups suggest that a high proportion of time was spent on assessing, as opposed to implementing, a care plan. At JFCS, the lack of customized care management training was cited as a weakness. As noted, it is not clear whether these weaknesses reflect failures in execution or design. However, the results clearly indicate that the intensity of the intervention was relatively limited in some experiments, so the absence of strong outcomes is not surprising.

It is also possible that failures in design and measurement may have contributed to the absence of positive outcomes. For most interventions, those in the control group could receive some or all of the services received by those in the intervention group, but they had to seek them out. In the Kaiser TriCentral project, not only was service use low among those in the experimental group, but also there was evidence that, in the first round of randomization, the control group was getting a much more robust intervention than intended because of the conscientiousness of the telephone case manager. Both LTCG and Sharp HealthCare perceived, in retrospect, that they might have defined their target population more precisely, and Kaiser TriCentral would have thought about more tightly targeting those eligible for the intervention.

**Perspectives of Program Office and Foundation Staff.** Program office and foundation staff reported a variety of factors to explain the lack of positive outcomes from the interventions. In terms of concept, it may have been unrealistic to expect change in the kinds of fundamental indicators examined. Program office staff noted that there was a lot of “noise” in the system.

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26 Two main kinds of analysis are included: (1) process measures of recruitment, participation, utilization, and referrals under the intervention that shed light on the “treatment” and, by inference, the extent to which the interventions actually occurred; and (2) surveys or focus groups with physicians, care managers, caregivers, or enrollees to provide a qualitative assessment of the effectiveness of the intervention and to identify factors contributing to or detracting from effectiveness.
Because frailty has many dimensions, it may have been unrealistic to expect that case management and community-based services alone would be strong enough to “move” indictors in a way that would demonstrate to purchasers and plans that there could be a positive return on investment.

In terms of design, staff said that one issue may have come from the fact that the interventions did not incorporate elements that motivate frail patients to want to take advantage of services. In other words, it was presumptuous to believe that patients will automatically take advantage of new services. On the contrary, an intervention will attract the target population only if it is created to respond to their concerns and needs. For instance, focusing on those in crisis may target resources to those most likely to take advantage of the services. Furthermore, doing so through an intervention that draws in medical staff and takes advantage of the trust they develop with their patients over time may make those in crisis more willing to accept help once they realize they need it.

In evaluating execution, program office staff pointed out that there were major challenges in simultaneously satisfying the research need for a clear design and the practical needs of organizations delivering health care. For instance, clinicians and case managers trained to view each patient as unique may have trouble accepting a standard treatment protocol, especially for patients with complex needs. Therefore, developing support for an intervention may require methodological compromises that detract from its potential effectiveness. Those approving grants, like the PEMC grants, typically have only a limited pool of applicants from which to choose. Moreover, there may be strong incentives in the applicant selection process to take advantage of sponsor interest and resources in ways that build upon applicant interest and provide awards to proposals with shortcomings, assuming problems can be dealt with later. The fact that PEMC focuses on frail elders, a group that many regard as being insufficiently served by the existing system, raises the level of interest in an intervention that would benefit this group, even if the evidence base for how to intervene effectively is lacking, as it was in a number of ways when PEMC was launched and as it remains today.

In Chapter III, the randomized design, which was an essential part of PEMC, and the lessons for future foundation programming are discussed in more detail.

4. Program Office Analysis of Factors Important to Success

In response to early feedback from grantee monitoring indicating the grantee evaluations were likely to show only limited change in measured outcomes, the program office (with support from CHCF) initiated qualitative research in order to better understand the implementation process and the lessons that could be derived from it (Jones, Reuben, and Frank 2004).

The analysis was based on semistructured, in-depth interviews with more than 60 individuals involved in different ways with each grantee. These interviews were recorded, transcribed, and imported into an ethnographic computer program for coding. Using codes applied by analysts to key statements in the interviews, the program facilitated analysts’ ability to draw out the dominant themes emerging from the interviews, according to the report’s authors.

The findings suggest that interviewees believe there were potential gains to each party from participating in the interventions, but there were also many challenges that need to be addressed.
The analysis concluded that recruitment is a key challenge, given both the reluctance of some patients—or some physicians—to “buy in” to the project goals and the constraints imposed by institutional instability and administrative procedures (such as access to data for patient identification). Another challenge identified is the establishment of good communication—among the organizations involved in each of the grants and within individual organizations—that addresses organizational, administrative, personnel, and cultural barriers. Good communication between the physicians and patients is also essential.

Interviewees suggested that capturing the attention and interest of physicians affiliated with the project and involving them in recruiting and intervening can help to build patient trust. But there are barriers to this effort as well, including physician time and scheduling constraints, an organizational culture that may not support change, physician attitudes toward chronic illness, clinicians’ professional views of their roles, communication barriers created by dementia and other illnesses, and a lack of incentives that encourage involvement. Overall, melding the diverse interests of patients, case managers, physicians, and researchers (especially evaluators) was undoubtedly a challenge. The changing landscape in which health care was delivered over the study period was also a challenge.

The analysis highlights factors that are important to consider in judging PEMC’s success, though it cannot completely explain why PEMC did not yield the positive outcomes anticipated. On the other hand, the findings do not shed light on how these factors played out under PEMC because the experiences of individual grantees were not traced. For example, the number and type of grantees that experienced particular challenges is not known. Also unclear is how each of the partners handled challenges and what the outcomes of their efforts were. As a result, it is not clear how important these factors were in contributing to success or failure. Despite these gaps, however, the analysis points to important issues to consider when implementing interventions like those in PEMC. It also reveals some areas that could be pursued in future research on this topic.

D. HOW PEMC FINDINGS COMPARE TO OTHERS

The lack of change reported in PEMC’s individual grantee evaluations of outcomes is not surprising. For the most part, the implementation grants facilitated the testing of a diverse set of general, but limited, case management models overlaid on medical care systems whose participants were not asked to change very much about the way they practiced. As noted, at the time PEMC was developed, positive outcomes from interventions targeting frail elders tended to be limited (Boult, et al. 1999, 2000). Reductions in health care use or costs through unstructured case management did not typically occur though these programs. (See Appendix E for annotated bibliography of related research on case management—or care management—and disease management.)

After an evaluation showing basically null results from a predecessor of the JCFS demonstration, Boult (2000) concluded that studies should capture more outcomes and test alternative types of case management. In particular, he encouraged the development of interventions that include specific protocols to identify individuals appropriate for case management, evidence-based algorithms, time-limited care for defined conditions, close communication, and more effective collaboration between case managers and primary care
physicians. Unfortunately, however, these conclusions were drawn after PEMC was formed, or at least do not appear to have been available to staff developing the program.

Evidence- and algorithm-based interventions were not very well developed in the five generalized PEMC case management interventions. However, they tended to be present in the condition-specific implementation grants and also (to an extent) in two of the five general care management grants that seemed to fare better in generating some kind of sustainable outcome. The two general care management grants—Kaiser TriCentral and Sharp HealthCare—both used well-defined screening tools and algorithms to identify those eligible for the intervention. Although neither focused on specific conditions, Sharp HealthCare did aim to track a set of clinical data to monitor enrollee needs. (While Kaiser TriCentral systematically tested alternative interventions, it was the form of the intervention, rather than patient need, that defined the strategy). Both grantees designed their programs to provide regular feedback between the care managers and the primary care physician. Kaiser TriCentral, in particular, focused on creating primary care teams that could take advantage of regularly scheduled appointments.

In contrast, these elements were less present in the other three general care management demonstrations. PacifiCare/Secure Horizons also used an algorithm, but it appears to have been more limited, as was the formality of the communication between the case manager and physician. The LTCG project was basically set up to focus on nonmedical behavior and essentially bypassed the health system. And JFCS was ultimately separate from its associate medical practices. The interventions tested by all five of these grantees were much less defined than those focused on Alzheimer’s, diabetes, or depression.

Frail elders reflect a diverse population with multiple needs that are influenced both by chronic disease and by various physical, cognitive, and mental impairments. The best-known model of how to intervene in treating chronic illness was originally developed by Ed Wagner and his colleagues (Wagner, et al. 1996). The current version of the model is based on the assumption that chronic care needs will not be met unless the health care system changes from responding to acute and urgent needs to responding to needs associated with care for chronic conditions (Bodenheimer, et al. 2002). The following six characteristics of such reformed delivery systems are part of his model:

1. **Community Resources and Policies.** To improve chronic care, provider organizations need linkages with community-based resources (such as exercise programs, senior centers, and self-help groups).

2. **Health Care Organization.** If an organization’s goals and leaders do not view chronic care as a priority, innovation will not take place. If purchasers and insurers fail to reward high-quality chronic care, improvements are difficult to sustain.

3. **Self-Management Support.** Support involves helping patients and their families acquire the skills and confidence to manage their chronic illness, providing self-management tools (such as diets and referrals to community resources), and routinely assessing problems and accomplishments.
4. **Delivery System Design.** The structure of medical practice must be altered so that practice teams with a clear division of labor are created and acute care is separated from the planned management of chronic conditions.

5. **Decision Support.** Evidence-based clinical practice guidelines provide standards for optimal chronic care and should be integrated into daily physician practice through reminders on needed care or follow-up.

6. **Clinical Information Systems.** Computerized information has three important roles. It serves as: (1) reminder systems that help primary care teams comply with practice guidelines; (2) feedback to physicians, showing how each is performing on chronic illness measures; and (3) registries for planning individual patient care and conducting population-based care.

