ASSESSING THE CONTRIBUTIONS OF ATLANTIC PHILANTHROPIES' PROJECTS TO IMPROVING CARE FOR VULNERABLE ELDERS

Shoshanna Sofaer, Dr.P.H., Stephen Carby, M.P.A. and Phil Opatz, B.A.

School of Public Affairs, Baruch College

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EXECUTIVE SUMMARY

This report analyzes the contributions of a group of Atlantic Philanthropies projects originally funded under its Human Capital Development program in Aging in the United States. The projects, which were often sustained for many years, are no longer highly relevant to the strategy of the foundation going forward, although they were relevant for a number of years. The new strategy focuses more directly on improving care of chronically ill vulnerable elders through changes in policy, practice, and the active engagement of elders and their advocates.

The purpose of the analysis is to address the following questions regarding the original set of Human Capital Development grants that have or will shortly come to an end:

- How do they relate to the overarching logic model and strategy of the Human Capital Development in Aging (HCD) program?
- What were their desired outcomes and to what extent were they achieved?
- As Atlantic exits from this focus, where is it leaving the field? How might the field build on the achievements to date?
- What lessons have we learned from the experience of these grantees? Who are the target audiences for these learnings?

The analysis built on the previous work of a cluster evaluation of the HCD program, including in-depth interviews with staff from each project. The evaluation team also conducted in-depth examination of multiple documents regarding each project, many of which were quite recent and included evaluative assessments.

We categorized the primary strategy of each project using the following typology:

- Scholarship and Fellowship award programs;
- Training programs for practicing professionals;
- Model service delivery programs;
- Efforts to scale up and sustain proven service delivery models;
- Infrastructure development and

- Policy development and advocacy projects.

The Projects' Relationship to the HCD Logic Model and Strategy

Our analysis showed that this set of projects all related to the then current logic model, which emphasized moving to a state in which evidence based practice in the care of older Americans was usual practice, primarily through the delivery of knowledge and skills to currently engaged professionals in medicine, nursing, social work and direct care. However, a few grants moved more directly into intervening in practice settings to make improvements (American College of Physicians/RAND), or supporting changes at the policy level (Better Jobs/Better Care). The typology summarizes the wide range of strategies used by grantees.

Were Desired Outcomes Achieved?

For the most part, projects were not assessed in terms of measurable changes in practice, as such changes are not only difficult to identify but can appropriately be attributed to multiple influences, rather than to a single grant. However, in almost all cases, the explicit short- and mid-term objectives of grantees were met. For example,

- **Fellowship programs** have produced a critical mass of academic physicians and nurses who have been successful in funding and carrying out relevant research, publishing a remarkable body of findings, raising the prestige of geriatrics in their institutions, and taking leadership positions in discipline-specific and other organizations, including and beyond academia. The presence of these committed individuals has also had some impact on students coming through their classrooms; the evidence for this is stronger within nursing than within medicine.

- **Training programs** have touched thousands of health professionals and direct care workers serving older adults, bringing them information on evidence based practices through a wide range of pedagogical techniques and in a wide range of settings. Perhaps more important, the grantees in question have become committed to continuing to be central to providing such training in the long term.

- The one grant we categorized as a **model program** was an effort led by the American College of Physicians (ACP) with support from the RAND Corporation. The project succeeded in engaging a modest number of primary care physicians in efforts to improve the quality of care they provided to older patients in their practices, using a carefully developed set of measures known as ACOVE (Assessing Care of Vulnerable Elders). On these measures, the practices did in fact improve, to a greater extent than other similar practices who had chosen not to participate. This project may well come closest to actually intervening at the practice level. Designed as a pilot effort, ACP intends to replicate it as broadly as they can, although they will no longer have access

to the remarkable geriatricians from the RAND Corporation who took such a "hands-on" role in the original pilot.

- Several projects had originally been pilots, but got to the stage of **scaling proven models**. The contribution of Atlantic Philanthropies has included assistance to efforts by grantees to develop a business plan to carry their efforts to a far wider audience. Indeed, such plans have been developed, the "ethos" they represent is being incorporated into the organizations doing the scaling, and multiple strategies have been used to market content and activities that can improve care for older adults across large numbers of individuals or institutions. Perhaps the most important outcome is that grantees have proved willing and able to adapt, become flexible in how they implement programs, and thus not been trapped by a "purist" attitude as they move beyond the pilot stage.

- Two **infrastructure development** projects are designed to increase the ability of organizations without a singular focus on aging to create the conditions needed to support such a focus. One project focuses on subspecialists in internal medicine, the other on human services agencies. In the case of subspecialty associations, interest groups are being successfully created (the project is only half completed), but it is too early to tell if they can be sustained with limited or no resources. In the case of human services agencies, the key element is actually the linkage with the grantee agency, which is also building its own capacity to disseminate and replicate.

- The Better Jobs/Better Care project, the sole **policy development and advocacy** project in this group, also focused on training (primarily of supervisors of direct care workers rather than on the workers themselves). However, policy development and advocacy was a major goal of the program, which was jointly supported by The Robert Wood Johnson Foundation. Multi-stakeholder coalitions were formed in five "demonstration" states. Only one of the five began with a focus on policy and advocacy and made progress in achieving the objective of differential reimbursement for long term care providers whose management practices created high quality jobs for direct care workers. A special designation was identified; the work now is to link reimbursement to that mechanism going forward. However, it was clear that in other states, coalitions were not at a sufficiently advanced stage of development to take on the challenges of articulating and pursuing policy objectives, especially when they might be viewed as more in the interest of one stakeholder (the direct care workers themselves) than the other (their long-term care provider employers).

What lessons have we learned?

With respect to fellowship award programs, we have learned the following key lessons:

1. Select the right grantee and grant leadership: A common factor of the funded programs is that they were operated by a range of national organizations with legitimacy in the broader disciplines of medicine and nursing, and supported by advisory groups studded with individuals of high repute in critically positioned organizations. Involving organizations who did not already have an explicit commitment to the aging population was especially smart.

2. Don't expect short-term results: The projects build a cadre of individuals who have the capacity to be leaders in the mid- and long-term. They will produce short term results: publications, grants, etc. But the long-term impact on medical and nursing students, on the evidence base, on the overall prestige of the field, will take even more time than the multi-year investment made by Atlantic. Involving funding partners both philanthropic and public can help institutionalize these efforts over the long-term.

3. Faculty development alone will never be enough to improve practice across the board. It is essential to link faculty development award projects to other efforts designed to impact educational curricula; licensing and certification/recertification standards and mechanisms; the generation of innovative model practices; the translation of research into products that can be more easily applied in practice settings; and, of course public policy. These linkages require time and resources from funders, including a relatively high number of internal staff or support from other organizations, such as the National Program Offices so often used by The Robert Wood Johnson Foundation.

   We have a specific recommendation that Atlantic work to link the individuals who have received awards to the current grantees pursuing policy improvements. While few are likely to be seasoned policy analysts or advocates, they have a unique depth of knowledge on the relative importance of different issues and on the supporting evidence for policy positions. They would need training to fulfill their potential.

With respect to training programs we have the following lessons:

1. Training is not just training: To change behavior, training must be of the highest quality, in terms of several key elements, including: evidence based content; a clear target audience and strategies to reach and motivate them; the right training methods; the use of methods to assess short- and mid-term improvements in knowledge and skills; methods to assess whether trainees put their skills to work and create a more conducive environment for adopting best practices; and a business model to make their work sustainable over the long term.

2. Programs based in academia can be effective if those operating them recognize that what they bring as academics is necessary but not sufficient: They need to be highly

entrepreunerial, willing to get into the field, listen to the field and learn from the field, and willing to adapt materials so they are easy to access, absorb and apply.

With respect to the single model program we examined, our lessons learned are the following:

1. Physicians, and other providers, will not embrace practice change efforts unless they see a clear and fairly immediate benefit to themselves in doing so: In most cases, external factors will loom large in motivating change. These factors include changes in financial incentives, in the requirements of licensing and certification organizations, in the metrics used and publicized to help people compare providers, etc. Of course, the new direction Atlantic is taking focuses on just this kind of policy change.

2. Make it easy to change: With respect to practice change efforts, the process needs to simpler, more specific, more step by step, more transparent. We know that people will not even try to change if they think they will fail. This is clearly true of patients but it is also true of clinicians and executives. Related to this lesson is that for people to take ownership of a change process, they need to be able to adapt as well as adopt. An overly heavy focus on pure implementation fidelity may be self-defeating.

With respect to scaling proven models, we find the following lessons:

1. Identify the most critical "active ingredients" in any major effort you want to scale and work to ensure these are sustained even if other pieces of the original plan do not survive: This is the other side of the coin from the immediately previous lesson. Replications do not have to be clones, but they do have to honor the underlying drivers of success in the original model. The challenge in following this lesson is that it is rare that we have strong evidence of which ingredients are most critical; typically, good judgment is required, as well as careful observation of the implementation of the original model.

2. Plan, but be ready to take advantage of unexpected opportunities: This lesson is specific to the current moment, in which the largest new health care bill of the last fifty years at least is in the process of being implemented. This legislation is rife with specific provisions that address hundreds of issues and create hundreds of opportunities to take good ideas and spread them more broadly. For Atlantic, it is important that the models created with their resources be promoted as viable options for further replication through the implementation of the law.

With respect to infrastructure development projects, we found these lessons:

1. The use of small grants can make a big difference: Both projects in this category were working to create a focus on aging in organizations whose mission was broader than, but included, care of older adults. In both projects, small grants were used to great effect and provided a specific focus that got people mobilized around an aging related issue or topic.

2. A mix of senior, mid-level and junior members are good ingredients for an effective interest group: Having individuals at all levels of experience and prestige works well because they can play different roles and also provide continuity over time.

3. Even the most minimal staff support can make a huge difference: When trying to build sub-groups within either a formal organization or across more informal groupings, even a few hours a month can provide logistic support needed to keep things moving.

4. This is a long struggle: With respect specifically to geriatric medicine, we are still a long way from having this field viewed as a prestigious, scientifically well-founded or lucrative focal point for a physician's career. It may well be a communications challenge that, in fact, the field remains less than glamorous, especially given its focus on management and palliation rather than "cure."

