APPENDIX G

ADDITIONAL INFORMATION ON PEMC PLANNING GRANTS

March 2005
Activities Conducted as Part of the Planning Grants

The core of the planning and implementation process for the PEMC planning grants was to identify and bring together partner organizations to form the collaborative. Often, prior relationships helped grantees identify their partner organizations. Sometimes, however, previous relationships did not exist, which required grantees to specifically seek out organizations with which to work. All of the planning grantees held meetings among the partner organizations. The purpose of these meetings varied by collaborative, but for many, they were intended to: learn more about what each partner does; assess what services each partner provides; and, vet ideas.

In addition to the work with the partner organizations, many grantees conducted reviews of the literature as part of their planning grant work. The purpose of this was to help inform their planning process by examining what, if any, related work had been previously done in the areas of interest. Often, the literature review was used to help the collaborative think more broadly about approaches by examining existing evidence.

For a few of the planning grants, legal issues were an important part of the planning grant process. One grantee, for example, was looking to create a managed care entity. This grantee said, “We felt that a separate entity was important, because if we were going to engage other service organizations, we needed a neutral entity. We didn’t want it perceived as a [grantee] entity, or an organization of any of the people convened around the table. Also, if it only included the organizations that we convened, others would not participate. Community organizations compete for funding. It is not as harmonious a community as one would think. Other organizations may need to front money to us, but eventually, it would need to be self-sustaining.”

Planning and implementation pertaining to the planning grants involved various other activities, as well. These included:

- Talking to people in other programs from which the PEMC grant was modeled;
- Conducting a feasibility study of creating a dual-eligibles program using a capitated payment methodology with a health plan that was not a Medicare HMO;
- Speaking with other health plans about their experiences with dual-eligible populations;
- Conducting site visits to other states to see how they had implemented programs for dual eligibles;
- Conducting focus groups with physicians to assess how things could change to improve care for seniors;
- Forming subcommittees to work on specific issues; and
• Engaging applicable federal agencies (for example, CMS) in the process.

**Consistency Between Planning Grant Application and Activities**

Generally, there were no significant changes to the planning grants as a result of the planning and implementation activities. Most grantees said that they essentially did what they had proposed to do. As one grantee said, “Sometimes we had to go back and haggle over assumptions, but that’s okay, that’s part of the process.” Changes that did occur were mainly around:

- Adjusting the time lines to compensate for delays resulting from the IRB approval process, and getting data (for example, from HCFA); and
- Scaling back on the scope of work, such as focusing on one site instead of two.

Planning grantees differed as to whether they would have done anything differently with regard to planning and implementation. According to one grantee, for example, “No, we wouldn’t do anything differently. There are maybe one or two things I would do differently, but we only know that retrospectively, as we have gone into implementation. I think we did the right thing all along.” Another added, “No, I thought we did a really good job. The funding we received was just wonderful. We really did appreciate it.”

Some grantees, however, said that they would have done things differently. Several expressed concern that the planning process was not long enough to accomplish what was needed. One grantee said, “Maybe [we would] have looked at a two-year planning grant. It was such a new concept. Maybe 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.” According to another grantee, “We didn’t get as far along as we thought we would. We probably got one-third of the way or halfway through the true planning process that we needed (to be effectively positioned to go operational). We did the task we said we would do, but in doing it, we were challenged with coming up with an implementation model in the time frame for the planning grant.”

Additionally, grantees discussed other lessons learned from the planning and implementation process. One grantee said, for example, “Make sure that all of the players are at the table or at once realize the need them to involve them more.” Another noted, “It might have made more sense to have a little more professional planning staff, especially for the part that involved the evaluation of community resources…If we had used professional facilitators, we might have gotten more out of it.”
Key Accomplishments of the Planning Grants

Many of the planning grantees cited the relationships that evolved from their PEMC projects as major accomplishment of their efforts.\(^1\) Partnerships developed between fairly disparate entities, including providers, health plans, and community-service organizations. Of these relationships, grantees said, for example:

- “Some of the other partners really appreciated getting a chance to understand the views of others…I’m not sure how much long-term value there was in getting to know each others’ views, but it was a good thing.”
- “We have developed strong multidisciplinary working relationships. These did not exist before.”
- “The leadership [of the partner organization]…was interested in expanding to other populations, and they are mission driven and are used to working with community organizations like us. Also, they understood multicultural issues in the community and seemed like a logical partner.”
- “It afforded an opportunity, provided an excuse, or gave permission for service providers to sit in one room together and talk about common patients. We had the two competing HMOs there in the room, and they were talking regularly about how to meet the needs of the patients. It opened dialogue about how to improve care. It was a huge accomplishment, to look critically at the service-delivery system. We were looking at patient-centered care. Also, service providers were willing to talk about how change can happen incrementally, without doing a whole new system of care.”