Because chronic disease and frailty are often associated, it is reasonable to ask whether interventions focused specifically on frailty should include the features that are thought to be important to success in chronic care management—and, if so, how the PEMC projects “stack up” against these criteria. The answer is not clear. There is no doubt that PEMC’s emphasis on community resources is very consistent with the chronic care model, and that PEMC’s effort to prioritize relationships between medical providers and community-based services in the program deserves recognition. PEMC also sought to engage the leaders of delivery systems, and some of the interventions included innovative features, such as teams (Kaiser TriCentral), health promotion and self-management (LTCG and several other projects), and automated decision support (Sharp HealthCare). For the most part, however, PEMC projects focused less on particular chronic conditions and more on frailty in general, for which guidelines are more difficult to establish. To complicate matters further, not all agree that guidelines are even valuable or feasible. Furthermore, PEMC did not, for the most part, seek to reorganize the entire delivery system. Rather, the goal was to better link these medical systems to community-based social service providers and to introduce more limited, but affordable, change. The idea behind this approach was to take advantage of the incentives of capitation to introduce marginal improvements (for example, the teams used by Kaiser TriCentral or the automated tools used by Sharp HealthCare).

Overall, the Program for Elders in Managed Care and the literature shed light on three possible strategies that may better address the needs of frail elders.

The first strategy is to continue to support more generalized interventions focused on frail elders but to modify the criteria or outcome measures by which success is judged. For instance, it could be that improving health outcomes in the traditional ways are inappropriate, at least for some frail elders who are on an irreversible downward trajectory. In this case, it may be that providing comfort in the way of caregiver and family support is the best one can achieve. Or, when so much is lacking in terms of systems integration, merely supporting efforts that improve communication between medical providers and community-based service providers may be valuable in itself, particularly if it provides the assurance that effective interventions were not overlooked just because the need was not identified. The fact that these kinds of outcomes are not likely to provide an immediately measurable return on investment does not mean that they are not valuable in other meaningful ways.
The second possible strategy is to try to apply some of the lessons of disease-focused interventions to construct interventions for frail elders that work better. For instance, interventions could be directed to frail elders at particular points of vulnerability (such as when they are in transition from one setting of care to another or during hospitalization) or for particular events or conditions (such as falls, dementia, or depression). This approach may be focused enough so that resources can be directed to the patients most ready to accept help and to the situations for which interventions could be most cost-effective. What appear to be promising results from Project IMPACT and the UCLA NPI interventions suggest that this strategy may have some potential.

The third strategy is to reorganize care systems according to the vision of Ed Wagner and others so that they are more responsive to the needs of the chronically ill patients, particularly those with multiple conditions and who are frail as well. This approach is based on the conclusion that limited interventions yield limited results and that the emphasis, therefore, needs to be on more massive change. Unfortunately, while such major system redesign may be valuable, the environment is such that massive change in financial incentives and in how institutions relate to one another are not likely to be forthcoming in the immediate future. The more practical approach for those who want to pursue this strategy may be to support more targeted reorganization efforts. The authority for specialized Medicare+Choice plans may provide the opportunity to further test and develop these types of models. Similarly, the interest in encouraging use of electronic health records should be maximized in order to enhance support for interventions that improve communications across providers—creating, in effect, “virtual systems.”

In sum, the PEMC experience highlights the value of developing interventions that have explicit goals. It also points to the need to think critically about these goals and to develop interventions that are designed specifically to achieve them.
III. FINDINGS ON OTHER PROGRAM COMPONENTS

In addition to the core implementation grant activities, PEMC involved various other program components. This chapter examines these other aspects of the program with a view toward determining their contribution to the success of PEMC and the implications for future program design.

Five particular components of the program were examined. The first was the use of planning grants. These grants were an important feature of the program, and MPR reviewed the outcomes of these grants and evaluated their contribution to PEMC. A second program feature was the provision of a limited amount of flexible funding, first to support related activities and later to augment implementation grantees’ analysis in targeted ways. Included are a description of how funds were used and an assessment of their contribution to program goals. A third program feature was the incorporation of a relatively rigorous independent evaluation as an integral part of each of the implementation grants. The infrastructure established for this purpose and the results from the evaluations, already described in Chapter II, are considered to draw conclusions about the value of this component. The fourth program component examined is the overall administration of the program itself. And the fifth is the program’s success in disseminating project findings.

A. WHAT DID PEMC BUY WITH THE PLANNING GRANTS?

The planning grants are briefly described here, including what they accomplished, and conclusions are drawn about the value of this type of component in the design of a program like PEMC. (See Appendix G for more information and additional detail on planning grants. This appendix includes information on planning grant activities, their consistency with proposed PEMC efforts, and accomplishments. Also included is the impetus for sponsors to develop planning grants and reasons for proceeding with a planning grant rather than an implementation grant. The appendix also presents some examples of the types of challenges grantees faced in moving forward under the grants.)

1. Description of Grantees and Outcomes

PEMC funded a total of 13 planning grants of up to $75,000 each for a total expenditure of about $1 million (see Table III.1).²⁷,²⁸ Planning grants were awarded to support the development of care systems (including partnerships among key organizations) and needs assessment and

²⁷ However, San Diego State University received a second planning grant for $100,000 in the second funding cycle. The purpose of the second grant was to conduct a small pilot program to test the intervention created in the initial grant.

²⁸ The types of grantees were relatively disparate and included health plans, care delivery organizations, community-based service organizations, and academic research centers. Organizational ownership varied and included both privately owned and government-owned entities; profit status also varied and included both nonprofit and for-profit organizations.
<table>
<thead>
<tr>
<th>Lead Organization</th>
<th>Project Name</th>
<th>Purpose of the Planning Grant</th>
<th>Outcome</th>
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<tbody>
<tr>
<td><strong>Cycle 1</strong></td>
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<tr>
<td>LTCG</td>
<td>Planning for Preventing Disability Through Community-Based Health Coaching and Services Enhancement</td>
<td>To create a seamless system of care to coordinate Medicare managed care benefits and long-term care benefits for CalPERS seniors with chronic illnesses.</td>
<td>Received an implementation grant in Cycle 2.</td>
</tr>
<tr>
<td>PacifiCare/Secure Horizons</td>
<td>Planning for Secure Horizons Eldercare</td>
<td>To develop a model to coordinate care between the primary care physician and community-based service providers for frail or at-risk seniors.</td>
<td>Received an implementation grant in Cycle 2.</td>
</tr>
<tr>
<td>On Lok Senior Health Services</td>
<td>Planning for Integrating Independent Medical Group Practices with On Lok Senior Health Services’s Interdisciplinary Approach to Serving the Frail Elderly</td>
<td>To develop a network of contracted physicians providing seniors in the San Francisco area with an expanded choice of providers and to help promote growth of the PACE model of care coordination.</td>
<td>Received an implementation grant in Cycle 2, but grant was terminated after 21 months because federal waiver approval was delayed.</td>
</tr>
<tr>
<td>San Diego State University Center on Aging</td>
<td>Planning for the Multicultural Outreach and Health Care Delivery Project: A Dynamic Approach for Improving Managed Care Through Community Liaisons</td>
<td>To develop a telephonic screening tool to identify at-risk Hispanic American and Filipino American seniors residing in the San Diego area who might benefit from care management services provided by Community Health Advocates.</td>
<td>Applied for a Cycle 2 implementation grant, which would focus on five groups. The review group perceived this to be overly ambitious but encouraged a small pilot project for $100,000 that would focus on two ethnic subgroups. The latter was implemented and, according to the grantee, led to positive outcomes—though it remains a challenge to get seniors to access care outside of urgent needs.</td>
</tr>
<tr>
<td>Kaiser Permanente Aging Network</td>
<td>Planning for a Senior Care Delivery System: A Provider Network Approach to Community Services</td>
<td>To design a new, single point-of-entry system (including community-based services) for seniors over age 65 receiving care through the Kaiser Permanente system and living in San Diego County.</td>
<td>Applied for a Cycle 2 implementation grant, but the review team did not feel there was sufficient capacity to implement. Grantee views this outcome as stemming from issues relating to the community-based partner.</td>
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TABLE III.1 (continued)

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<thead>
<tr>
<th>Lead Organization</th>
<th>Project Name</th>
<th>Purpose of the Planning Grant</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>LA Care</td>
<td>Planning for Chronic Care Connection</td>
<td>To develop four long-term care products to integrate long-term care and acute medical care for seniors residing in Los Angeles County.</td>
<td>Applied for Cycle 2 implementation grant, but was unsuccessful. reportedly because the consortium had not obtained a strong managed care partner and the review team did not sense they were ready. Little knowledge of the experience remains because of organizational instability and staff turnover.</td>
</tr>
<tr>
<td>Contra Costa County Office on Aging, Social Service Department</td>
<td>Planning for the Medicare Managed Care Partnership Model</td>
<td>To develop a new system of care to target case management and disease management to at-risk seniors enrolled in Medicare managed care in the Contra Costa Health Plan.</td>
<td>Applied for Cycle 2 implementation grant, but was unsuccessful reportedly because the project was not ready. Making the concept work with Medicare and having data reportedly were major barriers. The organization has received three additional years of planning funds from the state and is applying for an implementation grant.</td>
</tr>
<tr>
<td>Redwood Health Services</td>
<td>Planning for an Integrated Services Delivery System for Seniors Enrolled in Managed Care Plans in Sonoma County</td>
<td>To develop a new system of care for seniors in Sonoma County to link long-term care and acute care services.</td>
<td>Applied for Cycle 2 implementation grant, but was unsuccessful. Applicant perceives successful grantees were larger in scale and further along. Appears to have created dialogue among wide range of community and managed care organizations, but with organizational instability and staff turnover, little remains today.</td>
</tr>
<tr>
<td>Southern California Healthcare Systems</td>
<td>Planning for Primary Care Physician-Supported Functional Fitness and Care</td>
<td>To develop VitaLink, a care management program to coordinate medical services, community-based services, and fitness programs for frail elders residing in southern California.</td>
<td>Implementation proposal not submitted because project was impeded by organizational instability, lack of physician relationships, and difficulty finding a community partner. (CHCF reports that a year later, the final report from the planning grant requested implementation funds, but the request was too late to be considered.)</td>
</tr>
<tr>
<td>CalOPTIMA</td>
<td>Development of a Managed Care Model for “Dual Eligibles”</td>
<td>To develop a managed care plan for dually eligible CalOPTIMA members integrating medical services with long-term care services.</td>
<td>A key feature of this grant involved developing a dual-eligibles database to support planning. Because of delays in receiving data from HCFA, the project was not ready to apply for an implementation grant in Cycle 2, and a request for a second planning grant was denied. The database eventually was developed and reportedly remains in use today.</td>
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<tr>
<td>Lead Organization</td>
<td>Project Name</td>
<td>Purpose of the Planning Grant</td>
<td>Outcome</td>
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<tr>
<td>Cycle 2 Grants</td>
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<tr>
<td>Community Health Group</td>
<td>CareLink: Elders in Managed Care</td>
<td>To develop screening tools to identify at-risk seniors residing in the San Ysidro area; and, to develop protocols for case management and home assessments.</td>
<td>Implementation grants were not available when Cycle 2 grants were completed. The tools were developed and remain in limited use today. The ability to mount an operational dual-eligibles project reportedly was hampered by a loss of interest within the state Medi-Cal agency.</td>
</tr>
<tr>
<td>LifeLong Medical Care</td>
<td>Feasibility of a Countywide Health Plan for Low-Income Elderly</td>
<td>To develop a Medicare managed care plan to serve dual eligibles residing in Alameda County.</td>
<td>Implementation grants not available when Cycle 2 grants were completed. Reportedly, the main barrier to getting an operational project was the lack of knowledge of the Medicare side of business and difficulty identifying what would be feasible. Staff hopes to use the knowledge and relationships gained in similar initiatives in the future.</td>
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*Includes two grants, one funded in each of the two funding cycles. The Cycle 1 grant was a planning grant and the Cycle 2 grant was a pilot, not a full-scale implementation grant.

