APPENDIX F

EVALUATION METHODS AND DATA SOURCES

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The evaluation of PEMC involved a multifaceted approach. Primary evaluation methods and sources of information included the following:

- Review of program/grantee documents;
- Semistructured interviews with key grantee staff, evaluators, program office staff, CHCF staff, and advisory committee members;
- Secondary data analysis including a synthesis of outcomes associated with each implementation and related-activities grant; and
- Review of the literature on integrated care demonstrations, and comparison to the results of PEMC to assess the program’s influence and ability to model future practices.

This multifaceted approach provides richer information and data than what might otherwise have been possible with a more limited evaluation design. Table F.1 identifies the methods and sources of information used to address each of the evaluation questions. Two types of analysis were conducted for the evaluation. The first was a broad reaching review of grantees’ experiences and perceptions. The second involved a targeted review of demonstration outcomes based on the internal evaluations that PEMC supported.

A. ANALYSIS OF GRANTEE'S EXPERIENCES AND PERCEPTIONS

One key analysis of the PEMC evaluation involved a broad reaching review of grantees’ experiences and perceptions, which is relevant to understanding the following:

- What was the impetus of grantees for their respective projects?
- How were the grantees’ models of care developed and evolved?
- What explains the outcomes?
- How sustainable are these models of care?
- What are the implications of the results for sick or frail elders in managed care?
- How do grantees view PEMC grant-making activities generally?
- How do grantees view the program office/foundation infrastructure, including lessons for future grant-making activities?
- What do grantees view as the broader lessons from PEMC?
TABLE F.1. METHODS AND SOURCES OF INFORMATION TO ADDRESS THE EVALUATION QUESTIONS

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<th>Evaluation Question (s)</th>
<th>Methods and Sources of Information</th>
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| 1. What kinds of integrated models of care for frail elders were tested through PEMC?   | • Document review  
• Semistructured interviews                                                                 |
| 2. What has been learned about grantees’ different models of care? What were the outcomes of individual grants and how did they vary? | • Document review  
• Semistructured interviews  
• Secondary data analysis of outcomes |
| 3. Which demonstration efforts appear most sustainable or applicable to other settings? What are the factors that lead to, or impede, the success of different models of care? | • Document review  
• Semistructured interviews  
• Secondary data analysis of outcomes  
• Review of the literature |
| 4. What are the implications of findings for managed care practices, Medicare policy, or care for frail elders? | • Semistructured interviews  
• Review of the literature |
| 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? | • Document review  
• Semistructured interviews |
| 6. What can we learn about program office operations? Which program office activities have been perceived to be the most useful and the least useful and why? What are the lessons for the management of other programs? | • Document review  
• Semistructured interviews |

This review of grantee’s experiences and perceptions with PEMC involved three distinct evaluation activities including a review of program and grantee documents, semistructured interviews with key grantee staff and other informed observers, and a review of the related literature. Each of these activities is described in further detail in the following sections.

1. Document Review

To provide background and context to the evaluation, program and grantee documents were extensively reviewed. The purpose of the document review was two-fold. First, it provided important descriptive information about the program overall. Second, it allowed for a better understanding of individual grants. Key documents that were reviewed for the evaluation include the following:
• Grant proposals;
• Interim progress reports;
• Site visit reports;
• Final reports (including information on outcomes);
• Program office documentation on grantee activities (conference calls, technical assistance notes);
• Materials from the annual meetings and other convenings of grantees;
• Program communications (newsletters, brochures); and
• Articles and other dissemination materials documenting grantees’ efforts and outcomes.

Several other documents were prepared previously based on the review of program and grantee documents, which complement the final evaluation report. These include:

• A report that synthesized key descriptive information pertaining to PEMC, which provided important background and context for the evaluation (Humensky and Gold 2002).
• Summaries of each of the PEMC grants—implementation, planning, and related activities—which provided important information on the individual grants including the intervention, timetable of grant activities, underlying hypothesis, study population, target enrollment size, changes from planned activities, and evaluation structure. These grant summaries are included with this evaluation report (see Appendices C and D).