Some planning grantees cited a major accomplishment as being that it helped people get experience working with the senior population. One grantee noted, for example, that people involved in the project went on to do other research in the area, saying that this grant experience helped build their expertise—helped build their sophistication in this type of research. The grantee added, “We didn’t go to implementation. But there was influence on the people that were involved with the grant…The grant gave us time to think through ideas and influenced all of us involved.” Similarly, another grantee said, “It affected those working on the project. The internal medicine physician had not worked closely with the elderly population previously, so this was a real learning experience for her, and she has been able to apply what she learned in her private practice. The nurse had no prior experience with geriatrics, but has become passionate about working with this population.”

Another key accomplishment of the planning grants was the heightened awareness that developed about certain issues. For example, grantees said:

\(^1\) Except for CalOPTIMA, all of the other planning grantees had partner organizations. CalOPTIMA appeared to have only had letters of support.
• “We got a good sense of the type of care management services needed by the ethnic minority communities...Things we felt were deficiencies were built into the care management model. We got a sense of the level of need, and we got specific in the focus-group process about how to talk to seniors about being better patients; how to make them more knowledgeable about self-care; how to interact with physicians; how to use services more effectively without running to the emergency room.”

• “We thought the care management model would overcome primary access difficulties, but it didn’t turn out that way. Seniors only access care when they have clear needs. Most needed medication assistance, and that is why they wanted to participate. I would have thought that seniors would have heard about the program and would want to sign up, whether they needed the services or not. Instead, we attracted the seniors who had needs. Those who didn’t have needs were less likely to participate. That is important to know for social marketing.”

• “As far as accomplishments, they all became more realistic in what it would take to sell themselves to a managed care plan as a collaborator or business partner. My sense is that they went into this thinking that the value of the collaboration would be appreciated apart from the dollars and cents. This was not the case. When it came to building the business plan, each organization’s board was overextended or committed to other things. The potential partnership with a managed care plan never took place. The consortium members came away from this discouraged but more enlightened.”

• “Internally, it gave us a greater awareness of the needs and realities elders face in insurance issues and social/self-care issues.”

Bringing greater awareness to the organization was another accomplishment cited by at least one grantee. That grantee said, “Locally, it raised [our] profile as a player in the clinical aging community. I don’t know how much that would have happened in the absence of the planning grant... It helped us to say we were working with CHCF.”

For some planning grants, the accomplishments were more tangible. Specific tools—care management and administrative—were developed for several of the grants. For one of the grants, for example, a high-risk index developed for the elderly was subsequently adopted by the partner health plan to identify high-risk seniors in care management. For another grant, screening and in-home assessment tools were developed, the use of which lead to other important project findings. According to the grantee, “For the PEMC grant, we provided in-home assessments, where we sent the physician and nurse into the home. The elderly appreciated the assessment and the individualized attention, but we found that the caregivers really needed to get out of the home. The caregivers were not so excited about the in-home services as they were about respite care and support groups.” Another grantee that was linking Medicare claims data with Medicaid claims data said, “We had a beautiful database to use for actuarial analysis. This was made possible by the planning grant... The most tangible, valuable thing to come out of the planning grant was the database.”

For a few grantees, the PEMC planning grant provided a stepping-stone to other funding opportunities. According to one planning grantee that was subsequently awarded an
implementation grant, “We got the funding, $1 million for the entire program, which was our goal.” Linkage to funding, however, was broader than PEMC. As one grantee noted,

“It jump-started the planning process. We had more resources put into planning. It led to a more lengthy planning process. We see it as the first year of a multiyear process. We got funding for the first year of planning from PEMC. We had another grant funded by the state for planning for the second and third year. The county is funding planning for the fourth year, and now we are applying to the state for an implementation grant. If we don’t get it, we will move more slowly with local funding. In the beginning, we had no understanding about the length of time needed for planning. It has been a five-year process.”