feasibility studies. (See Appendix A for more background information on planning grants.) Ten grants were awarded in Cycle 1 of PEMC, with the expectation that they would be eligible to compete for implementation grants in Cycle 2. An additional three grants (one for a pilot to a grantee in Cycle 1) were made in Cycle 2, with the recognition that additional implementation funding would not be forthcoming; therefore, the grants needed to provide an outcome of intrinsic value to the organization.

Of the ten Cycle 1 grantees awarded planning grants, eight submitted applications for a Cycle 2 implementation grant (see Table III.1). Three received such a grant (LTCG, PacifiCare/Secure Horizons, and On Lok Senior Health Services); a fourth grantee was provided an additional planning grant in Cycle 2 to carry out a more limited pilot of their proposed intervention (San Diego State University Center on Aging).29

In general, those turned down for funding were viewed as not ready—meaning that their organizational infrastructures and specific project plans were not sufficiently developed. Two of the four that were denied implementation grant funding (LA Care and Contra Costa County Office on Aging) involved interventions for dual eligibles by Medi-Cal plans knowledgeable

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29 One of the three, On Lok Senior Health Services, had its grant terminated before it was operational. The reason for termination was a delay in receiving HCFA’s approval for a necessary waiver.
about Medicaid requirements but unable to develop the Medicare component. A third attributed failure to its initial selection of its community partner and the ensuing difficulty in moving to firm implementation plans (Kaiser Permanente Aging Network); a fourth was a community initiative in a single county where communication seemed to have been strong, but formal programming for implementation was more limited (Redwood Health Services). In the case of Contra Costa County Office on Aging, additional planning has moved forward with state support. Organizational instability and other factors led to the other three efforts dissipating after additional support was not forthcoming.

The two Cycle 1 planning grantees that did not submit applications for implementation grants in Cycle 2 generally did not perceive they were ready. In one case (CalOPTIMA), the planning grant involved a relatively intensive feasibility assessment for a dual-eligibles project delayed by problems in receiving access to Medicare data that was necessary to support an important part of the work. The other (South California Healthcare Systems) was delayed in planning by the limited availability of a key leader, the absence of a strong physician link, and difficulty in arranging the community component. In the case of CalOPTIMA, the data are reported to still be in use; in the case of Southern California Healthcare Systems, the project is viewed as enriching the knowledge of its associated partners and staff, though no specific change has been made.

Cycle 2 planning grants were not expected to compete for implementation funding. The two new grantees both focused on dual eligibles; the third was a Cycle 1 grantee that received funding for a pilot. One (Community Health Group) used the planning grant to develop screening tools and protocols for care management that remain in limited use today. The second (Lifelong Medical Care) used the grant to develop a feasibility analysis for a dual-eligibles project that could sidestep the federal waiver process and could also build on some related work funded by another foundation. In both cases, grantees viewed the work as useful in the long run in positioning them to consider these kinds of projects.

Beyond the tangible accomplishments, virtually all the grantees perceived that their involvement in the planning grants had enhanced their insights and skills relevant to issues important to frail elders and those who care for them. Relationship building was an important outcome that was sometimes sustained for the relevant organizations and other times was not because of staff turnover and organizational change. Those leaving programs sometimes said that the relationships went with them, especially if they stayed in the same geographical area.

2. Evaluation of the Planning Grant Component

Feedback from those that implemented projects (see Chapter II), as well as those that did not, supports the value of planning grants in building effective operational projects. Those applying for planning grants generally were attracted by the concept of what a larger operational project would accomplish, but they also perceived that their organization was not yet well-enough positioned to undertake such a project. Key gaps included: (1) the need to identify required partners and formation of necessary relationships for partnering; (2) gaps in knowledge (for example, organizations primarily familiar with Medicaid needed to learn about Medicare or those in acute care needed to learn more about community services); and (3) the need to better define and explore the feasibility of their concepts (for example, defining benefit structures, assessing financial feasibility, and determining market interest).
While most grantees were aware that they could have proceeded directly to implementation, most said they just weren’t ready. Planning grants provided useful time and support to carry out this work and leveraged what many saw as “the prestige of the Foundation” toward their efforts. Even those that proceeded directly to implementation later perceived that more support for initial planning could have been valuable, particularly if the intervention had been relatively untested and new.

In general, the success of planning grants in allowing grantees to move forward to full implementation appeared in the bounds of what might be expected, particularly given the timing of awards. Those receiving planning grants that sought to compete effectively for an implementation grant had to move very rapidly. Though grantees were originally scheduled to have a full twelve months to plan, the request for proposals for Cycle 1 grants was issued less than six months after PEMC was authorized (November 1997), although awards were not made until a year later (October 1998). The call for the second cycle of grants was announced very soon afterwards (January 1999), with awards made a year later (January 2000). CHCF acknowledged in interviews that this amount of time probably was not ideal, neither in giving those with planning grants in Cycle 1 the opportunity to benefit from planning before submitting an implementation grant proposal, or in giving CHCF time to learn from the first grant cycle. (See Appendix A for more information.) However, the timing was determined in response to grantee concerns to ensure that there was no gap in funding for planning grantees that received implementation grants in Cycle 2; grantees also needed to keep staff they had hired during the planning grant. That only three of the ten Cycle 1 planning grants were approved for implementation, and a fourth led to a more limited pilot, is arguably an excellent outcome for the planning grants, given the pace of competitive cycles.

In addition, PEMC’s planning grants appear to have provided a way for CHCF to test riskier or more cutting-edge projects whose feasibility was uncertain, particularly projects for dual eligibles and multicultural interventions that departed from the model of “mainstream Medicare managed care.” Such interventions are important, but they are very challenging, as they require coordination between two major financing programs (Medicare and Medicaid), and among a host of diverse provider types and the complex multicultural environment in which programs operate in California. Typically, these projects were based in Medicaid managed care plans in which knowledge of Medicare was limited and whose organizations had fewer resources to invest in such interventions than major managed care firms and provider systems.

One lesson from this evaluation may be that there is a need for increased effort to match the extent of planning support to the level of challenge of the intervention and to grantees’ available resources for support planning. In particular, projects that address the needs of frail elders jointly eligible for Medicare and Medicaid need a much longer planning horizon and more technical assistance. Apparently, so do community-based efforts involving multiple organizations with limited preexisting history. As one grantee observed when asked what they would have done differently (if anything):

30 From 117 letters of intent for either planning or implementation grants in Cycle 1, only 21 were invited to submit full proposals, leading to the ultimate selection of 10 planning and 3 implementation grants.
“Maybe [I would] have looked at a two-year planning grant. It was such a new concept. Maybe [it would have been better to] break down implementation into pieces. It was a huge undertaking in this community to attempt this. It was bold and exciting to attempt this, and there was a sense in the community that we can really serve seniors better. Trying to cram the planning grant into one year was rushed. It takes time to create and manage such a huge change. I would have liked more time.”

On the other hand, intensive planning efforts require more foundation commitment with perhaps less potential for success. Resulting projects may also be fairly unique and less readily replicable for larger populations. This means that there are tradeoffs between reaching more people by going after large mainstream applications and addressing perhaps the hardest challenges, which are important but more likely to require additional time and resources to surmount.

In general, the experience of PEMC suggests that planning grants are most likely to move forward when key organizations and their partners are stable and have previous experience working together. Strong leadership, without turnover, is important. Environmental challenges, even unanticipated (like the meltdown of the Medicare managed care program nationwide and the shifting interests of California’s Medi-Cal program), make success more difficult. Financial stress, distracting priorities, and situations leading organizations to focus on survival make successful planning substantially more difficult, if not impossible. In addition, the movement from planning to implementation seems more likely when initial concepts and partnerships are sound, and when the change called for is not exceptionally challenging. All this suggests that the kind of careful scrutiny given to the initial selection of grantees and concepts is very important for programs like PEMC.