With respect to policy development and advocacy, we examined one set of projects in the Better Jobs/Better Care. As policy is a primary strategy being pursued under the new direction, however, lessons from this project may be especially helpful.

1. It may not be wise to engage the same grantees and coalitions for purposes of policy development and advocacy on the one hand, and direct service improvement on the other: This does NOT mean that direct service providers should not be involved in policy advocacy, or the reverse, just that having the same coalition work on both kinds of issues may be almost impossible to achieve, except over a long time period.

2. Coalitions do not start out fully capable of taking on complex policy analysis and advocacy tasks; they have to develop over time: Coalitions take time to develop mutual trust and respect and a deep understanding of what each party needs and can contribute. Those characteristics are especially needed when pursuing policy objectives in a highly partisan and polarized environment such as exists in this country today. When coalitions are forced to take on tasks for which they are not yet "developmentally ready" they often not only fail to make progress, they can go backwards.

3. Multi-stakeholder coalitions take even longer to develop and take on policy changes: Again, building mutual trust may be not just difficult but close to impossible in situations where the reality, or even the perception, is that one group is trying to

undermine the position of the other. Some multi-stakeholder groups do share core values and vision, but others do not and the reality of conflicting interests has to be recognized.

I. INTRODUCTION

Atlantic Philanthropies created a sub-program in Human Capital Development within its Aging Program in the United States in 2004. A total investment of approximately $145 million has been made in projects in this sub-program through 2008; only a portion of that investment is reflected in the grants reviewed here. At that time, Atlantic Philanthropies decided to conduct a review of its Aging Program as a whole and made a significant shift in focus and strategy. While retaining the original focus on improving the health and lives of vulnerable elders, they determined that they could have a more significant impact in the relatively few years remaining until their endowment was spent down if they focused their health work on changes in policy that would support the adoption of more evidence based best practices, particularly in the care of people with one or more chronic illnesses.

This report summarizes, at this critical transition point for the foundation, the contributions that its original focus and strategy have made over the many years of its implementation. The report covers a total of 17 grants made to 13 organizations. In several cases a series of grants was made over time to the same organization for the same purpose; in one case two somewhat different grants were made to the same organization. While most of these grants have ended, quite a few remain in place, although grantees are aware that these are "close-out" grants from the perspective of the foundation. Appendix A provides information on the Grant Number, Grantee Name, Grant Title, Start Date and End Date.

The bulk of Atlantic's grants had originally been categorized on the basis of the particular health care professional/worker addressed, i.e. physicians, nurses, social workers and direct care workers. In our earlier work, we had created an alternative approach to categorizing these grants, based more on their programmatic strategy than on their professional target. Here are the categories we created:

1. Scholarship and Fellowship Award Programs
2. Training programs for practicing professionals
3. Model service delivery programs
4. Efforts to scale and sustain proven service delivery models
5. Policy development and advocacy projects[1]

We used these categories in our analysis for this report, as we used them in our initial analysis of the cluster as a whole. However, we have added a new category, Infrastructure Development, to address the focus of two projects with the Alliance for

[1] A sixth category we originally created, Information dissemination projects, was not represented in the set of grants we examine in this report.

Children and Families and the Association for Subspecialty Professors, which do not clearly fit into the existing categories.

We remain convinced that this approach will generate more learning for future efforts than categories which speak to the "target audience" (e.g. medicine, social work) alone. The foundation has appeared to find it useful in the past. Appendix A also includes a column indicating what category each grantee has been placed into. In a few cases, a grant can be placed in more than one category. Where this has been true, we have discussed the grant in the category we believe represents its primary focus.

Three objectives are specified in the logic model for the Human Capital Development in Ageing Sub-Programme (HCD) created in 2004. Two of the three are of particular relevance to this assessment of contributions:

1. Within five years health care practice for older adults will have been improved by increasing the supply and improving the quality of education and training efforts for key professionals, including physicians, nurses and social workers.

2. The quality of geriatric care provided by direct care workers in home and institutional settings will have been improved in three states.

Desired outcomes reflecting these objectives have been defined as follows:

1. To transform best practice into usual practice

2. To improve the capacity of older adults to access good health care

3. To improve the capacity of other care workers

4. To sustain both professional and paraprofessional geriatric capacity

5. To improve financial incentives for geriatric care

We decided it would be valuable to insert in this report excerpts about the assumptions underlying each category of program, to put it in an analytic context. These are found at the beginning of each section in italics.

Note that the report does **not** review grants funded prior to the strategy shift that focus more explicitly on improvement in chronic care for older adults. Of course, it also does not address newly funded projects tied to the new focus.

II. METHODS

The report is based on existing data of several kinds, including:

- Summaries of interviews conducted by the Baruch College Team with directors and/or other key players since the Cluster Evaluation began in 2006; and
- Proposals, summaries written by foundation staff for board action, progress reports and final reports.

In one case, the evaluation team has access to far more detailed information on an Atlantic Philanthropies grantee, the American Academy of Nursing, in support of the Claire M. Fagin Fellowship program. Our team was selected by the John A. Hartford Foundation, in 2008, to evaluate key grantees of its Hartford Geriatric Nursing Initiative (HGNI), including the Building Academic Geriatric Nursing Excellence (BAGNC) program, of which the Fagin fellowship program is a key element. We therefore have access to considerable information regarding the Fagin Fellows from the time of the program's inception to the present. We gathered these data through web-based annual surveys of Fagin Fellows current and past. In this report, we will primarily depend on surveys submitted in 2009. The most recent survey results are still being analyzed, but one or two key outcome data points are already available and will be incorporated into this report. Unfortunately, the data available covers all Fellows who received awards since the initiation of the initiative in 2001, so we are reporting on this entire group. In addition, since individual fellows are not "assigned" to one or another source of support, the data are for all Fellows.

Based on the existing data, detailed summaries of each grant were created. The summaries were organized according to the focal points we identified earlier for our study:

- How does each grant or group of grants relate to the overarching logic model and strategy of the Human Capital Development sub-program?
- What were the desired outcomes of each grant?
- To what extent were these outcomes achieved?
- As Atlantic exits from this set of grants over the next few years, where is it leaving the field? How can the field in general build on the achievements to date?
- What lessons have we learned from the experience of grantees in pursuing their objectives? Who are the target audiences for these learnings?

Ultimately, however, this report is based on our interpretation of the available data, especially across grantees. Such an interpretation is naturally influenced by other information and ideas which seem to us highly relevant to the task at hand.

III. FINDINGS

A. Scholarship and Fellowship Awards

Atlantic Philanthropies has made a major investment in the development of high ability, high prestige academic geriatric leadership in medicine and nursing, through support for faculty development efforts. These include:

- The Paul Beeson Career Development Program in Aging Research, which focuses on both geriatricians and faculty in other medical and surgical specialties;
- The T. Franklin William Awards for Junior Faculty, which focus on faculty in the sub-specialties of internal medicine (including geriatrics);
- The Jahnigen Career Development Awards, which focus on additional medical specialties and sub-specialties, including several that are surgical; and
- The Claire M. Fagin Fellowships in Geriatric Nursing, which focuses on people who have already achieved a research doctorate in nursing.

3. How does this group of grants relate to the overarching logic model and strategy of the Human Capital Development sub-program:

Here are the comments we made in 2007 in our initial analysis of this set of programs:

The focus of these programs is on academic settings and academic work – helping scholars get funding for and carrying out high quality research, getting their work published in peer reviewed journals, getting them promoted through the academic ranks, and eventually seeing them get chosen for high profile and prestigious positions from which they can become leaders with substantial influence on future scholars and professionals. On one level, this is field-building. In addition, however, there is an assumption such individuals will have both direct and indirect influence over the quality of care provided to older adults, the number of clinicians who choose to specialize in geriatrics or in conditions critical to older adults, and in the content and effectiveness of curricula so they more fully address current and emerging geriatric knowledge and the skills required to implement it with patients. The assumptions are plausible to some degree, but questions remain about how much change can be achieved through a small cadre of individuals, and exactly what roles they would have to take and what strategies they would need to employ to achieve such change. It is important to note, however, that we have not had access as yet to all the potentially relevant documents regarding these programs, since many reside with co-funders such as the John A. Hartford Foundation, which has engaged high level experts to evaluate the efforts over the years.

New directions are emerging in AP's use of this kind of project. For example, the newer Fagin nursing scholars program is emphasizing the need for participants to learn leadership skills and to build an enduring network of relationships with other

participants in the program (including not just other Fellows but other mentors, other organizational participants, etc.) This is an acknowledgement, however tacit, that being an excellent researcher is not sufficient for having an effect on either clinical practice or professional education. Indeed, our interviews revealed that an important "active ingredient" for all these projects relates to the development not just of individual "stars" but rather the creation of a network or cadre of people who have built relationships with one another through their participation in the fellowship and beyond.

From the vantage point of 2010, an additional feature of these projects emerges. Especially within medicine, the strategy of moving aging research out of geriatrics alone and into the broad range of medical, surgical and scientific specialties and disciplines has proved critical. Geriatrics *per se* will probably never be a "glamorous" career choice. By broadening the focus to the care of older adults across the board, these programs have moved the work of improving health care and health of older adults to something that should be relevant to almost all clinicians, rather than the purview of a small subset. The recent, somewhat controversial but probably wise decision of nurse practitioners to drop separate certifications for adult and geriatric practitioners and create a new "adult/gero" certification reflects this same kind of thinking. When one considers the proportion of health services overall that are provided to older adults across all settings, this approach makes enormous sense.

4. <u>What were the desired outcomes of this group of grants and to what extent were they achieved?</u>

These grants were clearly intended to produce cadres of scholars in medicine and nursing who would:

- be highly productive researchers in geriatrics and aging;
- progress through the academic ranks and obtain leadership positions;
- infuse geriatric knowledge into the medical and nursing school curricula; and
- improve the quality of care provided to older adults, not only in their own institutions but in other parts of the health care delivery system, through identifying best practices, training students at all levels, mentoring other faculty, and hopefully developing and promoting model programs, standards, and other vehicles.