The grantee went on to say,

“I applaud the Foundation itself. It has been quite involved with us and with other counties that went after state-funded grants for planning resources. The Foundation provided linking resources. We were joined by 10 or 12 counties that met with the help of the Foundation to look at long-term care planning. CHCF has helped the counties collaborate. This collaboration has allowed us to have relationships with counties. Our affiliation with CHCF wasn’t limited to PEMC, but it was our first contact with the Foundation. The Foundation has been a major player.”

Other tangible accomplishments of the PEMC planning grants were the feasibility work that was done. Along this line, grantees said, for example:

- “I think that we got a decent and good feasibility study done for our partnership. The partnership has continued to meet to look at ways to proceed in an environment where Medicare HMOs are pulling out of the market and state budgets are being cut. It’s now more of a challenge. We took the whole sophistication level further.”

- “We came to realize that it wasn’t financially feasible to do a [Medicare+Choice] plan, and the planning grant helped us make a sound business decision.”

- “Since we didn’t implement it, it is hard to say what we accomplished. There was a lot of process, but not a lot of outcomes.”
G-2. IMPETUS OF PROJECTS FUNDED AND RATIONALE FOR USE OF PLANNING GRANTS

Project Impetus

Impetus for the planning-grant projects generally arose from perceived inadequacies of existing health care delivery models in serving the elderly. In particular, the coordination and linking of medical and community-based services was viewed as especially problematic. Grantees said, for example:

- “We had a reasonably rich history…with geriatric care coordination and assessment. We felt that medically, geriatric services couldn’t do much to identify unmet social needs and link people to services in the community to meet those needs. We felt that the social needs were overwhelming. [We] felt that this was where we needed to invest our time and effort.”

- “My organization had a lot of seniors enrolled and didn’t know how best to serve them. I would hear from our case managers that they didn’t know how to get more efficient care for the senior population. We tried to deliver as good, if not better, care for seniors in the HMO and tap into community resources, even though we had limited funds.”

- “[A] new HMO had started that was approved as a Medicare provider and got its Knox Keene license to be a Medi-Cal provider—[the] only HMO at the time in the area that served seniors. It was interested in learning how to work more effectively with seniors. There was no other continuum of care system that spanned health care and community care services at the time.”

- “Most probably my vision as having been in the community and knowing this was an area that needed help [with the coordination of services between the Medicare HMO and community-based services]. The senior population was a growing part of the community. Since this was my background, and I was pushing the grant, it focused on areas that I knew and was most comfortable with.”

- “We had already been looking at the Medi-Cal population. We’ve always felt that we would need to look at Medicare managed care to generate enough savings to fund home- and community-based services.”

- “We wanted to develop the model of care management that would address the needs of elders in multiple ethnic groups. If seniors are over age 65, they tend to be both Medicare and Medicaid eligible. These are the most expensive patients, and they have problems with access and compliance. Our idea was to have people already well known in the communities as gatekeepers who were already working as case managers to build capacity in delivery systems.”
For other grantees, the complexities associated with providing care to dual eligibles provided the impetus for their respective projects. Along this line, grantees said:

- “We had been working on the concept of how to get the appropriate package of care for dual eligibles, an enriched package of services. We were having trouble coming up with the right rates, model, and policy to go to a managed care type of approach… We thought that we needed something in between Medicare+Choice and PACE in terms of risk adjustment for a population that has some level of disability but are considered high risk in the Medicare+Choice world.”

- “There really is a need for coordination of care between Medicare and Medicaid benefits.”

- “There is mandatory enrollment of dual eligibles, but what that means was different in different counties. None were enrolled in a care-managed, managed care system.”

I was brought in to look at the dual-eligible population in the county and at other states’ models of financing to determine if there was anything replicable for us—this all started about the same time as PEMC.

There were also other reasons why grantees said they sought a PEMC planning grant. One grantee, for example, wanted to test a specific type of program. According to this grantee, they “wanted to find out if proactive programs like nurse health coaching, exercise, education, and empowerment could prevent future disability and lower health care costs for seniors.” The grantee said, “[We] wanted to know if specific interventions could change morbidity curves, while at the same time do something innovative for a major client.” Another grantee said that the impetus behind their PEMC planning grant was to build on a prior project. This grantee said it was “a follow-up to an earlier project funded by another foundation in the early to mid-1990s.

“We had been part of a physician practice care management initiative funded by Hartford. It was one of 10 sites funded, each with strong track records of caring for elders. Funding was received between 1992 and 1995. Each site was expanding the scope and content of physician practices. The Hartford initiative tried to influence physicians’ work with seniors, including health education, prevention, and minority health status. Our original PEMC proposal tried to build off of this physician partnership project. It had been successful in changing physician practices. We saw physicians draw a pivotal link between community-based services and managed care. That’s how the PEMC grant got going.”