B. DID PEMC’S FLEXIBLE FUNDING FOR RELATED ACTIVITIES AND PROJECT AUGMENTATION PAY OFF?

Both by design and by chance, PEMC had available a limited amount of funds that could be allocated for purposes related to the goals of PEMC. Originally, a limited amount of program funds were set aside to support implementation grantees by making available to them the tools they needed. For example, if grantees said they needed case management software, CHCF might sponsor a grant to develop generic software that could be used by multiple grantees. Additional funds were made available by the early termination of two implementation grants. (Foundation staff commented that CMS discouraged work in one possible area—risk adjustment—because CMS had already done a lot of work in that area.) The National Committee for Quality Assurance was also approached about providing funds to develop care management guidelines.

According to CHCF staff, the kinds of tools envisioned for support through these funds were not identified as needed by the grantees, and demand for such products was low. It is likely that the absence of a dedicated program office in the early years of PEMC contributed to the absence of initial plans for the use of these funds. (The role of the program office is discussed in Section D of this chapter.) Ultimately, these funds were used by the Foundation for grants that related to the purposes of PEMC in a number of different ways.
1. Use of Funds for Related Activities

Three related-activity grants were funded. One supported a test for instruments to be used in the national PACE program to measure satisfaction with quality of care for frail elders. They included one regular instrument and one targeting those with mild to moderate cognitive impairment. The investigator was co-located at On Lok Senior Health Services, the originator of the PACE concept and an independent participant in PEMC. CHCF cofunded the development and testing of the instrument with the Archstone Foundation. The impetus for the project apparently was the interest in a tool that could help PACE projects meet a federal requirement mandating that consumer satisfaction be assessed. Under the grant, the tool was developed, tested, and sent to all sites; the availability of a successful model for data collection from mild to moderately impaired individuals is one of the major advances noted for the instrument. At this stage, the tool’s long-term value appears uncertain. Reportedly, the instrument is expensive to field and its utility varies for administrative staff (who look for quick measures of many dimensions of performance) and providers (who want operational detail). The grantee does not have funding to monitor implementation but hopes that the shelf life of the instrument will be long as PACE expands and interests remain focused on the important issues that underlie the tool’s development.

The other two grants involved operational interventions whose design and outcomes are described in Chapter II—Project IMPACT, which supported California’s additional participation in a national depression management initiative of the Hartford Foundation; and UCLA GIM, which developed and tested evidence-based guidelines for the diabetes care of older persons. The Project IMPACT collaboration was developed jointly with CHCF. The Foundation’s willingness to provide support for an additional Kaiser site was contingent upon adding the third non-Kaiser site, which they hoped would make the project generalizable beyond Kaiser’s unique model. The “forced marriage” of diverse systems created some tensions, though seemingly not inordinately so. The UCLA GIM grant came about because the grantee was looking for funding and heard from David Reuben, a colleague at UCLA, that PEMC existed and might be looking to develop an additional project to focus on disease management. Related-activity grants suffered to an extent for their lack of a defined role in the program. For example, MPR learned of inconsistencies in having these grantees report along with implementation grantees at meetings some of the time but not at other times. The role of the program office in supporting them was also not clear. Both Project IMPACT and another project that was part of a national program faced tensions that resulted from competing pressures to fulfill the needs of the national program and to address unique California concerns. These issues arose most prominently in relation to evaluation design and reporting of site-specific data.

Both the Project IMPACT and the UCLA GIM related-activities grants appear to have enriched the learning from PEMC substantially. In particular, the projects introduced experience with disease-focused interventions that provided a valuable contrast to the more generic care management focus of most of PEMC’s interventions. By involving participants from the related-activity grants in program meetings, grantees appeared to have been encouraged to think more about the role of the evidence base in support of interventions. Grantees also seemed encouraged to think about the tradeoffs involved in focusing heavily on particular needs, as opposed to trying to deal more generally with a set of frail elders with many needs and complicated conditions. Having both approaches represented in the room and having each focused on frail elders was particularly valuable in a context in which care management for Medicare beneficiaries is
becoming more prominent, even though the focus is not always on the needs of the frailest elders (Foote 2004; Alliance of Community Health Plans 2004). This point will be discussed further in considering the long-term contributions of PEMC.

2. Use of Funds for Augmentation Grants to Implementation Grantees

The other use made of flexible funding was to provide support for selected implementation grantees to augment work beyond that covered by their initial grants. Three implementation grantees received up to $60,000 each in augmentation monies (see Table III.2). These grants provided an opportunity for implementation grantees to pursue targeted analysis designed to help learn more about the interventions tested. For Kaiser TriCentral, it allowed for a lengthier test and more analysis of the response to enhanced benefits for community services after the unanticipated initial finding that such services were not heavily used. For Sharp HealthCare, the funds allowed for the development of a software tool based on the intervention. For LTCG, the funds allowed the team to learn more about why people used or did not use services and how feasible it would be to focus the program on a sicker population.

Respondents from grantees receiving augmentation monies said that these funds were not part of their original grants because they covered activities that were beyond the initial scope of work. As one respondent described the scenario, “It’s learning as you go along and developing a wish list and a list of more questions.” The augmentation monies helped promote this additional learning by addressing new questions that arose as a result of the intervention. One respondent corroborates this and says of the additional work, “We only realized [the need] once we got into the intervention.” Another respondent that used the augmentation monies to develop case management software adds, “As we went forward, we realized that additional tools would be helpful. The tools that were available in the market were expensive and did not provide the detail we needed, so we got the extra money to develop what we needed.” The respondent noted, too, that PEMC staff was interested in funding this additional work because they realized that it would both help the grantee and move the field forward.

Grantees say that the additional monies provided by the augmentation grants helped to answer additional questions and confirm and expand insights into the original study findings. One grantee explained, “I don’t know what we’d have done without it. We would have been stuck.” Another said that the additional monies helped to better target the type of intervention needed, given the problems frail elders present. Had the augmentation monies not been made available, most grantee recipients said that they would not have been able to do any additional work.

Augmentation grants appear to have provided PEMC flexibility to build on existing grants that would enhance the knowledge that they generated. Grantees generally learned about the availability of augmentation monies from program office staff. Those receiving grants appeared to perceive the application process differently. While one indicated that the effort involved a
### TABLE III.2. PURPOSE OF AUGMENTATION MONIES

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Lead Organization</th>
<th>Purpose of the Augmentation Monies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation and Evaluation of the Community Partners Project</td>
<td>Kaiser TriCentral</td>
<td>To keep a research assistant on board to perform, and extend the length of, the follow-up; also to do actuarial estimates of intervention costs, including a chart review and survey of care managers to determine how much time they were dedicating to the intervention.</td>
</tr>
<tr>
<td>Preventing Disability Through Community-Based Health Coaching and Services Enhancement</td>
<td>LTCG</td>
<td>To keep the project team intact in order to conduct exit interviews with program participants to delve deeper into what actually happened in the intervention; to develop a program operations manual (including policies and procedures); and to conduct further data analysis to determine if the program was feasible for a sicker population.</td>
</tr>
<tr>
<td>Frail Elderly Care Management Project</td>
<td>Sharp HealthCare</td>
<td>To develop a case management software system that specifically focuses on the problems of frail elders.</td>
</tr>
</tbody>
</table>

Source: MPR analysis of PEMC program documentation and interviews with grantees.

small, and not very arduous, process, another described the process as painful. To some extent, the disparity in experience may reflect: the varied ability of grantees to prepare strong proposals; the informal processes used to make such funds available; the resource demands at the foundation; and the funds available for the augmentation grants. As one grantee said, “What happened with the augmentation monies is that they were available, and then all of a sudden, they weren’t. An open window of opportunity became closed.” However, CHCF was also balancing the demand for funding with a timeline created to support a programwide evaluation.

In the case of both related-activity and augmentation grants, the ability to make ad hoc decisions on funding provided valuable flexibility both to PEMC and to CHCF. In particular, the fact that these funds were available helped the program and foundation staff to capitalize on opportunities to strengthen the outcomes of PEMC and to address some of the limitations that arose. While more up-front thought and systematic planning for their use could have helped, foundation staff reported that the use of these funds was discussed at the program advisory meetings without any resolution. Certainly more clarity on the role and availability of these funds would have made grantees more comfortable.
C. WHAT WAS ACCOMPLISHED BY FUNDING RELATIVELY RIGOROUS INDIVIDUAL GRANTEE EVALUATIONS?

PEMC’s structure aimed to ensure that grantees implemented the interventions in such a way that they could be tested in a scientifically rigorous manner. Grantees were required to include an independent evaluation as a core component of the grant, and interventions were to be assessed using a randomized control design. All but one implementation grant used such a design. The exception was the grant to the Institute on Aging, which used a less demanding, quasi-experimental design developed as part of a larger national intervention (the Chronic Care Network for Alzheimer’s Disease), which included IOA. The results of these evaluations are summarized in Chapter II, and project-specific outcomes are summarized in the individual summaries of each implementation grant (see Appendix C). The role of evaluators in each of the implementation and similar related-activities grants is reviewed here, and an overall assessment of the individual grantee evaluations is provided.

1. Staffing and Role of the Individual Grantee Evaluator

The role of the evaluator differed across projects, even when the form of evaluation was relatively similar. Two of the nine implementation and related-activities projects that reached operational stages—IOA and Project IMPACT—did not have evaluators designated specifically for the PEMC grant, since they were part of national interventions for which an evaluation was done at the national level.\(^{31}\)

Of the remaining seven grants, four (JFCS, Sharp HealthCare, LTCG and Pacificare/Secure Horizons) had separate subcontracts with evaluators from other organizations (see Table III.3).\(^{32}\) Of the other three, one (Kaiser TriCentral) evaluation was conducted by an evaluator who was a consultant with a grantee partner (Partners in Care Foundation) and two (UCLA GIM and UCLA NPI) were conducted by the co-principal investigator. UCLA GIM did only a pilot test and UCLA NPI was independent of the organizations implementing the intervention.