In terms of achievements, this set of grantees, across the board, has:

- recruited and selected highly qualified candidates;
- almost always seen candidates complete their award;
- almost always seen candidates remain in academic settings, continue to focus on geriatrics at least in their research, and achieve tenure and promotion;

- resulted in the publication of hundreds if not by this time thousands of publications, primarily in peer-reviewed journals;
- resulted in the completion of significant geriatric research during the award period;
- resulted in garnering millions of dollars in additional geriatric research funding, public and private, including program project awards;
- produced a strong cadre of people willing and able to mentor others in careers in aging research; and
- given greater visibility to the care of older adults as a place where highly qualified individuals can and do make significant contribution to science and clinical practice.

The available data is not as clear regarding the impact of the award programs on outcomes that go beyond research productivity and mentoring. Thus, there is less clear evidence that awardees have succeeded in infusing sophisticated knowledge about caring for older adults in medical and nursing curricula among those whose careers will be primarily clinical in nature. Nor is there much evidence that scholars have a significant impact on clinical practice through other pathways beyond professional education.

We will explore in depth the largest and most prominent of the awards projects in medicine, the Beeson program, and as something of a contrast, the Claire M. Fagin Fellowships in nursing. We do this in part because of the richness of available data on both these projects.

Beeson Awards: A study by Warshaw and Bragg was commissioned by Atlantic Philanthropies to examine the impact of the Beeson program on broader impacts of this large group of faculty on their home medical institutions. The report on this study noted:

- There is no difference between Beeson and non-Beeson schools in the percent with student chapters of the American Geriatrics Society; a structured basic science curriculum that addresses geriatrics; or required geriatrics clinical training (although all schools report a required geriatrics clerkship or a geriatrics experience integrated into a required clinical rotation);
- Beeson scholars appear to have had no or minimum impact on the scope of clinical geriatrics programs at their medical schools; however
- Beeson schools do have an easier time attracting geriatric fellows, more geriatric educational grants, more time of faculty teaching geriatrics.

Academic leaders interviewed for this study were split about whether the Beeson Scholars had a positive influence v. no or a modest influence on the educational program at their medical school.

When we move beyond geriatric education to the delivery of clinical geriatric services, the impact of the Beeson's declines further. This appears to be because the Beeson

Scholar program emphasizes "protected time" for research, limiting the impact, at least during the award period, on actual clinical practice. However, the researchers note that since many of this group of faculty come from specialties other than geriatrics, they may well not be fully capturing their impact on either clinical education or practice.

Fagin Fellows Program: To balance this detailed discussion of the Beeson program, we now present data on the Claire M. Fagin Fellows program, which focuses on geriatric nursing. There are clear differences, which may well reflect different underlying cultures in academic medicine and academic nursing. Although research is still the predominant focus of nursing scholars, they are more likely to be assessed institutionally in terms of their contributions to teaching as well. The data here, as noted earlier, comes from our own evaluation of the Hartford Geriatric Nursing Evaluation, and in particular the BAGNC Scholars and Fellows program. We report results almost entirely as of mid-2009; additional data will be available by the end of this calendar year on results through mid-2010. The most important caveat is that in most cases, we have data available for all individuals receiving Fagin Fellowship since the inception of the program in 2001; we can rarely isolate achievements of the cohorts since 2004, when Atlantic Philanthropies became a funder.

We can report the positions currently held, as of 2010, by all Fagin Fellows responding to our survey (75 individuals, including current Fellows; response rate 96.2%). Of a total of 57 responding alumnae/i of the program, 12% have research positions only; 17.5% are in faculty positions that are not on a tenure track; 40% have tenure track faculty positions but are not tenured; while 30% are tenured.

Considerably more data are available from our 2009 results, for which we have a 91.3% response rate.

- The average number of publications of all kinds produced by Fellows was 10.35 prior to the award; 5.63 during the two year award, and 8.1 since the award.
- This comes to a total number of publications by Fellows of 671 publications during and after awards, of which 484 were peer-reviewed articles and 47 were peer-reviewed book chapters.
- The vast majority of these publications concerned clinical care (522 publications), but 64 did address education, while 21 addressed policy.
- Like their colleagues in medicine, nursing scholars did well at generating additional funding. Fellows had 84 grants funded during their award period (with the proviso that they had to be a PI, a Co-PI or a Project Director for a non-research project), and 88 more since their award.
- Fellows received approximately $6 million in funding during their award period (we excluded any Hartford Foundation funding in this calculation) and about $23.5 million since completing their award.

When we move beyond research productivity, we find a somewhat different picture among nursing fellows than among the Beeson awardees, although we must note that the difference may reflect data availability as much as the underlying reality.

- Two-thirds of fellows report working on a curriculum or course development related to the care of older adults **during** their two year award while 80% did so after their awards.
- Half the Fellows gave a presentation on care of older adults to a public audience during their award and 62.5% did so after their award.
- Over three-quarters gave a presentation of this kind to a clinical audience during their award and a similar proportion did so afterwards.
- One-fifth report organizing and delivering a multi-session training for a clinical audience, which is quite an undertaking, during their award, while 30% report doing so afterwards.
- The total of 69 nursing fellows responding have taught courses with at least 50% geriatric content to nearly 1,900 undergraduate students, about 1,800 masters students, and 139 doctoral students, since their award ended.

It appears, therefore, that nursing awardees, while focusing heavily on their research, are also playing a role in ensuring that future nursing graduates get at least the basics of geriatrics during their training, even if they do not go on to specialize in it. It is of particular interest that these awardees share their knowledge with clinicians, sometimes in quite an intensive manner, as well as with the public at large. In addition, almost all Fellows report encouraging nursing students to go into this specialty.

What is much more difficult to ascertain, from existing evaluation data, especially of the programs in medicine, is the extent to which former awardees do indeed find participation in these programs an important source of peer and mentor support for them as they proceed through their careers, and whether they seek to, and succeed at becoming "leaders" and in what contexts. It appears that all the programs have increased their emphasis on both networking and leadership over time. Since the Fagin fellows are explicitly asked about these areas, we know both are extremely important to them. But even for them, it may actually be too soon to discern the emergence of a new crop of leaders. The Beeson, which has been present in some form since 1994, has indeed produced leaders; former Beesons are now selecting current Beesons, and taking very senior positions. Some former Fagin Fellows are now mentoring current Fellows as well.

Why would "networking" be important? Certainly, having a support group beyond one's home institution is very valuable when there are not that many people with similar interests down the hall. Networking helps people move ahead in their careers. What is not clear is whether networking actually leads to more active *collaboration* in pursuit of objectives that go beyond one's own setting. With the growth of multi-site research efforts, networking can be of substantial significance. But it may well be the case that

having an impact on curricular content and emphasis, both didactic and clinical, will require reaching the state and national bodies who make decisions about licensing, certification, re-certification, and other issues. We know little about the extent to which research-intensive scholars move into those very different arenas, or can be attracted to them, and how.

3. As Atlantic exits from this set of grants over the next few years, where is it leaving the field? How can the field in general build on the achievements to date?

Atlantic Philanthropies is leaving medical and nursing faculty who specialize in the care of older adults in a much stronger position than when they began their work. The reality that older adults are a significant, and costly, user of medical and nursing services is well understood. The reality that their biological, psychological and social characteristics, in response to both age and cohort effects, mean that "normal" treatment may often be entirely inappropriate, is beginning to seep into the understanding of clinicians on the ground. The availability of meaningful scientific evidence has certainly promoted this gradual shift in the mental model of clinicians.

However, there are still all too many individual clinicians, institutional providers and funders who don't recognize the implications both of how older people are different and how they are the same compared to other patients and clients. We can only speculate, and hope, that the quite substantial number of individuals whose careers have been profoundly affected by their receipt of an award support by Atlantic, will have important "ripple effects" on the field over the course of the rest of their careers, which can span as much as 30 or 40 more years.

In the short term, the most important focus should be on helping to achieve sustained support for this work. The involvement of NIH agencies has been of great significance here, and if there is any way for Atlantic to continue using its good offices to promote their greater involvement, that would be excellent. It may also be important to identify ways in which grantees supported under the new direction of the foundation can be made aware of the resources represented by the individuals who have or currently do hold awards, and the institutions with whom these projects have been associated (not just the grantees but the host organizations for awardees). We make a specific suggestion for this at the end of Lesson Three in the next section.

4. What lessons have we learned from the experience of the grantees in pursuing their objectives? Who are the target audiences for these learnings?

The target audience for this set of learnings is, primarily, funders, public and private, who have the resources and inclination to seek significant impact on a field or on a problem. A close secondary audience would be organizations whose mission is long-term and

broad in nature and which seeks to have an impact on a substantial problem facing a substantial population.

Lesson One: Select the right grantee and grant leadership

By nature, the strategy of providing monetary awards for current and potential faculty members to produce research will, indeed, produce research. We have clearly learned that it is possible to build a research field through such awards. If the timing is good and the stewardship is as well, highly qualified candidates will take advantage of the resources provided: money, protected time, mentorship and linkage to a prestige effort (both through the naming of the fellowships and the foundations that support them).

While the evaluation data we have does not focus *per se* on stewardship, one common factor of all these programs is that they have been led by a combination of a national organization with considerable legitimacy in the "broader" disciplines of medicine and nursing, as well as advisory groups studded with individuals of high repute who are also often in critically positioned organizations. Atlantic Philanthropies has always paid as much attention, in our judgment, to the "who" of its grantees as it has to the "what" and "how" of its projects. With grant programs involving faculty development awards, in which the intervention is not particularly innovative but nevertheless has to be well executed, the "who" is especially important. We note in particular that the foundation wisely chose to move beyond the "usual suspect" grantee – the American Geriatrics Society, to include medical and nursing organizations with a broader mission and mandate, such as the Association of Subspecialty Professors, the American Federation for Aging Research and the American Academy of Nursing.