Finally, the impetus for one other PEMC grant was to test derivations of an existing model. The grantee said, “We already have enrollees in a care program. This was a stretch for the model. The hypothesis was ‘Can the model still provide outcomes given this variation [in care delivery]?’…Also, whether we could develop the infrastructure and develop sufficiently strong relationships to support this integration, even if the physician was not an employee [of the partner organization].”

**Rationale for Planning Grant Application (versus an Implementation Grants)**

Grantees cited a number of reasons for applying for a planning grant rather than a full-scale implementation grant. Most often, however, they said it was because they were not ready to
proceed to full implementation. The planning grant provided them with the time and resources that were needed for planning. Grantees said, for example:

- “I didn’t think that we were ready or positioned to go right out of the chute. We needed to think through the approach and get the right players. We needed to have time to organize our thinking. Also, the project [as a full implementation grant] required a significant research design, which also required that we come up with a way to evaluate it. The program needed fleshing out.”

- “The complexity of it. We would need multiple partners and a lot of resources. We needed to identify and get buyin from other partners. We needed to scope out the complexities. One goal was to create a separate entity, and we needed legal advice on that. Part of this was that we needed to do a needs assessment; another part was that we needed to come up with a structure we could do conceptually on a smaller scale before it went to a communitywide effort. The planning grant led to that.”

- “Because we were just in the very initial stages, we were not near implementation. We didn’t have then and don’t have now a predominant senior population in the health plan. We have Medicaid enrollment, and we see so many that have Medicare in addition, their care can be really disjointed.”

- “We knew we were very much in the preliminary phase of identifying where we wanted to go. We did not have our organization concept. We had cooperated in the past, but never considered the macroorganizational change that would be needed to develop the partnership.”

Besides the need for planning, there were additional reasons why grantees initially opted to forego full implementation. One grantee said, “We knew [that] because we were under the federal waiver, the idea of going into implementation was premature until we got federal approval. Getting federal approval involved significant planning.” At least one grantee thought that having a planning grant was first required. According to this grantee, “I don’t think that in the first year, implementation grants were available. My understanding of the rules was that in order to get an implementation grant, we needed to be invited or have some formal planning process in place prior to submitting an implementation grant proposal. We needed to do planning. Locally, we didn’t have enough information to go straight to an implementation grant.” For another grantee, there were issues of getting a key partner organization to commit to the project. As a result, they were reluctant to move towards full implementation.

Regardless of the reasons grantees sought a planning grant versus an implementation grant, many saw it as valuable to have an affiliation with CHCF. Grantees’ said, for example:

- “It was viewed as prestigious. I had thought a while about this, trying to serve seniors in managed care. It is challenging, because managed care systems and community-based and hospital systems were not always meshing well. This presented an opportunity to change how managed care and seniors hooked up. It was also prestigious to be a part of a California Health Care Foundation program.”
• “Frankly, the grace was that this was a foundation-supported idea. It was a door-
opening opportunity. Having the name of the California Health Care Foundation and
having the funds in focus helped us in our effort.”

• “[H]aving a partnership with CHCF would help profile our activities across the
county and across the state. It would help to improve our profile if we were
associated with the Foundation.

Barriers to Success

• **Organizational Instability.** This includes financial problems, downsizing, leadership
turnover, organizations just trying to survive, changing players, distractions, and
competing priorities. As one grantee noted, “What I learned from this was the
importance of having a stable system during the planning; also, stable players. Where
you put the grant in the organization, make sure that it makes sense. Some areas of
the organization may not be able to focus enough to make it happen. The downside
of having the grant at my level in the organization was that I did not have enough
influence at the broader system level. Maybe you have to actually have a person of
influence, as well as a person able to staff it and get it done.”

• **Sophistication in Planning Skills.** Some grantees perceived they could have been
stronger in knowing how to get or use information in planning. One said, for
example, “I wish we could have done more with the site visits in terms of getting
‘lessons learned’ extracted. Our follow-through on the reports could have been more
rigorous—let it steep for a while. When you have professional evaluators, you get
more information on ‘lessons learned.’ The site visit reports that we produced were
very descriptive. It would have been valuable to have presented it to someone with
more experience, one of the other grantees, for example, or one of the other hospitals,
and ask them how they would apply the experiences of another state to the work that
they do. It all seemed deeply important to us. We didn’t have the context to
determine ‘lessons learned.’”