External contracts (Sharp HealthCare, LTCG, and Pacificare/Secure Horizons) were typically about 10 percent of the total grant amount. This amount excluded important evaluation costs, such as those related to data collection. The remaining separate evaluation subcontract (JFCS) was 50 percent of the total grant amount, though the scope of work for this subcontract was more comprehensive and included both primary and secondary data collection.

The stage at which the evaluator got involved in the project also varied. In three cases (JFCS, Kaiser TriCentral, and Sharp HealthCare), the evaluator drafted the original evaluation.

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31 The evaluation of Project IMPACT was done entirely at the national level. The co-principal investigators and the project director for the Institute on Aging’s grant did an evaluation of the PEMC grant in addition to the larger evaluation.

32 Robert Newcomer, from the University of California at San Francisco, evaluated two of the grants (Sharp HealthCare and LTCG). He was added to the second of the grants at the suggestion of the program office, which was concerned about the initial evaluation design.
### TABLE III.3. ROLE OF THE INDIVIDUAL GRANTEE EVALUATOR

<table>
<thead>
<tr>
<th>Grantee</th>
<th>Evaluation Done by Organization Heading National Intervention</th>
<th>Evaluation Contract with Separate Organization</th>
<th>Evaluation Done by Co-Principal Investigator(s) and/or Project Director</th>
<th>Original Evaluation Design Drafted by Evaluator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Grants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JFCS</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Kaiser TriCentral</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Institute on Aging</td>
<td>X&lt;sup&gt;a&lt;/sup&gt;</td>
<td>X</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Sharp HealthCare</td>
<td>X</td>
<td>X</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>LTCG</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UCLA NPI</td>
<td>X</td>
<td>X</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Pacificare/Secure Horizons</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related-Activity Grants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project IMPACT</td>
<td>X</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>UCLA GIM</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: MPR analysis of PEMC grantee final reports and interviews with grantees.

N/A = Not applicable because the grant did not have an evaluator, and the evaluation was done either by the co-principal investigator(s) and/or the project director (Institute on Aging, UCLA NPI) or was done entirely at the national level (Project IMPACT).

<sup>a</sup> In addition to the national evaluation, the PEMC grant evaluation was conducted by the co-principal investigators and the project director.

<sup>b</sup> Evaluator was a consultant with Partners in Care Foundation, which was one of the grant partners.

design. In two other cases (LTCG and Pacificare/Secure Horizons) the evaluation design was developed during the planning grant, with the evaluator helping to refine a design that was in place. Since the evaluation of Project IMPACT was done at the national level, staff from the PEMC-funded sites generally made major decisions about the design and choice of outcomes in collaboration with principal investigators from the six other sites in the national project, as well as with staff from Project IMPACT’s UCLA Coordinating Center. For the IOA’s grant, each medical group developed its own intervention, which conformed to the goals of the Chronic Care Network for Alzheimer’s Disease initiative. However, evaluation personnel at the national level of the Chronic Care Network for Alzheimer’s Disease formulated the evaluation design for the national project, and it appeared that there was little need for the additional expertise of an evaluator hired specifically for the PEMC grant. Not surprisingly, evaluators viewed their contribution more positively when they were able to be involved from the beginning.

The amount of writing evaluators did for the final report also appeared to have varied somewhat across projects. Of the five grants that had evaluators specific to the PEMC grant, the
evaluator was the primary author of the report on four of them (JFCS, LTCG, PacifiCare/Secure Horizons, and Sharp HealthCare). For the remaining grant (Kaiser TriCentral), the evaluator was not directly involved in writing the final report.

There was not sufficient information to fully assess which of these diverse models is better. In general, experience suggests that both having the evaluator involved from the beginning and using an evaluator with experience carrying out rigorous evaluations in real-world settings is important.

2. Assessment of the Individual Grantee Evaluation Requirement

In general, grantees that were interviewed, both evaluators and others, were supportive of the inclusion of this type of formal evaluation design, even though the outcomes were disappointing to them. Some said a rigorous evaluation was essential in identifying that an intervention did not work, so that attention could be focused elsewhere. For the most part, evaluator reports suggest that developing a sound evaluation design is feasible for these kinds of interventions, though issues exist (such as getting consistent data from physician offices and bridging the privacy wall between provider and evaluator).

More challenging is the task of assuring that the project evaluated is soundly designed and structured in a way that warrants a rigorous evaluation. Several evaluators expressed disappointment with the design of the interventions tested, though they did not necessarily make their concerns known at the start. General care management interventions, in particular, were often perceived as inadequately built on an evidence base with unrealistic assumptions about the likely success. The outcomes measured tended to be important ones from the perspective of key sponsors, such as purchasers or plans, but the changes sought or their magnitude was not necessarily realistic. Even when grantees met the goals for participation, the power to assess all relevant outcomes was often lacking (for example, long-term care use when power tests were defined by hospitalization rates). In some cases, grantees wondered if more testing for intermediate outcomes could be valuable.

Specific features of a project could also be problematic from an evaluation perspective. In some cases, key aspects of an intervention were lacking or inadequately implemented, such as physician involvement. In other cases, the intervention may have been “over designed.” For example, some involved in Kaiser TriCentral’s efforts now recognize that the careful distinctions they tested among interventions didn’t differ all that much and depended on the skills of the staff carrying them out. In hindsight, more powerful tests of a smaller number of distinct alternatives could have been better. Failure to account for preexisting care patterns (such as whether the intervention included systems that already stressed exercise or control of diabetes) was another issue some identified in retrospect. Both too little targeting (LTCG), or too much (if those targeted were already being managed), were issues participants perceived with diverse interventions.

The timeframe for the evaluation was also a concern for some grantees. The UCLA GIM intervention, which was started later than others as a related-activity grant and focused on pilot testing, was pushed for intermediate outcomes as early as three months into the intervention (which had been delayed) so that there could be some feedback for the MPR evaluation; staff were uncomfortable with this short time period. In another case, a grantee was concerned that the
12-month outcomes were too early given the need for patients to develop trust in the care manager. Other grantees were also interested in a longer test; however, it is not clear that increased time would have resulted in different outcomes because the interventions themselves were limited as implemented.

Many grantees went out of their way to commend CHCF for their commitment to the evaluation requirement, as the opportunity to obtain foundation support for such rigorous assessment tends to be lacking. For clinical researchers, having such a randomized control trial is the “gold standard” when assessing evidence from demonstrations. The inclusion of rigorous evaluations undoubtedly helped the program in its dissemination, making publication easier. (See Section E of this chapter for more on this topic.)

Views on the role and form of evaluation have evolved to some extent since the evaluations were initiated for PEMC. Berwick, for example, argues the merits of conducting small, local tests (which he described as “Plan, Do, Study, Act”) as an alternative to randomized design (or simple implementation without reflection or evaluation) (Berwick 1998). Though randomized trials may be good for a final test of well-crafted, unitary changes, he argues they are less appropriate when the intent is to develop the change or to adopt a proven treatment in a local setting with its own conditions. Others have similarly focused on such models in encouraging improvements in chronic care delivery (Wagner, et al. 2001). These distinctions appear relevant to the PEMC context in which, it appears, some interventions could have benefited from more flexible pilot testing and refinement prior to formal testing. Others, perhaps, did not sufficiently reflect the state of the art.

Developing evidence-based interventions appears particularly challenging in trying to meet the needs of frail elders. The challenges of mounting successful case management interventions are well recognized. So are the disagreements between those who accept (apparently as a matter of faith) that they work and others, who believe (apparently equally strongly) that they don’t. One source of the conflict stems from the relative importance placed on client and caregiver perceptions versus influence on overall costs and patient outcomes. A bridge across these competing concerns would be to use the kinds of interactive models now proposed to encourage change to explore evidence-based interventions that can accommodate complex needs.

D. WHAT WERE THE STRENGTHS AND WEAKNESSES OF THE WAY THE PROGRAM WAS ADMINISTERED?

PEMC was the first grant program commissioned by CHCF. As a newly formed foundation, CHCF wanted to quickly and visibly assert its presence as a grant-making organization. PEMC was developed very rapidly. At the start, the program was administered internally by the Foundation under the direction of Jan Eldred and later under Andrea Gerstenberger. After CHCF staff members realized that their other work responsibilities left them too little time to effectively carry out the task of managing PEMC activities, the Foundation established a program office at UCLA, where David Reuben and Janet Frank directed the program. Key activities of the program office included: (1) support for review of Cycle 2 grant proposals; (2) monitoring and support of ongoing grants; (3) planning and dissemination activities for the program as a whole; and (4) technical assistance to grantees. (See Appendix A for more detail.) This section reviews findings about the effectiveness of the administrative infrastructure on which the program functioned.
1. Effectiveness of the Grant Giving and Reach of the Solicitation

From what grantees told MPR about how they learned of PEMC grants, it appears that CHCF was successful in “getting the word out.” Both formal and informal routes were used to reach people. Having an advisory panel that included a mix of relevant leaders and stakeholders from California and elsewhere meant that knowledge of the forthcoming program was well diffused. (See Appendix A for more information on the advisory panel.) Though the panel created some potential conflicts because it included many who would submit grants, these conflicts were probably an effective tradeoff for gaining support for the program and interest in participation. The ability to evaluate the grant giving was, of course, limited by the fact that MPR had access only to information on those successful in receiving grants, not on those who either did not know about the potential or who were not successful.

The application process appeared to have been a bit chaotic, particularly in Cycle 1, because CHCF was so new and because procedures were still being developed. As one grantee observed, “In the beginning, they were kind of new at this, but it was never really a problem—just not that sophisticated.” Those familiar with other grant programs (as most were with only a few exceptions) differed in their assessment, noting the comparative ease of CHCF versus others they had been involved with. For the most part, respondents perceived the grant application process positively, with clear application rules that they thought were not very cumbersome. The Foundation was complimented on its flexibility, collaboration, and attention to evaluation and improvement. Those less complimentary expressed frustration that some rules changed and that they found the applications to be more complicated than other foundations. The fact that interviewees differed in points of reference probably contributes to the variation in perspective, with interviewees spanning small community-based groups to large managed care organizations and experienced research grant seekers.