Lesson Two: Don't expect short-term results

Again by its very nature, the short-term outcomes of award programs are, in terms of a logic model or theory of change, several steps prior to the ultimate objective of improving not only the research underpinnings of a field, but actual practice in the field. In this situation, a funder has multiple choices:

1. Be willing to make an investment of up to ten years, and be satisfied with outcomes that focus strictly on what happens to the individuals who receive awards in the early- or mid-stages of their career.
2. Make an investment of much longer than that, 20 years or more (or even in perpetuity), and support assessments that move considerably beyond short-term outcomes, by intense follow-up of individuals, their home institutions, and key characteristics of the field itself.
3. In either case, involve funding partners, either private (like the John A. Hartford Foundation) or public (like NIA and NIMH) who have the wherewithal and

infrastructure to share the resources and administrative burden and who can, if at all possible, institutionalize the effort.

Lesson Three: Faculty development awards alone will never be enough to improve practice across the board.

The work of individual researchers, even thriving research centers, is necessary but not sufficient to bring professional practice to a high standard and keep it there. The common and distressing wisdom says that in medicine, in particular, it takes 18 years from the time that a major clinical breakthrough is discovered to the time that it is broadly used in practice. We have seen in the past decade or so, many efforts, from translational research to implementation science to quality improvement, to increase the speed not only of initial adoption of evidence based practices, but their long-term integration into the fabric of institutional and professional behavior. These efforts are only beginning to bear fruit.

What is to be done? Our team believes it is essential to link faculty development award projects to other efforts designed to impact educational curricula; licensing and certification/recertification standards and mechanisms; the generation of innovative model practices; the translation of research into products that can be more easily applied in practice settings; and, of course public policy.

Linkage can happen in many ways. One is to have the same group fund at least some of these efforts in addition to awards. It can be said that Atlantic Philanthropies has increasingly done that. But that may be neither necessary nor sufficient. If others are supporting these efforts, funding may not be key. What is essential, however, is for a funder to "connect the dots," perhaps in a far more intensive manner than is typical practice, in order to bring relevant resources together. A funder who does this is either going to need a substantially higher number of internal staff in relationship to the size of its portfolio, or it will need to support (individually or collaboratively with other funders) organizations capable of carrying out this work. And the work is not easy. It involves constant environmental scanning, strategic thinking, the ability to negotiate, mediate and broker relationships, and lots of patience. It may also involve recognizing, in assigning resources to faculty development projects, that the lead staff need to be supported for enough of their time not only to carry out their own projects, but to participate in such linkage activities.

As promised above, we have a specific "linkage" suggestion that Atlantic Philanthropies may want to pursue. That would be to make available, to the National Partnership for Woman and Families and its collaborating grantees, a data base of all the individuals who have, over the years, received a Beeson, Williams, Jahnigen or Fagin award. It is likely that very few of these individuals are seasoned policy advocates or even policy analysts. But they do have knowledge and legitimacy that can be mobilized in arguing for the

needs of vulnerable older adults, if they are so moved and if they are provided with relevant training, especially in communicating with policy-makers and policy advocates. If even five or ten percent of these individuals were to make themselves available as resources to the current campaign, it would be worth the effort.

The foundation may also need to fund special training for this work, as other groups have done. For example, the Robert Wood Johnson Foundation supports training in strategic communication for key grantee staff that focuses on influencing policy. For many years, the Agency for Healthcare Research and Quality has supported "knowledge transfer" grantees who identify health services/policy researchers who are experts on topics of interest to state and local policy-makers and train them to provide their insights in highly practical workshops for this audience.

B. **Training Programs**

Although Scholar and Fellow Award programs work to influence the faculty at major academic institutions, Atlantic Philanthropies' has historically distinguished its work on aging as focused on the work of clinicians and facilities already in practice. It is not, therefore, surprising that over the years, the foundation has supported a large number of grants to provide professional development through training/continuing education. Six of the grants we are reviewing in this report focus on such training; however three have other focal points as well. Specifically, we are examining:

- The Better Jobs/Better Care (BJ/BC) program, through its external evaluation by Penn State University. This project, jointly funded by The Robert Wood Johnson Foundation, had goals related to both practice and policy change. Within the rubric of practice change, nearly all of the five state level projects funded under BJ/BC made efforts to provide training, create curricula, or otherwise influence the behavior of practitioners in different long-term care facilities. While the focus of the project was on direct care workers, training was actually more likely to be addressed to senior leaders/managers (two of the five state projects) and supervisors (three of the five). Caregiver skill development was a potential element in two of the five states; team building in three.

- Two grants to The Institute for Geriatric Social Work (IGSW) at the Boston University School of Social Work. The first, relatively short project (#15864) was focused entirely on a wide mix of objectives to provide training, build training infrastructure and relationships, and document results of training, and lasted until early 2009, but included elements intended to build toward self-sufficiency. The other project we reviewed is the third supported by the foundation and began in late 2008. This last project focuses as well on "Scaling a Proven Model," and bringing IGSW to the point where it can be fully self-sustaining in the delivery of its multiple training programs.

- The Hartford Institute at the NYU College of Nursing was funded in 2007 for a project entitled "Increased Competency of Practicing Nurses through Continuing Education." Even this project, which is close to a purely training effort, is designed to move the Hartford Institute toward greater self-sufficiency. The other project we are reviewing that is held by this organization is explicitly designed to bring the "NICHE" model to scale and sustainability.

- The American Academy of Family Physicians (AAFP) was funded in 2007 for a project entitled "Improving Geriatric Skills of Family Physicians." This supports a new commitment by AAFP to add geriatrics to their complement of continuing medical education offerings, and to widely promote those offerings. The project involved the development, implementation and evaluation of multiple offerings, some in traditional formats some in newer formats, on both general topics such as geriatrics and chronic disease and specific topics such as hypertension and depression. Quality improvement activities have been incorporated into some of the offerings. State affiliates are hosting several of the activities, although they learned that state affiliates were not up to the job of actually delivering the training. An evaluation is in the final stages of completion but sadly was not available for incorporation into this report.

1. <u>How does this group of grants relate to the overarching logic model and strategy of the Human Capital Development sub-program:</u>

Here are excerpts from the comments we made in 2007 in our initial analysis of this set of programs:

Several projects involve the development, or further refinement, and provision of training programs to enhance the skills of clinicians and lay persons in managing the health and related social problems of older adults. These include the efforts of the Boston University School of Social Work; the Alliance for Children and Families; the Visiting Nurse Association of America in partnership with the Center for Home Care Policy and Research of the Visiting Nurse Society of New York; the Direct Care Association; and the National Council on Aging's effort to "spread" the use of the Chronic Disease Self Management. Many of these efforts are very ambitious in terms of the numbers of individuals and/or organizations to be reached. Many involve testing non-traditional approaches to training but at the same time many attempt to add value in a quite traditional manner by offering some form of continuing education credit.

Other more targeted practice improvement projects, such as the collaboration of the American College of Physicians with researchers at RAND/UCLA, involve elements of training, typically in how to address specific problems of older adults such as their high risk of falls. Similarly, the work of the BJ/BC demonstration projects involved identifying and providing training and other support to providers who use direct care

workers so they could improve the work environment, improve retention, and thus improve the care provided by these workers.

The underlying assumption of these programs is that many people who work with older adults lack the skills and knowledge to provide them with the best, evidence-based care, and that the provision of training is at least a necessary condition to improve care. There is ample evidence that training, while a necessary condition for practice change in professionals, is far from a sufficient condition. In addition, those in greatest need of training may be those least willing or able to take advantage of training resources. Most projects deal with this potential barrier by trying to identify those with up front motivation and indeed it is probably sensible to work with those further along on any "readiness" scale.

However, even if training is done superbly well, even if those trained actually master needed knowledge and skills and are motivated to use them, barriers can exist to their application of that knowledge and skill in the day to day health care delivery context. These barriers can reside within the person trained, but at least as often reside in the context in which they provide care or interact with the care delivery system.

Interviews make it clear that AP's grantees are fully aware of these limitations in the potential impact of training efforts. Some are simultaneously working on other fronts, either in the context of the AP project or through other activities of their organization and its partners. All too often, however, the logic models for projects using training as a major intervention do not acknowledge the barriers to the use of new skills and knowledge nor specify strategies that will be used to overcome those barriers.

Meanwhile, it remains the case that, given the gaps in the formal preparation of most health and social service workers, and the further gaps in our provision of support to patients and their families, the development of training that is state-of-the-art both in content, in pedagogical design and in delivery mechanism remains critical and an important focus for evaluation.

As noted above, even prior to its shift in strategy, Atlantic Philanthropies began working to make some of its major training programs more self-sufficient, in part by encouraging grantees to identify clients who could pay for their training services so they would not need perpetual underwriting. In the course of this transition, grantees such as IGSW and the Hartford Institute both needed to develop the capacity to provide resources not just to individuals but also to agencies and organizations. This may be a move in the direction of training "critical masses" of staff within a given organization, who are being given skills their leadership recognizes as important and needed. As we note above, when individuals get trained and return to an unchanged work environment, their ability to enact new skills and knowledge may be seriously compromised, and little if any practice

change may result. This agency-based approach may be more promising. Linking training to quality improvement and to re-certification are also promising directions.

2. What were the desired outcomes of this group of grants and to what extent were they achieved?

The primary objectives of the IGSW, Hartford Institute and AAFP projects included:

- Continuing to develop evidence-based curricular materials on topics critical to improved care of older adults;
- Delivering training using these materials to large numbers of, respectively, social workers, nurses and family physicians; and
- Build infrastructure and external communication capacities to reach out to potential trainees and deliver training through traditional and non-traditional means.

The earlier IGSW project had a number of highly specific objectives that focused on:

- Building relationships with local, state and national agencies to deliver training (and have it paid for in the case of multiple state agencies);
- Development a variety of assessment and evaluation tools; and
- Conduct a randomized trial of social work in primary care.

Projects have achieved these short-term outcomes, in many cases producing more curricular materials and training more individuals than they originally committed to doing. IGSW completed its study. Both organizations, in their last projects, are also working hard on outreach and in particular the development of user-friendly websites to encourage practicing professionals to take advantage of their resources. So far so good. Once again, however, we do not have data available to determine if those trained not only gained and retained knowledge and skill (IGSW is working hard on developing systems for making such measurements) but also were able to use their knowledge to change their own practice and potentially those of their colleagues or their agency. The exception is the small randomized trial run by IGSW, which had mixed results in its assessment of patient satisfaction and physical functioning following their intervention. IGSW achieved considerable success in moving toward providing training to groups of people from the same or similar agencies, under contracts or grants with state agencies. Over time, it may be possible to learn about their results in those settings.