2. Semistructured Interviews

A key component of the evaluation involved conducting semistructured interviews with lead grantee staff (for example, principal investigator), others knowledgeable about the work, and the independent evaluators.¹ These interviews provided the opportunity to gain richer insights into grantees’ experiences with and perceptions of PEMC than would have otherwise been possible with the document review alone.

The semistructured interviews were conducted using standardized protocols. The protocols were specific by type of grant—planning, implementation, or related activities. Topics covered during the interviews included: (1) impetus for the project; (2) planning and implementation experiences; (3) outcomes; (4) sustainability and replicability of the models of care; (5) lessons and implications of results; (6) dissemination efforts; (7) grant-making activities; (8) program

¹ Others knowledgeable about the work were often coprincipal investigators.
office activities; and (9) sense of community among grantees. Additionally, there was a separate protocol for use with the independent evaluators, which addressed: (1) evaluator’s relationship to the grantee; (2) the evaluation design; (3) evaluation process and results; (4) sustainability and replicability of the models of care; (5) lessons and implications of results; (6) dissemination efforts; and (7) program office activities.

Interviews pertaining to the planning grants and terminated implementation grants were conducted between May and August 2003. The interviews for the remaining implementation grants and related-activities grants were conducted between November 2003 and February 2004.

3. Review of the Literature

To understand how the activities and findings of PEMC fit in the national context, a review of the literature was conducted. This assisted with the assessment of the influence of PEMC on care delivery for frail or sick elders in managed care. It also allowed for a gauge of how the findings of PEMC might influence the development of future models of care for this population. Key phrases on which the literature review was conducted include the following:

- Models/systems of care for vulnerable populations in managed care;
- Models/systems of care for frail or sick elders in managed care;
- Medicare managed care models/systems of care;
- Elders in managed care;
- Care coordination/integration for frail or sick elders in managed care; and
- Outcomes of elders in managed care (including Medicare managed care)—service utilization, costs of care, health status, and patient satisfaction.

Based on our review of the literature, an annotated bibliography was prepared, which highlights key information relevant to PEMC (see Appendix E).

B. REVIEW AND SYNTHESIS OF EVALUATION DESIGN OUTCOMES

The evaluation designs and findings on the major outcomes of the seven implementation grants and two of the three related-activities grants were reviewed and synthesized. Projects were classified based on whether their interventions were focused on general care management or the management of a specific disease. The major source of data for this task was the final reports and any journal articles or other publications from individual grantees. These documents

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2 Results were not synthesized for the third related-activities grant to the National PACE Association because its purpose, to develop a consumer satisfaction measurement tool, did not involve testing a health care service delivery intervention.
were reviewed in detail, and the following are among the major outcome areas of the general care management projects for which effects were summarized:

- Health and functional status;
- Quality of life;
- Utilization (inpatient hospital, physician, outpatient, emergency room, nursing room, and home health);
- Costs (total, physician, outpatient, inpatient hospital, emergency room, and nursing home); and
- Patient and caregiver satisfaction.

Outcomes were also analyzed by a smaller number of these projects, such as exercise, use of community resources, and member retention. The disease-specific project evaluations, and thus the outcomes synthesis, focused on outcomes directly related to the targeted disease: Project IMPACT focused on depressive symptoms; IOA presented results on the use of Alzheimer’s Association services; and UCLA measured adherence to dementia care guidelines.

Several of the grantee reports conducted a process analysis to assess the implementation of their intervention, and key findings are presented from these analyses. Data analyzed in these process analyses included: (1) the frequency and duration of care management consultations with enrollees; (2) data on the number of referrals made during the intervention; and (3) surveys or focus groups with physicians, care managers, or caregivers about satisfaction with the program.

No primary data collection or individual-level data analysis was included for the outcome synthesis because each project conducted data collection and analysis, and thus additional efforts would have been duplicative. The UCLA program office had planned 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 analysis.