The long delay between application and award was probably the most consistent criticism. In general, the application process appears to have been smoother in Cycle 2, though this cycle also involved a lengthy time between application and award. CHCF staff say that the time between application and award was, for the most part, consistent with the way the timing for the program was originally planned.

2. Role of Program Office and Program Infrastructure

For the most part, grantees believed that establishing a separate program office had a positive effect on the program, although some said the “extra layers” were an inevitable tradeoff. While the transition was perceived to have worked relatively well, some said that, in the future, it would be better if a program office were to be used, but to have it in place from the beginning. Without that, grantees had to learn new ways of relating part way into the program. This was especially true because the program office staff, by design, had more time to devote to oversight of the program and took a more “hands-on” approach than had foundation staff when they ran the program directly.

Views of the program office generally were positive, though there were exceptions and areas mentioned that needed improvement. Most credited the program office for their flexibility in allowing grantees to learn and their willingness to provide help when asked (for example, with getting physician data). The UCLA team generally was well respected, and grantees appreciated
their oversight. One observed, “The involvement of the UCLA program office made an enormous positive benefit. I saw the program evolve over time. At the beginning, it was weak and vague on the science side. UCLA improved this. The program got better and made projects more accountable.”

There were some criticisms, however. Grantees’ views of the responsiveness of the office varied; some noted that the program office staff were very responsive, while others either found communication more difficult or were confused over the respective role of the program office and foundation staff. One credited the program office for not being “nitpicky,” while another suggested “less micromanagement” would have been better. Grantees of a few projects that appeared to have been struggling were more critical than others; they perceived the program office staff to be unsupportive. For example, one grantee said, “The program office was critical of the fact that we weren’t meeting goals. They didn’t seem to understand the difficulties we ran into.” On the other hand, foundation staff perceived that some grantees were reluctant to acknowledge problems or accept technical assistance. The most common criticisms across all grantees appeared to relate to: (1) getting feedback late about requirements for meeting presentations; and (2) having additional requirements placed on their projects after the fact. The latter appears especially related to requests for publications and for data to support the program office’s meta-analysis, and to the review of manuscripts by the program office. The fact that manuscripts were reviewed was an issue for some grantees; and, program office staff noted that getting these manuscripts was difficult, particularly in a form acceptable for publication.

The program office appears to have been most visible to grantees through the annual meetings. Participants varied in their views of these meetings, perhaps reflecting general differences across respondents in their relative interest in any form of big meeting. Some were highly positive about the experience. As one noted, “They brought people together.” Another remarked that the meetings helped “seed a field of innovation” with “chances for grantees to communicate and share experiences.” One grantee, whose planning grant had ended, said that they appreciated being included in the meetings and believed that their inclusion gave them a chance not only to find out what was going on, but also to continue to have the “opportunity to share ideas and information.” While grantees appreciated getting information on what other grantees were doing as a core part of the agenda, some said that having short presentations on projects was less preferable to having more time for interaction and discussion of relevant issues.

The program office appeared to have been most relevant to implementation grantees. While those with planning grants were invited to attend the meetings, most planning grants were completed by the time the program office was created. Even those planning grants that were complete appeared, for the most part, to have limited interaction with the program office. Related-activity grantees also reported less interaction with the program office than did the implementation grantees. Also, as noted previously, when grantees were part of national programs, tensions arose in meeting any specific expectations for California data or PEMC-specified information.

Grantees perceived, for the most part, that the program office was focused on the annual meetings and on monitoring activities. While some grantees went out of their way to indicate gratitude for help received in response to problems they raised with the office, most said they had not requested specific assistance. Others said that there were areas in which additional assistance would have been valuable. One specific area mentioned was institutional review board
approval, an issue that was much larger than many sites had anticipated. Another, particularly from planning grantees and especially from those dealing with dual eligibles, was the desire for more general access to technical assistance. A number of planning grantees also said it would have been useful to them to have had more explicit midcourse benchmarks for assessing progress and for getting feedback on their performance. Structuring the program to involve competition for implementation grants may have complicated the task of providing technical assistance, as giving technical assistance could have caused these competing organizations to perceive the assistance as an unfair advantage. However, given that the planning grants were designed, at least in part, to improve planning grantees’ potential for successful implementation, providing as much technical assistance as needed would have both been consistent with the goal of the planning grants and would have improved the planning grant process.

More dedicated focus on technical assistance and guidance to grantees was a suggestion made by a number of evaluators. These evaluators were responding to what they saw as inconsistencies between often weak and not very structured interventions that were being rigorously evaluated.

3. Grantees’ Sense of Community

Because of PEMC’s use of annual meetings and newsletters, and its geographical focus on California, MPR asked grantees about any sense of community that this program may have created. PEMC grantees that were interviewed generally said they believed the program had created a sense of community, though their views on its strength and importance varied.33 Implementation grantees were most likely to perceive such a sense of community. About nine out of ten interviewed felt this way, which compared to only one in four of those in related activities in which there typically was a separate national program or other audience for their work as well. Overwhelmingly, respondents said that the grantee meetings were responsible for creating this sense of community.34 One respondent highlighted this by saying, “It’s funny because, for example, Kaiser and PacifiCare are competitors; but it was nice to talk about common issues and challenges.”

Few respondents believed that the sense of community developed through PEMC is sustainable now that funding has ended. One respondent said, for example, “There are a lot of relationships that will be sustained, but I’m not sure about the group as a community.” Another added, “I’m not optimistic, given the demands on each of the organizations. The fact is that most players are wearing multiple hats. I do think that everyone remembers the network and would feel comfortable contacting fellow grantees.” Other respondents supported these comments, saying that with the relationships that developed as a result of PEMC, people would be comfortable contacting each other. Others said, too, that because there is a relatively small circle

33 Questions on this topic were asked only of implementation and related-activity grantees, not of planning grant interviewees.

34 These meetings included the annual meetings as well as other meetings of grantees, such as the Dissemination Summit held in October 2003.
of people that do the kind of work that was the focus of PEMC, people know each other and will continue to work together on other efforts.

Respondents varied in their views of the importance of community to the success of programs like PEMC. More than half of the respondents said that it is not important. Several noted that PEMC projects were so different and that grantees were doing their “own things,” which minimized the importance of having a sense of community. For example, one said, “I don’t think that they have to have a sense of community, but they need to know who else is doing work in the same field.” Another said, “We had so many players that trying to connect with another group of people would have been hard and not important.” A sense of community was particularly important for about one-third of the grantees. The particular appeal was the sense of being part of something bigger than the individual projects. As one respondent observed, “Any time that you don’t feel alone in the design or evaluation of something—it’s positive.” The remaining respondents did not have an opinion as to whether a sense of community was important or not.

4. Grantees’ Views of CHCF in the Context of the Program

For the most part, grantees credited CHCF for giving them clarity and consistency over time in their goals as they related to PEMC. They were also universally positive about the CHCF staff working on PEMC over time. Some typical comments include, “This has been my first experience working with them. It’s been nothing but delightful,” or “CHCF staff is wonderful, and they have been all along.” One grantee who was somewhat negative about the program office said about CHCF staff, “They are smart, thoughtful, and knowledgeable.” Another, despite having been turned down for an implementation grant, said that “working relationships with CHCF were very positive, especially compared with governments, but even compared with other foundations…There was a lot of flexibility when we ran into problems. Even though we were turned down, we still have a good positive relationship with them.” Another credited CHCF for arranging to fund the UCLA staff, who they said, “kept us on our toes…with very smart people and…a lot of good suggestions.”

The only real criticism came from some researchers active in the program who were disappointed that, from the researchers’ perspective, CHCF had not made more of an effort to solicit grants that went beyond the traditional loosely structured care management models shown to be weak. They also criticized the failure to complement CHCF’s strong support for individual grantee evaluations with equally strong guidance and direction for the actual interventions. However, this feature, at least in part, reflects the deliberate decision to allow flexibility as opposed to the more prescriptive approach favored by some foundations.

5. To What Extent Has PEMC Achieved Its Dissemination Goals?

CHCF sought to use PEMC as a model for the nation in learning how to build on the growth of Medicare managed care and link it with community-based services to improve care for frail elders. While the premise of a growing Medicare managed care sector nationally has not materialized, the interest in improving care for frail elders through more effective care delivery remains important today. Therefore, evaluating how well the program is achieving its goals for diverse modes of dissemination to the target audiences is important.
With PEMC just ending and evaluations just being finalized at the time of this report, it is not possible to comment fully on the question of dissemination—a goal important to CHCF. At this stage, PEMC’s efforts to disseminate appear appropriate. As a result of annual meetings and the newsletter, grantees appear well aware of the experience of other grantees. Dissemination of the experience of particular work has been enhanced by the involvement of national groups. For example, the UCLA GIM effort to develop guidelines for seniors with diabetes benefited from the national advisor and cosponsorship of the American Geriatrics Society. Articles describing the program have appeared in peer-reviewed journals (see Table III.4). Projects that are part of national programs, like Project IMPACT, with multiple sites, have been especially well represented. The experience of PEMC grantees appears to have been well represented in the programs of relevant national groups, particularly involving geriatrics. The program office gets particular credit for encouraging and prodding the development of such activities.

Notwithstanding the successes to date, the ability to pursue dissemination goals for PEMC faces challenges. In many cases, with grant funds ended and evaluations complete, there are no additional plans by individual grantees to publish or disseminate the work. Incentives to publish are particularly lacking for more operationally based organizations and for investigators for whom publishing is not a primary interest or capability. Without an additional push (and potential support) from the Foundation, some worthwhile learning may not be conveyed.