BJ/BC projects, as noted above, incorporated different sorts of training into their implementation. However, we do not have access as yet to details about the extent to which the training had any impact on improved quality and reduced turnover. Indeed, a recent article by the evaluation team notes that even measuring turnover is a more complex venture than is often assumed. We have chosen to focus our attention, vis a vis

this project, on its policy development aspect, for which more in-depth evaluation data and potential lessons learned are available.

The AAFP project involved the delivery of "Practice Enhancement Forums" incorporating quality improvement efforts in 18 states, in collaboration with state chapters; the development of "METRIC" (Measuring, Evaluating and Translating Research into Care) modules in hypertension, geriatrics and depression, one of which has been approved as an alternative program to meeting maintenance of certification requirements; a self-directed learning pilot project for a small number of family physicians, that uses the American Geriatrics Society case-based resource tool as well as a Web-based meeting tool called "My Committee;" and more traditional courses in geriatrics and chronic care incorporated into the CME schedule of AAFP. It appears that AAFP also did a lot of work on finding new ways to promote these offerings. However, we do not know what if any effect the offerings have had on practice.

3. <u>As Atlantic exits from this set of grants over the next few years, where is it leaving the field? How can the field in general build on the achievements to date?</u>

One long-term consequence of the investment made in training for practicing professionals is the development of curricular materials based on current evidence that can be used not only by the developers but in some cases by others. Of course, these curricular materials will need to be periodically updated, and new topics will need to be addressed. Nevertheless, the field as a whole, especially in nursing and social work, and to a more limited extent with respect to direct care workers and their management, is much enriched by the translation of evidence into learning tools.

Another positive consequence is that IGSW and the Hartford Institute, as a result of Atlantic Philanthropies' funding as well as support from other funders and the high quality of their staff, have clearly become "go to" places for people looking for the most current training materials regarding the care of older adults for those two groups of professionals. They have become more sophisticated with respect to their websites, and their delivery of knowledge. The use of videos both to motivate and to train has been greatly enhanced.

What is now needed are more powerful incentives for professionals and agencies to take advantage of these resources and apply them in practice. These incentives could include the following:

- The adoption and use of quality metrics on which high scores can only be achieved by staff who are genuinely up to date in their training;
- The use of those metrics in the comparative assessment of providers, by those in a position to make individual provider choices (patients, family members, referring

professionals), choices to include providers in their networks or in the future "accountable care organizations;"
- The use of metrics to determine reimbursement levels or encourage choice by reducing financial barriers[2];
- The publication of comparative metrics in a transparent manner that encourages providers to improve, preserve or enhance their reputation;
- The incorporation of specific skills and knowledge provided through such training into licensing, certification and re-certification standards and testing; and
- Ensuring that reimbursement systems actually reward the application of the relevant skills and knowledge rather than outmoded methods.

Here, again, is a link to the current direction that Atlantic Philanthropies is taking, i.e. advocating for policies that change, among other things, the incentives facing providers. The current constellation of grantees would do well to learn about the key factors that make a difference in the health and quality of life of older people, as these are reflected in current evidence and current curricula developed by the foundation's grantees in this area.

4. <u>What lessons have we learned from the experience of the grantees in pursuing their objectives? Who are the target audiences for these learnings?</u>

The audience for the learnings of this subset of projects are institutions who either fund or carry out large-scale efforts to train practicing professionals in health and social services.

Lesson One: Training is not just training

Training is a terribly vague and generic term. In the context of efforts to improve care for vulnerable elders, training has to focus on changing the behavior of individuals and organizations. It appears that IGSW and the Hartford Institute have, based on their many years of work in providing training/continuing education, realized that there are several key elements that must be in place for a viable, sustainable, effective training program. These include the following:

- Current content, preferably evidence-based;
- A clear target audience and a strategic approach to reaching and motivating the audience to participate;
- Appropriate pedagogical methods that succeed in taking people from their current knowledge and skill base to a higher level; this means being able to accurately assess the current knowledge and skill base; determining how to correctly sequence the

[2] In the context of "Value Based Purchasing," some employers, for example waive co-pays when their employees and dependents use highly rated hospitals and physician practices.

delivery of new skills and knowledge; so people are going from A to B to C rather than from A to G to L to C;
- Pedagogical methods that are engaging, that increase self-efficacy, and that make content highly actionable;
- Methods to assess changes in knowledge and skills in the short- and mid-term;
- Methods to assess whether trainees are able to put their skills to work in their professional environments as well as, potentially, methods to help them create an environment which is more conducive; and ultimately, to be self-sustaining
- A business model/plan that accurately calculates the time and costs needed to achieve targets, that accurately assesses market preferences, competition and potentially successful "frames" for engagement; and that strategically introduces products at prices that will be paid by clients and that will cover costs.

Further, all these elements need now to take into consideration the use of a far wider range of media and mechanisms for recruitment and product/service delivery.

To us, what this implies is that "mom and pop" training enterprises are not likely to succeed, not merely in capturing audience but in affecting practice. There is plenty of "training" out there, and there is plenty of money spent on such "training." At this stage, when the goal is achieving complex and sustainable change in something as subtle as caring for vulnerable elders, funders need to be realistic about the relatively small, perhaps even tiny, percentage of potential "trainers" who are really going to be up to this task, or can become prepared in a reasonably short time frame.

Lesson Two: Programs based in academia can be effective if they recognize that what they bring to these efforts is necessary but not sufficient.

People in academia increasingly recognize that "the ivory tower" is more and more a high speed environment in which an entrepreneurial spirit and a willingness and ability to collaborate not only with other academics but with many other kinds of organization are essentials for success. One of the key elements we laid out above for successful training programs is current content, preferably based in evidence. Those we want to train also want to be sure, especially if they are paying, that the material being presented is legitimate intellectually. There is also an expectation (perhaps not so evidence-based) that academic institutions understand pedagogy. This means that academic institutions are naturally appropriate sites for major training efforts. On the other hand, all too many academic institutions are not only out of date in terms of the content they present, but have little genuine expertise in pedagogy, although that is beginning to change under pressure from accrediting bodies. More important, however, is that the kind of training enterprise we have described needs to be remarkably strategic, flexible, nimble, and other-directed. Now academic institutions do have these skill sets, though they often use different terms to describe them. They have to, if they are to survive and thrive in implementing their core functions, let alone take on additional goals and roles. But not

all are willing to operate in this more entrepreneurial manner on behalf of the needs of the "field" rather than the institution.

Both IGSW and the Hartford Institute are based in academia, derive legitimacy from that base, but are extremely well-connected to their environments, and especially in the case of the Hartford Institute, extremely jealous of their reputation among their peers. In particular, engagement with those whose behavior they wish to influence, on the organizational and individual levels, is key to their work. Boston University had to begin working intensively with aging agencies; Hartford Institute has for years been working intensively not only, it is critical to note, with nursing leadership but with executive and medical leadership as well. The development of these two efforts reveals that it takes time to build this skill set and ability to interface with the practice and policy world. Not all academic institutions will make it easy for their members to go in this direction, unless they see fairly immediate rewards. This implies that those who want to engage in significant training enterprises as individuals need to find salubrious environments in which to operate, and that funders, too, need to assess the home institution to see whether and how it will support the more outward-facing members of their faculty and staff.

C. Model Programs

In this review, there is only one grant that we have categorized as a "model program." It is "Improving Internists' Management of Geriatric Conditions Through Practice Redesign" (also called ACOVE Prime) and efforts led by the American College of Physicians with extensive support from key physicians at the RAND Corporation. In 2007 (see below) we characterized BJ/BC as a "model program," but given the wide variation in how the individual states implemented the general approach, we do not believe it qualifies as a true "model."

1. <u>How does this group of grants relate to the overarching logic model and strategy of the Human Capital Development sub-program:</u>

Here are excerpts from the comments we made in 2007 in our initial analysis of this set of programs:

A common and long-lived strategy for achieving improvements in the delivery of services of all kinds to clients of all kinds has been to design, implement and evaluate model programs that can "demonstrate" the nature and value of a particular innovation. It could be said that the field of program evaluation was built in order to assess the value of such innovations using the methodologies and mindset of social science research. So model programs are often evaluated, for a variety of reasons. Sometimes, the purpose is to provide defensible evidence to motivate others to adopt an innovation. Thus, the practice sites included in the ACP/RAND/UCLA project are being evaluated more systematically than would otherwise be the case in order to convince other practicing

physicians that the intervention will have desired results (although the research design is far from resembling a gold standard experimental or quasi-experimental study). Sometimes, the purpose is to understand in greater detail what it takes to implement an idea or a set of ideas in the field, as opposed to more "laboratory-like" settings. This can be said of the BJ/BC demonstration projects and its evaluation.

Ultimately, to make a difference, model programs need to be well specified. Their implementation needs to be examined to assess the fidelity to the model in question and to identify changes in the model required in particular real world settings or even to be generally feasible. The program needs to be documented in sufficient detail so that someone motivated to replicate it will know concretely what it involves. Finally, model programs' value or effectiveness needs to be assessed, as rigorously as possible.

When model programs are shown to be feasible to implement and effective in the real world, the work has still just begun, since the next steps involve taking the innovation "to scale" and ensuring at the same time that high-fidelity implementation is sustained. Once again, we assume at our peril, that "if you build it they will come," that if you simply offer up the model program to the field, no matter how great its added value, they will respond. An important issue for AP is exactly at what point and how its support of former "model programs" should phase out or terminate entirely.

AP's approach to using model programs has been significantly influenced by its more general decision to seek out potential grantees rather than welcoming unsolicited proposals. Thus, it has worked with strategically positioned lead organizations to identify sites for the implementation of promising, or in some cases evidence-based, interventions and approaches, in communities and organizations that look more "average" than "special." Sometimes, as in the case of BJ/BC, a "call for proposals" is issued to which potential model program sites can respond, but it remains the case that the innovation to be implemented has been at least substantially pre-determined. In operation, sites for model programs are likely to be different from average in some highly appropriate ways: they have to be willing to try the innovation; they have to accept the fact that they will be subject to evaluation; and in many cases, they have to be willing to work collaboratively with an AP grantee who is taking the lead in identifying and supporting the model program sites. The process of selecting these sites is critical to their ability to achieve their objectives in a timely manner.