• **Lack of Internal Resources.** Some organizations—public entities/quasi public
entities—do not have the same access to capital as private organizations, so programs
were more difficult to start.

• **Data Limitations.** This was expressed as follows by one grantee: “When we began
planning, we realized how much more planning that we needed to do. As we
identified the obstacles and barriers to setting up home- and community-based
systems in the HMO, we had a lot of unanswered questions and needed a lot of data
that weren’t available.”

• **Partner Selection.** When partners and the team were not well organized, or when key
members were weak in particularly important skills or understanding, success was
more difficult. Different groups had to be brought together, with different
organizational structures and histories that, at times, made interactions adversarial. As
one partner observed, identifying and getting the right partners to the table at the very
beginning was important. “About halfway through, we realized we had a major
weakness. We didn’t have but wanted to work through physicians’ offices. We were
missing the physician influence. So we hit a wall halfway through. If I could do this over again, I would ensure that physicians were involved from the beginning. We had to take our idea to physicians. They were fairly supportive, but we would have had better buy-in if we had involved them from the beginning; but, then again, it is hard to get physicians involved in things like this because they are so busy. Also, we had hoped to work with community fitness programs such as the YMCA to use some of their programs for our seniors. The YMCA came to some of our meetings and was enthusiastic, but we realized that adding a big senior program to their program just wasn’t going to be easy. We needed to have involved these two key players [physicians and community fitness programs] from the beginning.” Matching partners to the needs of the project is important.

- **Scale of Intervention and Breadth of Participation.** As one grantee observed, “[It] could be a lesson, that this could have been overly ambitious. The idea was to be so inclusive. Maybe what was important was to include only those providers [including community-based services] serving the majority of seniors.” Another noted that they had bitten off too much and needed to scale down some efforts. For example, instead of focusing on five different ethnic groups, they should have focused on two; instead of two sites, they should have had only one. Instead of integrating home- and community-based services into the managed care model, they should have excluded them.

- **Strength in Coalition Building.** One grantee noted that it was important to make sure that the intervention was not identified with any single partner, but with the collaborative—creating a neutral entity. Otherwise, people would be less likely to participate (for example, community-based organizations or others that might be competing for funds). Being culturally sensitive to different requirements of providers is also important.

- **Regulatory inertia.** There were problems caused with the interpretation of regulations. “We always knew that this project would be a variation of the regulations, but even when the regulations came out, we were still sanguine. The interpretation of the regulations by CMS took us by surprise.”

**Other Lessons from the Planning Grants**

A number of grantees expressed concern that the resources were not necessarily matched to what grantees could reasonably deliver. For example, one respondent claimed to have done the last six months of the project work pro bono. Another scaled back the number of sites from two to one.

In general, respondents said that the planning grants made them more aware of what it takes to adequately plan for an intervention. Examples of comments include:

- “We are probably more aware now of what this really takes. If we were to do this now, we would perhaps pursue the same thing, but with greater resources on our part. The agencies themselves in the consortium were not in a position to come forward with these kinds of resources. Someone has to fulfill that role. Either we need to be
clearer about what resources will be needed, or the group (the consortium) needs to be more realistic in understanding what can be done with the resources available.”

• “One thing that we learned…is trying to develop managed care models that integrate medical and other services (for example, home and community based) are long-term projects that don’t happen in a grant cycle. If you look around the country, these are ten-year projects. Planning is the first step in a much longer process.”

• “We did all of the tasks, but it took longer.”

• “It took longer than I thought to get the Medicare data from HCFA, but we did get the data. We accomplished everything we wanted to, but some things took longer than originally envisioned.”

An important element of the time required for planning involved the need to develop relationships with organizations. Planning grantees said, for example:

• “There were no glitches in implementing the planning grant. The issues that came up were, if the design went as it did, the hospital would have to give us XYZ services. The problems were more looking long range. People were excited about the planning grant. It created an opportunity to have discussions that would not have happened without the planning grant. Some of the discussions were difficult.” Turf issues, legal issues, and politics were involved. “People were willing to take risks, to ask tough questions, and even if it caused issues in their own organizations, they were still willing to ask the questions. It was really thrilling to watch the level of trust increase, and the willingness to take risks.”

• Dealing with turf issues and making sure that people don’t feel like this is a threat—for example, community physicians who worry you may steal their patients—is important. “That is the first-level thought that physicians have of any managed care organization that has staff physicians.”