Further, knowledge of PEMC to date can be viewed as mainly “among the converted.” Information on the program is best known to those California-based plans, providers, and community organizations that were interested enough to begin with to want to participate in the program. Outside California, knowledge is most widespread among academics and national organizations that are focused very directly on geriatric care. In addition, there has been limited work to date to abstract particular tools or findings from PEMC that may have broader application.

A key challenge for PEMC is to move knowledge of PEMC and its lessons beyond the immediate audience of California-based plans, programs, and national attendees at geriatric care meetings to the broader national audience. With other means of controlling costs or enhancing care out of favor, there is increasing interest at the national level in quality improvement, especially in improving care for chronic illness patients and for those with above-average needs, like the frail aged that are the focus of PEMC. Awareness of PEMC appears low among these audiences and current dissemination does not reach them.

The challenge then is to convert the experience of PEMC into findings and lessons that can be relevant to a broader audience and to a set of policy issues. With the program winding down, CHCF has begun to consider the broader question of moving relevant findings forward. The Leadership Summit that CHCF convened in October 2003, with grantees and other selected stakeholders, was a good start in examining the project findings to identify particular tools/findings that may have broader application. The program office has developed a list of such tools, and CHCF is considering developing a web site to disseminate them.
| GRANTEE PUBLICATIONS
| IMPLEMENTATION GRANTS
| JFCS |
| IOA |
| LTCG |
| Kaiser TriCentral |
| Sharp HealthCare |
| PacifiCare/Secure Horizons |
Table III.4 (continued)

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<td>With Chronic Care Needs.</td>
<td><em>Family &amp; Community Health.</em></td>
<td>26(3), 221-229</td>
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<td>Wilber, Kathleen H., Douglas Allen, George R. Shannon, and Sam Alongi.</td>
<td>“Partnering Managed Care and Community-Based Services for Frail Elders: The Care Advocate Program.”</td>
<td>51(6), 807-812</td>
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**RELATED-ACTIVITIES GRANTS**

**UCLA Division of GIM**

California HealthCare Foundation/American Geriatrics Society Panel on Improving Care for Elders with Diabetes. “Guidelines for Improving the Care of the Older Person with Diabetes Mellitus.” *Journal of the American Geriatrics Society*, vol. 51, no. 5.

**Project IMPACT**


Note: UCLA NPI and the National PACE Association had not published any articles related to the PEMC grant when this report was written.
But while there is potential value to the field in making some of the tools and concepts developed by PEMC available more broadly, the most important lessons from PEMC may rest elsewhere. One program participant observed after the last meeting that developing business plans for interventions—which in their pure form are often “tired old stuff”—is not the answer because there is little in most of the models to “replay...[without being] refined and retested.” Potentially some of the most valuable lessons of PEMC stem from its failures, since these can be very valuable to others. The MPR evaluation is viewed by foundation staff as particularly valuable in extending knowledge of PEMC’s lessons to a broader audience. This topic will be covered in Chapter IV, which focuses on the conclusions from this evaluation.

E. WHAT LESSONS CAN BE DRAWN FOR EFFECTIVE PROGRAM DEVELOPMENT FOR FRAIL ELDERS?

MPR’s evaluation of both the strengths and the weaknesses of PEMC highlight a number of areas that are important to consider in future programming for frail elders. Readers should note that these points are not an assessment of PEMC since the list draws both on what PEMC did well and that which might have improved the program had it been included. While funders are the primary audience for these lessons, those seeking to pursue innovations in care for frail elders may also find many of them valuable.

- Clearly define the program goals, the logic of the interventions, the expected outcomes, and the evidence base on which these elements rest before deciding to go forward. That is, it is very important to understand the logic of the processes that need to intervene between grant and outcome and the strength of the evidence to support the intervention.

- Invest in developing solid clinical guidelines and tools to support the program or individual interventions. Even if care needs involve multiple complex conditions, consider focusing on a single defined point of reference—like dementia, falls, depression, or diabetes care for those who are frail—to expedite the development of guidelines and the targeting of care based on needs.

- Seriously explore alternative ways of targeting the individuals (such as patients and/or their caregivers) that are appropriate for the intervention, with a view toward determining which patient identification criteria provide the best balance between intervention costs and burden, and its likely payoff.

- Work with potential grantees and allow sufficient time to ensure that the proposed interventions can be implemented in an appropriate period of time and that the environment is well suited to effective execution. Assume that, to be successful, interventions will have to be consistent with the strategic direction and business needs of each organization. (This was one reason for which Foundation staff say they let organizations develop their own evaluations and contract with evaluators directly.)

- Work to encourage appropriate partnerships and collaboration among organizations demonstrating solid leadership and a commitment to the project and processes.
• Give serious consideration to including a planning grant or a planning phase with time and resources that are commensurate with the task and the organization’s capabilities. Assume that the challenges will always be greater than anticipated.

• Despite the temptation, don’t be seduced into expecting outcomes that are more ambitious than is likely to be supported by the intervention, environment, or time frame. Look for short-term intermediate measures of outcomes that may indicate whether or not a given intervention has promise.

• Anticipate adversity. Seek to ensure that the intervention’s success is not dependent on a few people but has organizational support, an established process to institutionalize the support, and a solid footing in helping participants further their business objectives.

• Consider building in fiscal flexibility, as available in PEMC, to take advantage of unanticipated opportunities or findings that warrant further exploration.

• Be aware that joint funding of interventions not only provides opportunities to leverage available resources, but also generates risks associated with differences in funding goals that could complicate execution by grantees and/or make it more difficult for the local foundation to get the information it needs.

• If a program is to have a central coordination point (such as a program office), establish it from the beginning, select a well-respected individual committed to the program goals to lead the office, and provide resources sufficient for the task.

• Establish expectations from the start on any data, measures, or evaluations needed to satisfy internal and external needs, and stay consistent over time on these expectations.

• Incorporate incentives and opportunities for sharing grantee experiences, and disseminate information in a well-targeted way to additional audiences of interest.

• Don’t assume that each grant needs to succeed for the program to be successful; both successful and unsuccessful efforts can teach something. Be prepared to invest in making the most of the opportunity.
IV. CONCLUSIONS AND LESSONS

A. OVERALL CONCLUSIONS ON PEMC

The first of CHCF’s grant programs, PEMC encouraged partnerships between managed care organizations, provider groups, and community-based service organizations with the goal of improving care delivery for frail, at-risk elders in Medicare managed care.

Both the individual grantee evaluations and MPR’s evaluation show that PEMC was an ambitious program with a good concept that produced modest results. Frail elders, the focus of PEMC, are without a doubt an important population with regard to program development. Their needs are great, the costs to serve them are high, their numbers are growing, and the care they now receive is widely perceived to be lacking in a number of important ways (Andersen and Knickman 2001; Casolino, et al. 2003; Chen, et al. 2000; HMO Workgroup on Care Management 2002; Reuben 2002; Wagner, et al. 2001). The Institute of Medicine lists care coordination as an important cross-cutting priority for national attention, along with frailty associated with old age and chronic illness (Institute of Medicine 2003). The needs addressed by PEMC are at least as relevant today as when the program began.

With PEMC, CHCF sought to take advantage of the California environment and its experience with risk-based managed care. Interventions organized through Medicare managed care should be more open to innovation, even though plans are still constrained by the need to control costs and by Medicare’s acute care benefits (Thornton, et al. 2002). Incorporating community-based providers and physicians into this environment are ingredients many view as important to success (Wagner, et al. 1996; HMO Workgroup on Care Management 2002).

The resulting program, PEMC, appears to have been well run and financed by a foundation with a strong, clear vision and supported by both influential grantees who worked hard to make their ideas a reality, a program office set up to help them do so, and an outside panel of experts positioned to provide access to existing knowledge in the area. Yet, few of the projects resulted in meaningful change in patient outcomes. Also, while some important tools, guidelines, and education were generated, most efforts have not been sustained. The question, therefore, is: Why wasn’t this more successful?

In retrospect, the outcomes sought by PEMC were probably too lofty relative to the interventions tested, the speed with which they were developed, and the existing knowledge on how to both improve care for frail elders and finance those improvements. PEMC’s goal—improving care for frail elders—is a challenging but important task. CHCF pursued it for this reason and was encouraged by others to do so. The form of the intervention—better communication that linked medical and social service providers, with limited change in medical practice (what Thornton and others term “constrained innovation”)—was well suited to the capitated environment in California (Thornton, et al. 2002). The decision to look at external returns, in terms of health outcomes and costs, was based on the market. In its planning, CHCF heard that if it could not make a business case for improving care to frail elders, plans would have a hard time accepting the results of any intervention and taking the next step. But PEMC grantees generally could not achieve this ambitious goal.
In addition to the fact that the goals were very ambitious, CHCF was probably not well positioned to achieve them, since doing so would mean resolving weaknesses in delivery that others before have failed to overcome. CHCF was a new foundation that aimed to move quickly. CHCF’s decision to give grantees flexibility was an understandable response to grantee’s interests in more flexible strategies that left more room for innovation than prescribed interventions. But flexibility may have diluted the emphasis on encouraging maximum use of evidence in both structuring the interventions and defining the outcomes. The absence of a program office from the start limited the support available to grantees. And, having only two closely spaced cycles of grants limited the amount of learning that was available to improve the program over time. In retrospect, it may have made more sense to invest in developing models before entering a large-scale test of the models.

CHCF’s experience is by no means atypical. Entities that fund interventions often want strong evidence of positive effects from their investment, and they want that evidence relatively rapidly. Achieving organizational change is difficult, however. The PEMC experience is a telling example of both how hard it is to establish interventions for frail elders in a way that seriously affects the care they receive and that it is even harder to do so while generating short-term savings.