This project is one of the most direct efforts funded by Atlantic Philanthropies to achieve practice change on the ground. As such, it does not closely relate to the HCD logic model's pathway from investment to long-term outcomes. The intervention is to engage the practices of what are termed "vanguard" primary care physicians (internists) in quality improvement efforts led by other physicians who are among the leading researchers and experts in care of complex older patients. The physicians in question have been intimately involved in the development of ACOVE (Assessing Care of

Vulnerable Elders) a set of measures for assessing quality of care for this population; measures are linked to 22 problems common in this population, which are often not managed in a manner consistent with evidence. The ACOVE-2 intervention is, according to the RAND website, designed to "develop methods for changing clinical practice that will be tailored to specific practice settings." ACOVE Prime, in turn, was designed to develop, implement and evaluate a **practice redesign intervention** to help primary care physicians provide high quality care for older adults.

2. <u>What were the desired outcomes of this group of grants and to what extent were they achieved?</u>

The objectives of this grant were:

- Recruit vanguard primary care practices in a pilot program of practice redesign to improve the quality of care provided to older persons; the specific problems on which this intervention focused were falls and urinary incontinence;
- Modify and increase the effectiveness of the ACOVE-2 intervention in real world settings;
- Evaluate the effectiveness of this intervention in improving quality of care of older persons; additional resources were provided to boost the sample size and thus power of the evaluation of the intervention;
- Create incentives for internists to adopt the intervention and integrate it into their practices; and
- Develop a business model to make the delivery of the intervention financially sustainable.

The integration of an evaluation into the project makes it much easier for us to report on the extent to which objectives were achieved. Specifically:

- Five practice sites were recruited and went through the intervention;
- Medical care for falls and urinary incontinence at intervention sites was improved such that 57% of patients were receiving recommended care, while control groups exhibited a 36% compliance, comparable to the typical range of around 30% seen in most practices;
- These results were better than a previous ACOVE-2 study, especially for falls; 60% of patients in the five intervention sites received recommended care; 47% did so for urinary incontinence;
- Results were achieved without adding staff, implementing an electronic record (except in one site which did do better) and in practices which did not have any research infrastructure; and
- The project did not exactly "create" incentives for internists to adopt the intervention; rather it took advantage of the relatively new practice by the American Board of

Internal Medicine of "re-certifying" physicians periodically, and including in their recertification requirements the implementation of a "performance improvement module," or PIM. ACP and RAND got ABIM to agree that participation in this project would "count" as a PIM; investigators indicated that this was an essential factor in recruiting practices, who were otherwise not highly motivated to participate.

Investigators note limitations of their study, including the inherent self-selection of practices as those interested in QI vis a vis older adults; the focus on process metrics related to recommended care rather than patient outcomes; and the inability to test the "condition finding" element of the intervention which was implemented across both intervention and control sites.

They also note considerable variation in the implementation of the practice redesign steps across practices. This can be viewed as a problem of "lack of fidelity" or it can be viewed as an indication that the intervention is actually feasible to implement even given the huge variation in practice sites within primary care. The latter view is supported by the fact that the level of improvement appears to have been similar across all sites. It may well be that adaptation is a sign of "ownership" of the intervention, as opposed to more slavish adherence to every detail.

The last goal was implemented by ACP itself – developing a way to deliver the practice redesign intervention without the in-person consultation of leading geriatricians. This was not complete prior to the end of the grant, and it appeared that additional funding would be required to achieve the transition to a web-based system of delivery. As of today, the following url takes you to a part of the ACP website that deals with the ACOVE intervention:
http://www.acponline.org/running_practice/quality_improvement/library/geriatric.htm
The language on the site indicates that materials are available through a link on this page. However, we have no information about how completely the available materials "replace" the face to face intervention.

3. As Atlantic exits from this set of grants over the next few years, where is it leaving the field? How can the field in general build on the achievements to date?

This single grant has not had, and should not have been expected to have, a major impact on the field, in and of itself. What it did demonstrate is that it is possible to have an effect on practice far more directly, by providing tools to practitioners who have a reasonable amount of motivation and who do not perceive the task as insurmountable. It is now in the hands of ACP whether and how they actually follow up on the project, and whether and to what extent they succeed. This is a case where the termination of funding may well change the internal priorities and dynamics of the grantee organization, as, especially in the context of health care reform, there are plenty of other pressing issues for ACP to address, and plenty of other programmatic and policy directions it could take.

The project itself was very "retail" – a fairly high cost intervention using clinical and practice change experts that are among the best in the country, for five sites in one state. Under normal conditions, an immediate move to an entirely "wholesale" venture may be ill-advised. Rather, a more gradual series of replications might have been more sensible, had funding been available. Thus, it might have made sense to generate a cadre of physicians (and perhaps other members of a primary care practice) who could deliver the intervention through a mix of in-person and web-based delivery, across a wider range of practice settings, including some that are larger than the ones in the study. It might also have been sensible to see if the intervention worked with other problems of elders, such as the remaining 20 for which metrics have been created.

4. What lessons have we learned from the experience of the grantees in pursuing their objectives? Who are the target audiences for these learnings?

The audience for these lessons are those who want to see improvements in care for vulnerable elders benefit from structured interventions that help practices redesign to incorporate evidence-based approaches. There are dozens of organizations and individuals, public and private, that fall into this audience.

Lesson One: Physicians (and probably other providers) are not likely to embrace practice change efforts unless they clearly see a benefit to themselves in doing so.

The project would probably never have been completed had it not been for the existence of the maintenance of certification (MOC) requirement of the ABIM, and the inclusion in that requirement of an actual attempt at practice improvement. Obviously, Atlantic has recognized that the policy environment of health care practice has a profound effect on the behavior of clinicians and institutions, and that its focus should indeed shift to policy.

But what policies will make a difference? What will be viewed as "benefits" and by whom? The easiest answer is to focus on financial incentives. There has been much attention paid to the need to alter reimbursement patterns, in terms of who gets reimbursed, what gets reimbursed, how much, and with how much hassle. There is no doubt that this is critical.

We might note, however, that the ability to get through MOC is not directly a financial incentive, especially for primary care physicians for whom hospital privileges are not much of a privilege. Many health care professionals are motivated by other factors besides the simple raw one of how much money they make. Dr. Sofaer participated in a study led by the ABIM that compared a group of physicians who had chosen to use their available quality data to improve their practices to a group who had quality data but chose not to use it. This small qualitative study found, quite surprisingly, that those who used the data for improvement did so primarily because it was consistent with their sense of what it meant to be a physician and a scientist, and made coming to work each

morning far more satisfying. On the other hand, those who did not use the data for improvement said they would not do so unless they had a clear financial incentive. One suspects that money may be an excuse, as well as a reason, for inaction in this arena.

This is an important issue because there may be many people for whom money is not just the only benefit they consider meaningful, but a benefit that, even so, is not enough to be past inaction. Money may not be enough to change the behavior of a large number of angry, over-worked, cynical and dissatisfied clinicians and executives.

Lesson Two: Make it easy to change

No matter what the benefits are that would motivate behavior change, if it is too difficult and convoluted, people will either never start or give up, even with incentives. The development of ACOVE has been characterized by attempts to make processes more specific, more step by step, more transparent. As the products related to practice change move to garner a larger market, they need to continue this process of simplification.

The variability of implementation is of interest here. People do not like being told what to do. They like to be given ideas, tools, and tactics, and then given some freedom to adapt as well as adopt. This requires that the perfect not become the enemy of the good, in terms of implementation fidelity. If letting people adapt to local circumstances makes it easier for them to change, why get in their way? On the other hand, it may be wise to document the adaptations and also see whether variation in implementation leads to variation in the achievement of objectives, as this project did.

D. Scaling Proven Models

There are three projects we characterized as involving scaling of proven models in this review. One, the IGSW Training effort at Boston University, has already been discussed under the Training category. The remaining two are:

- The NICHE (Nurses Improving the Care of Healthsystem Elders) operated by the NYU Hartford Institute; and
- The Nursing Home Collaborative Business Planning project, operated by Sigma Theta Tau, the honor society of nursing. Note that the predecessor project was operated by the American Academy of Nursing, and that this project was only nine months long.

1. <u>How does this group of grants relate to the overarching logic model and strategy of the Human Capital Development sub-program:</u>

Here are excerpts from the comments we made in 2007 in our initial analysis of this set of programs:

As noted in the previous section, "demonstrating" the feasibility and effectiveness of a new model is only the first step in the process of achieving wide-scale and enduring change. One of the most innovative aspects of the AP HCD portfolio is the inclusion of several efforts to take an existing model of reasonably well proven value and support a process through which it can be broadly adopted by a large number of highly diverse organizations and professionals. One example of this is the effort, led by New York University's School of Nursing, to spread the NICHE model of incorporating geriatric resource nurses into considerably more hospitals across the country. In this type of project, an effective approach to improving care for the elderly has already been developed and has already been adopted by a substantial number of organizations or professionals. The goal is clearly to go to scale, in the case of NICHE to move from a couple of hundred hospitals to perhaps three or four times that number. Another more recently funded example is the effort to replicate in numerous sites the Chronic Disease Self-Management Program, which is just getting off the ground but has considerable promise both because of the content of the work and the expertise of the organizations and individuals engaged in the work[3].

Another key element of this approach is for AP to provide support to the "inventors" in creating a business plan that will support continued spread over time without the need for continued infusion of grant dollars. This is also an element of the Paraprofessional Health Institute initiative to disseminate its coaching supervision training and of the work of the American College of Physicians in integrating and sustaining its efforts to encourage practice improvement among a significant percentage of its constituency.

The underlying assumptions for these efforts is that for innovations to spread broadly enough to have a meaningful impact on the care of older adults, they need a long term distribution channel that can eventually operate independently of grant funds. Almost all foundations say they want their grant-funded projects to be sustained; few currently take steps to increase their grantees' capacity to sustain and expand operations at a high level of quality without grant support. Creating a business plan that acknowledges what it will take to penetrate a particular market with a particular product requires skills and indeed a mindset not always found in academic settings, professional societies, or advocacy organizations. At the same time, a business consultant has to work closely with the product developer in order to ensure that in the process of marketing and delivering a product broadly, it remains effective. There is a huge opportunity for learning about this approach in the HCD as well as in other program areas at AP; we will return later to suggestions about how to take advantage of this opportunity.

[3] This project, with its focus on chronic disease self-management, is considered a part of a more ongoing focus for the foundation, so is not discussed here.

Both the grants in this review focus on improving care in a particular kind of institution (hospitals for NICHE, nursing homes for Sigma Theta Tau (STT). Both were part of the "nursing" portfolio of projects. The projects are both designed to bring evidence-based practices not to just a few but to large numbers, eventually a preponderance of such institutions, through different kinds of efforts. However, they are actually at very different stages of development, and involve quite different strategies.

The NICHE effort began over 20 years ago; the Nursing Home Collaborative (NHC) began with a planning grant in mid-2006. The NICHE effort involves a long-term process through which hospital nurses assess perceived needs for improving care for older adults, focus education for practicing nurses on evidence-based protocols, train leaders in change processes, plus provide targeted consultation to improve nursing services. When the scale up grant began, nearly 200 hospitals had enrolled in NICHE. These facilities pay a fee to NYU and cover travel costs and the time of participants.

The Nursing Home Collaborative focuses on the role of nurses as leaders for quality improvement in nursing homes. The NHC, at its outset, included five Hartford Centers for Geriatric Nursing Excellence (HCGNE), representatives of the nursing home industry, nursing organizations specific to long-term care, and the American Nurses Credentialing Center. They were brought together by the American Academy of Nursing (AAN), which serves as the Coordinating Center for the John A. Hartford Foundation, of the Building Academic Geriatric Nursing Excellence (BAGNC). One of the roles of the Coordinating Center has been to promote and support collaboration across HCGNEs, which is why the planning grant went to them. The focus of the NHC is to provide gerontological and leadership training to RNs in nursing home settings, and to improve the overall nursing home environment by changes in its governance structure.
One could say that both of these scale-up models focus on education and training as the core intervention. However, while the NICHE program's educational offerings are well developed, those of the NHC have yet to be designed and implemented to any extent. In our view, the NICHE effort is a much better example of Atlantic Philanthropies' approach to scaling a proven model. We have therefore chosen to focus just on this grant in this review, as there is little to learn from the experience of the NHC[4].

[4] Ironically, at the time the NHC was being created, The Commonwealth Fund staff helped get another collaborative off the ground to improve the quality of care in nursing homes, called **Advancing Excellence in America's Nursing Homes: The Nursing Home Quality Campaign.** Advancing Excellence is a voluntary, coalition-led effort that builds on the success of the culture change movement and other quality initiatives. Launched in 2006 with Commonwealth Fund support and headed by a national steering committee of 25 organizations comprising nursing home associations, health care professionals, direct-care worker representatives, consumer advocacy groups, and government agencies, the campaign is helping nursing homes to improve the quality of care for residents and the quality of life of both residents and staff. To join the campaign, nursing homes must select at least three of the campaign's eight goals, which represent key indicators of clinical quality—like better pain management, fewer pressure ulcers, and reduced use of physical restraints—and organizational improvement, such as lower turnover rates for staff. As of October 2009, 47.6 percent of America's 15,800 nursing homes have signed onto Advancing Excellence. Consumers and nursing home staff are also welcome to participate. Through its website and 49 state-

2. What were the desired outcomes of this group of grants and to what extent were they achieved?

The desired outcomes for NICHE, within the five years of its grant, are to

- Increase the number of hospitals using NICHE to improve care to 600;
- Increase the impact of NICHE on current and future participating hospitals through greater nursing staff participation and thus more patients served; and
- Generate sufficient revenue from participants to sustain the project without reliance on grant funding for routine operations after 2012.

The long-term (10 to 15 year) outcome hoped for is to improve nursing skills and processes of care for older adults in 1,200 to 1,800 hospitals.

Atlantic Philanthropies does not currently have documents with respect to the number of hospitals that have been engaged; the NICHE Website indicates it is about 300. It appears that they are experiencing a classic problem in adapting their approach to hospitals unlike those which have been their typical enrollee. Specifically, they need to change the model to fit the needs and resources of smaller, especially rural hospitals, which predominate in many geographic areas. They are experimenting with replacing an in person Geriatric Nurse Specialist through on-line interactions of many kinds to facilitate NICHE involvement, including the creation of a learning community for nurses' professional development. They have already created a Leadership Training Program that is delivered on-line. In addition, they are exploring the benefits and opportunities of tapping into NICHE leaders at NICHE hospitals to represent NICHE within a particular geographic region, as a way of facilitating expansion. They note that in some areas, sites are already beginning to informally promote the program to other hospitals.

NYU has continued to develop and disseminate new tools and has several more in the pipeline; they are adapting existing resources in this process as well as "starting from scratch." Realizing that they need to reach overall hospital leaders as well as nursing, they are working on a new business tool to estimate the cost savings from the use of NICHE both for individual hospitals and to create a benchmarking data base for peer comparisons. They are involving a relatively new NYU faculty member with extensive leadership experience in the hospital setting as a CNO, and in a non-profit setting as a

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based networks (known as Local Area Networks for Excellence), the campaign is lending technical assistance to providers to help them with their improvement efforts. More than two years of data tracking progress toward clinical goals show that nursing homes participating in the campaign are improving at a faster rate than those that are not. These two efforts appear to be moving forward with little if any contact between them, which in the view of this reviewer is unfortunate.

CEO, in their efforts to reach out to and engage hospital managers. They are also moving beyond the hospital setting to work with physicians and physician groups who want to expand the use of a variety of models and programs to improve care of older adults and who seek to work with NICHE and its infrastructure.

It is frankly too soon to say whether the multiple strategies and tactics being pursued will ultimately result, by the end of 2012 with 600 hospitals enrolled in NICHE, and a self-sustaining enterprise. What is evident however, is that there appears to be no limit to the ongoing creativity and energy that the Hartford Institute brings to this work. Their reputation, in addition, makes them highly viable as a grantee for other private and public organizations.

3. <u>As Atlantic exits from this set of grants over the next few years, where is it leaving the field? How can the field in general build on the achievements to date?</u>

By definition, grants of this kind are intended to result in a lasting infrastructure that can deliver valuable resources for as long as the need is present. The foundation is fortunate that there are several other philanthropic organizations with a strong commitment to the care of older adults in general and/or to spotlighting the contributions of nursing in particular. The field will miss both the financial and the intellectual resources that Atlantic has provided over the last decade and more. However, there are strong and skilled individuals and increasingly institutions that are willing to use what is currently known, add to that knowledge, and perhaps most important, support collaboration.

4. <u>What lessons have we learned from the experience of the grantees in pursuing their objectives? Who are the target audiences for these learnings?</u>

The target audience here would be other institutions and foundations who wish to bring major efforts to scale.

Lesson One: Prior to and during scaling, work to identify the most critical "active ingredients" in any major effort and work to ensure that they are sustained even if other pieces of the original plan do not survive.

This is a hard lesson, for many reasons. First, people who have put years of their life into bringing an intervention from the stage of "twinkle in the eye" to at least late adolescence have a hard time with the notion that everything that could be documented need not be replicated. Second, from an evaluation research perspective, there are few studies that can accurately identify these most critical ingredients with great confidence *prior* to scale up. This implies that the scale up process itself is a time when experiments (or perhaps more accurately trial and error) will have to be used to determine whether it is (a) feasible and (b) justifiable to drop a particular element of a model. A lot of the effort during most scale-up efforts is on the sheer effort of expansion. For NICHE and many other efforts,

however, it will be important to keep at least an informal focus on what changes are tried and generally, what happens as a consequence. This kind of inquiry is not a matter of tight experimental designs capable of supporting causal attribution; it is a matter of being open minded and highly observant, and of trying to get confirmatory evidence from multiple "tries" rather than depending on just one.

Lesson Two: Plan, but be ready to take advantage of unexpected opportunities.

Even though on the surface, health care reform does not focus the bulk of its resources on older adults, the bill is studded with provisions that provide opportunities of all kinds to those who want to improve the quality of care for this population. There are probably even more opportunities for those who want to contain growth in the costs of care for this group, but fortunately there are many ways to improve quality and safety at the same time that costs are restrained. On the one hand, the bill includes things like the Center for Medicare and Medicaid Innovation which have the potential to start the "new model" cycle from scratch. But given the strong awareness that our problem as a nation is not one of coming up with new ideas but in getting them implemented and brought to scale, "innovations" can include ways to take what we know and put it into practice through new strategies for engaging and supporting those who care for older adults (and ultimately older adults themselves).

On the surface, much of the bill is about insurance coverage, which is entirely appropriate – even though this was not "well-advertised" during the campaign for its passage, the bill is about covering 30 million people without insurance, few of them elders. But it is clear to this observer that within the current administration, there is a very strong focus on delivery system reform as well as insurance reform.

Indeed, this may be a moment for those who have been nurtured primarily by private philanthropy to seek both opportunities to influence and opportunities to garner resources from the public sector. One relevant example: the Geriatric Education Centers which have existed for decades are getting some new funding from the Affordable Care Act. Interestingly, this program, which for years has supported a scattershot approach to training professionals, is in its current round of funding asking grantees to show actual patient outcomes as a result of training. This will likely require that the training strategy change to focus on defined populations of patients whose caregivers are trained as a group (an interprofessional group is actually mandated). Linkages between many of Atlantic Philanthropies' older and newer grantees could be highly productive in this context.

E. Infrastructure Development

As noted earlier, we developed a new category for two of the projects chosen for this review:

- Transforming Human Services to Older Adults, a project of the Alliance for Children and Families
- Integrating Geriatrics into the Specialties of Internal Medicine: Moving Forward from Awareness to Action, a project of the Association of Subspecialty Professors in Medicine (ASP)

The last grant was originally designed to generate, within several subspecialty societies, guidelines that reflect specific evidence about the handling of specific conditions within an older population. The rationale was that several guidelines supported by these societies were, in fact, incorrect if applied to older people. It proved virtually impossible to pursue this original objective, primarily because of the wide variations in timing and procedure for guideline development across societies.