B. LESSONS FOR CHCF AND CALIFORNIA PLANS/PROVIDERS

1. What PEMC Gives to Build On

PEMC was CHCF’s first program. While the outcomes are disappointing given the effort that went into the program and the expectations, PEMC established the Foundation as both a presence and an important participant in the effort to improve health care in California. It also contributed to CHCF’s positive reputation in California. Those affiliated with PEMC speak positively of the Foundation, its staff, and their own experience with program.

The PEMC experience also lays the basis for CHCF to follow through on the interest in improving care for frail elders in California, to the extent that this is still a goal. At a time when Medicare leaders are searching for ways to improve care for beneficiaries, CHCF’s work has greatly expanded the experience of state leaders and providers with initiatives to improve care for frail elders beyond that of any other locale. The interventions tested by PEMC grantees notwithstanding, it is not clear that they are any more limited than those being pursued by most other groups. This potential makes California a wonderful natural laboratory for examining and developing insight into the challenges associated with improving care for frail elders and the approaches that can realistically encourage success.

2. Other Opportunities

The PEMC experience suggests that there are at least three areas that offer opportunities for progress in care for frail elders:

- More Deliberate Development of Evidenced-Based Interventions That Focus on Frail Elders. The PEMC experience reinforces concern that relatively unstructured
and limited generic interventions involving care management are likely to yield limited results. There is a danger, however, that frail elders will be left out of disease-based and highly targeted interventions because of the complexity of their needs and lack of clarity on how best to intervene. California’s experience with developing diabetes guidelines under PEMC (along with the dementia guidelines) is an example of merging the interests in more targeted approaches while keeping frail elders as the focus. Additional work consistent with this goal would do much to ensure that frail elders, among Medicare’s most vulnerable subgroups, are not ignored as Medicare moves forward in encouraging pilots to improve care coordination.

- **Potential Base for Analysis of Care for Dual Eligibles.** While programs directly focused on dual eligibles were not a priority for PEMC, a number of the planning grants provide rich experience with the challenges of doing so. The experience also shows that despite the challenges, interest in better integrating care for dual eligibles remains strong. Additional analysis of the experience of the more successful PEMC planning grants focused on dual eligibles could help to address questions facing policymakers today about the key barriers to success in building such programs.

- **Opportunity to Learn More About Coordinating Medical and Social Services.** The financial barriers to integrating medical and social services are well known. A key part of PEMC’s thrust was to take advantage of California’s risk-based environment to incrementally improve coordination between managed care organizations and community-based providers of largely social services often not covered by Medicare. Further, the PEMC experience shows success in developing communication across these organizations. It would be valuable to learn in a more organized form about the potential constraints involved in such coordinated efforts given current funding streams. Further study would arguably give CHCF an opportunity to learn how far managed care organizations are willing to go given fiscal realities and what is left undone. This information could be useful at the national level in better articulating the challenges for bridging the divide between medical and social care delivery for frail elders, particularly those without some form of long-term care coverage.

3. **Insight into the Use of Rigorous Individual Grantee Evaluations**

It would be unfortunate if the null findings from the PEMC individual grantee evaluations led CHCF to reject the use of such tests in the future. Such evaluations are indeed the main way to demonstrate whether an intervention is working—something that grantees found very useful. The following lessons may be important in identifying when and how to best use such evaluation tools.

First, while flexibility is valuable to grantees, an interest in a rigorous test of an intervention by its nature makes it desirable for CHCF to do more to specify what it seeks to test or what potential grantees need to show for a demonstration to be testable.

Second, anticipated outcomes themselves need to be evidence based. The interest in quality-enhancing, cost-reducing outcomes is understandable in today’s environment, as only interventions that meet these criteria may be acceptable to payers. However, it may be difficult for many interventions to meet this test even if they have other positive attributes. Determining
realistic expectations about outcomes can help funders decide, from the start, whether anticipated outcomes make the intervention worth pursuing. The discussion also might lead to including other outcome measures, such as intermediate changes in care, provider knowledge and satisfaction, positive effects for patients (regardless of their costs), and lessons for operational design of system improvements. Such information can help program participants and others determine whether the tested intervention is either just not very good or good but just not ultimately effective in reducing costs or improving outcomes. However, such analysis is only valuable if alternative outcome measures are acceptable to those who ultimately will have to pay for them.

Third, program participants should not underestimate the substantial lead time and resources needed to plan, pilot, and build good interventions or overestimate what is currently known about the form of effective intervention for the frailest of elders. Developing and pilot testing tools that can be useful in this area is very important, and arguably it is more important in the short run than evaluations to rigorously assess specific interventions.

4. Insight on Structuring Program Design and Oversight

Program Design and Planning Grants. The preceding discussion highlights the importance of taking the time to identify the specific interventions and goals for programs for frail elders (and probably most other programs as well). Though providing grantees with flexibility can be valuable and welcome, features known to be important to the quality of the research need to be specified in advance in calling for applicants, and those weighing the merits of competing applications may want to look carefully to judge the extent to which an applicant can introduce a sound intervention. Such an examination could assess, for example, whether case management is to be a fully integrated component of care delivery or merely an overlay, as seems to be the case for many of the PEMC grantees.

PEMC grant making may have involved a trade-off between achieving a desired number of awards and the caliber of projects. A smaller pool of grantees makes the risks of any one failing more serious. It could be that the more important lesson is less the selected number of grantees than the up-front time devoted to developing the intervention and applicant pool to help craft demonstrations with greater potential for success. This strategy, however, requires a longer time horizon and a greater organizational commitment, both from the funder and the applicant. Securing such a commitment could be difficult, particularly if turnover is anticipated and markets are unstable.

More extensive use of planning grants, for example, like those historically used in demonstrations by some large established foundations (such as the Robert Wood Johnson Foundation) could provide a vehicle for testing the probable success of an intervention before moving forward. Though planning grants were included in PEMC, their timing and the overall limitations on new PEMC starts limited the Foundation’s ability to take advantage of them. The circumstances surrounding the start of PEMC were unique, and future programs are likely to face fewer constraints in making more use of planning grants.

Program Office Responsibilities and Involvement. The PEMC experience highlights the value of using a dedicated program office for complicated, multisite interventions. Foundation staff did not then, and probably do not now, have the time to provide such support or necessarily
the expertise. The program office established for PEMC was well known and respected by program participants through their prior work—a fact that served them well. Marrying part-time known staff with more committed junior staff is a common model that appears to have worked well here. A late start is obviously a feature that CHCF would not want to replicate in the future, since involvement from the start builds the capacity to shape the program and individual grantees at the start when the influence is most likely to be effective.

In the future, it would probably be useful to identify the best way to both identify grantee needs for technical assistance and to provide that assistance. The difference between the program office’s and the grantees’ perception of technical assistance is striking. The office perceives that it went out of its way to ask grantees about their needs and to create opportunities for grantees to get assistance, while grantees who perceive that they needed assistance say they did not get it. A strong technical assistance component appears to be an essential component to these types of grants. In the eyes of foundation and program staff, efforts to identify the need for technical assistance and to provide it must be more proactive so that the act of identifying the kind of assistance needed in itself becomes the first step in providing assistance.

C. NATIONAL RELEVANCE AND LESSONS

The Program for Elders in Managed Care experience should be of considerable interest at the national level. As noted, the Institute of Medicine has concluded that efforts to improve care coordination are an important national priority and that frail elders are an important target population (Institute of Medicine 2003a). Demonstrations of how to redesign the delivery system so that it provides ongoing care that is coordinated across multiple providers—including acute care, long-term care, and social services—and supports patient self-management are important (Institute of Medicine 2003b).

Improving care management is particularly important for Medicare beneficiaries. Interest in this topic is high both in Congress and in CMS, which administers Medicare. For several years, CMS has aimed both to encourage coordinated care through enrollment in Medicare+Choice and to extend management concepts via demonstrations in the traditional Medicare fee-for-service program. With the enactment of the Medicare Modernization Act (MMA) of 2003, interventions will be expanded (Alliance of Community Health Plans 2004). Quality improvement programs that include chronic care are required in both Medicare Advantage (MA, formerly Medicare+Choice) plans and the traditional Medicare fee-for-service program. MA plans must include a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions. To expand care management in the traditional Medicare program, a pilot program involving a partnership between Medicare and private organizations offering coordinated care to large populations is to be established and evaluated by randomized trial (Foote 2004). While modeled on experience with disease management programs, the pilot will be allowed to move beyond the primary condition to address co-morbidity and case management as well as disease management. In addition, the MMA provides authority to contract with specialized private plans that focus on care for Medicare beneficiaries with special needs.

The PEMC experience underscores the importance of well-structured, evidence-based interventions to successful outcomes and the particular challenges associated with identifying and implementing these interventions for frail elders. It is not clear from the PEMC experience whether the interventions to be included in the federal pilots will be adequately scaled to the
ambitious policy goals set for them, particularly given the speed with which they are likely to be pursued and the limited scope of their authority (especially for interventions outside provider systems). Further, it is easier to develop interventions for relatively healthy people who can largely care for themselves but who have chronic care needs. Thus, it is possible that the pilots will have an incentive to focus less on elders with ill-defined conditions and larger care management needs than on other populations. If so, it may be that an important opportunity will have been missed to improve care for frail elders. In addition, because frail elders account for a large proportion of Medicare spending, it will be hard to control expenditures if programs do not adequately focus on this population.

Though outcomes from the PEMC are generally disappointing, both the program and the literature supports the importance of programming that addresses needs of frail elders. Further, several of the projects highlight the value of developing condition-specific guidelines that take into account frailty, including the projects that targeted patients with diabetes (UCLA GIM), depression (Project IMPACT), and dementia (UCLA NPI).

In this context, national policymakers may find it of value to monitor the rollout of coordinated care pilots and other demonstrations to assess the relevance of the interventions tested for the frailest of elders. Further, because of the challenges associated with developing effective interventions for this population, CMS may want to consider whether it should cover some of the costs of development since private entities may have insufficient financial incentives to do so.
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