1. How does this group of grants relate to the overarching logic model and strategy of the Human Capital Development sub-program:

Both of these projects aim to increase the ability of existing organizations without a singular focus on aging to create infrastructure that would support such a focus. In the case of the Alliance, the goal is to have their member human services agencies increase their focus on vulnerable elders. In the case of ASP, it was to create and build geriatric interest groups across as many of the medical subspecialty societies as possible. The link to the HCD logic model is that in both cases, projects are working to build awareness, capacity, and competency to address the issues of older people in organizations that include large numbers of individuals who actually serve their needs.

2. What were the desired outcomes of this group of grants and to what extent were they achieved?

The specific objectives of each of these two projects are quite different. The focus of the Alliance was, within five years, to:

- Use mini-grants with 100 of their member agencies to change the practices of these agencies with respect to serving older adults
- Create 20 mentor-mentee relationships between member agencies, and use these to build regional training partnerships
- Build the skills of 80 key staff members across member agencies in geriatric social work

The objectives of the ASP were to

- Support some form of geriatric interest group across 12 specialty societies

- Support small projects for several of these interest groups to increase physician involvement and create tangible products
- Host annual section meetings at the AGS Annual Scientific Meeting for these interest groups
- Develop educational materials for the groups; and
- Provide a forum for them.

The Alliance, about half way through its project, appears to have made good progress in meetings its objectives. Twenty mini-grants were awarded; results were not available for review. Twenty of the forty of the mentor-mentee relationships have been created. Through a partnership with IGSW, over 200 social work and human services professionals have participated in their training, in part through provision of scholarships from the Atlantic Philanthropies' grant. In addition, nearly 200 have participated in IGSW on-line training.

In addition, the Alliance, in pursuit of longer-term goals, has offered a Leadership Academy for 18 mentor agency staff, conducted webinars on gerontology supervision and dementia, and conducted aging focused workshops at its national meetings. It is also building the capacity of its own Department of Evaluation and Research Services to enable it to conduct an internal evaluation of its activities. This work, however, is in the future.

ASP, after going through the transition from its original goal to new objectives, awarded mini-grants to four specialty societies to modify curricula for fellows in the discipline to include geriatric competencies. These societies address gastroenterology, oncology, nephrology and general internal medicine. They have convened meetings of interest groups and conducted quarterly conference calls for the interest groups.

2. <u>As Atlantic exits from this set of grants over the next few years, where is it leaving the field? How can the field in general build on the achievements to date?</u>

Both of the projects described are not yet completed. The Alliance project goes through 2012; the ASP project ends, according to our information, at the end of this calendar year. What happens going forward appears to depend on other factors. With respect to the Alliance, given the under-resourced nature of most human services agencies, especially those serving vulnerable populations, their best resource going forward is likely to be to take advantage of the partnership with IGSW, and to use IGSW's greater track record and internal infrastructure to seek funding from other agencies. Atlantic should seriously consider supporting such pursuit of funding, depending upon what happens between now and 2012. With respect to the ASP, the subspecialties are, essentially, left somewhat in mid-stream with respect to their attention to care of older adults. Other funders are already in place, which is to the good. It would also be wise for ASP to explicitly engage current and former Williams awardees in supporting the geriatric interest groups.

4. What lessons have we learned from the experience of the grantees in pursuing their objectives? Who are the target audiences for these learnings?

The initial lesson for Atlantic Philanthropies from the ASP grant is that both the applicant and the foundation need to do considerably more homework before pursuing an activity that is as complex and fraught as guideline development. It is actually quite surprising that neither learned, beforehand, what the guideline development and approval process involved in at least a sampling of specialty societies.

Given that the Alliance project is only about halfway completed, we cannot identify lessons from that project at this time. However, an independent entity supported by the John A. Hartford Foundation, Strategic Communications and Planning (SCP) has conducted a study of the work of ASP with their geriatric interest groups that is replete with interesting findings. We will highlight just a few here:

Lesson One: The use of small grants can make a big difference.

The $15,000 grants ASP provided to four societies has generated considerable activity and increased interest among members. To this reviewer, the money may not be as important as having support for pursuing a highly specific *focus*, rather than simply being a part of a group with no clear agenda.

Lesson Two: A mix of senior, mid-level and junior members are good ingredients for an effective interest group.

SCP notes that senior leaders provide prestige, visibility and legitimacy, mid-level leaders provide solid experienced people to take responsibility for action, while junior folks provide more hands to spread the workload, energy, and a sense that there is a future. In the case of the ASP interest groups, Williams awardees were critical to the third group of junior faculty.

Lesson Three: Even the most minimal staff support can make a huge difference.

In my earlier work on coalitions, we learned that any nascent group that does not have a formal administrative support system will be dependent upon 'the kindness of strangers" to generate what we called the "glue," i.e. the ability to handle meeting logistics, send out emails, keep lists of members, etc. SCP confirms this earlier finding. Even three hours of administrative support a month proved to make a huge difference in making it unnecessary for the physicians themselves (or their staff if any) to take on these jobs.

Lesson Four: This is a long struggle.

While SCP understandably put this in terms of communication challenges, the more fundamental issue is that convincing members of a specialty society that they should focus on an interest group such as geriatrics within the specialty is a heavy lift, and will continue to be so for some time. Geriatrics, as noted earlier, is still not viewed as a prestigious, scientifically well-founded or lucrative focal point for a physician's career. In a sense, this is an indication that more time is needed for the many awardees who have come out of the investments of Atlantic Philanthropies to demonstrate that geriatrics does have a strong scientific foundation and that aging researchers in medicine can have prestige and acquire funding. It may well be a communications challenge that, in fact, the field remains less than glamorous, especially given its focus on management and palliation rather than "cure."

E. Policy Development and Advocacy

In this section, we examine only one project, Better Jobs/Better Care, with a focus on its policy advocacy work. This project effectively ended prior to the new direction taken by Atlantic. As policy is a primary strategy being pursued under the new direction, however, lessons from this project may be especially helpful.

1. <u>How does this group of grants relate to the overarching logic model and strategy of the Human Capital Development sub-program:</u>

Here are excerpts from the comments we made in 2007 in our initial analysis of this set of programs:

As noted earlier, building partnerships and taking steps to identify and pursue policy objectives is one of three major pathways that AP identified in 2006 as essential for the achievement of practice change. The AP projects addressing social workers and direct care workers are examples of initial efforts in this arena. In some cases, for example the planning grant to the New York Academy of Medicine, the focus is on building a focused policy agenda that is evidence based and can be pursued by a broad based coalition of social work leaders. In other cases, as with the work done by individual demonstration projects of the BJ/BC initiative, the focus is on building multi-stakeholder coalitions (a much more difficult enterprise) to identify and pursue adoption of one or more policy objectives to promote desired changes.

Not all important policy is "public" in the sense of governmental. One of the most critical synergies in the AP portfolio is represented in the work of the American College of Physicians in partnership with RAND/UCLA to encourage practice changes by physicians in the outpatient setting. Many participating physicians will have to go through the relatively new "maintenance of certification" process of the American Board

of Internal Medicine. This process includes the completion of at least one Practice Improvement Module (PIM), and ABIM has agreed that participation in the ACP/RAND/UCLA project will count as a PIM. Our interviews reveal that this, and to a more limited extent the use of continuing education credits, has made a difference in the difficult task of recruiting practices to the project.

In addition, some would argue that practice change, especially in larger institutions such as hospitals, must be built on organizational policy changes. In a sense many of the changes being pursued by the BJ/BC demonstration involve organization adoption of new policies (such as higher salaries, better benefits and more voice) for those working in the organization, in order to create a work environment in which care can be improved. This approach is not limited to "low status" employees such as direct care workers, however. It may be that AP needs to identify institutional policy changes, as well as external policy levers, that can create a more positive environment for change among higher status professionals such as physicians.

There is no question that changes in law, regulation, public and private policy are major levers for changes in practice. Policy projects can remove barriers and create incentives for practice change. They are an essential ingredient for achieving AP's long-term objectives in particular. The key assumptions that need to be further elaborated address what strategies are most effective in leading to different kinds of policy change in different contexts.

Especially because a substantial external evaluation is available with respect to BJ/BC, we believe there are important lessons to be learnt from this specific national program.

2. <u>What were the desired outcomes of this group of grants and to what extent were they achieved?</u>

BJ/BC supported five states to pursue policy changes that would improve both the quality of care provided by direct care workers and the retention of workers so that training efforts would actually bear fruit. The vehicle for doing this was to create multi-stakeholder coalitions in each of the states. In four of the states, these coalitions focused initially on working with their members to improve quality through a variety of techniques. Only at the end of their grant period did these states turn to policy issues. In the fifth state, North Carolina, policy was the focus from the outset, and only in this state was a policy objective pursued and achieved. Working from what Kemper, the external evaluator, calls a "single clear vision," North Carolina's long-term aim was to create a reimbursement differential for long term care providers whose management practices created high quality jobs for direct care workers. They succeeded in passing legislation establishing a special designation for such facilities, and a mechanism for determining which providers would receive the designation. Their ultimate hope is to link the

designation to a reimbursement differential, but this had not happened by the end of the grant period.

More broadly, the policy objectives across the five states included the following:

- Improving wages and benefits for direct care workers;
- Creating incentives for job redesign;
- Making changes in curriculum and credentialing;
- Creating professional association; and
- Promoting awareness of public policy.

Here are some of the specific activities and achievements:

- Iowa: Studying and promoting the need for health insurance benefits for DCWs in a variety of public and legislative forums; achieving passage of a law modifying the state's registry of nurse aides to include classifications that specified education and training; and creating a Direct Care Worker Education Task Force.
- Oregon: Limited policy-related activity, mostly related to nursing delegation and education.
- Pennsylvania: Developing a Universal Core Curriculum for DCWs across settings, which was adopted by two Area Agencies on Aging; developing a competency exam based on the new curriculum that is expected to be used in the state's emerging personal care attendant training regulation; creation of a direct care worker association to promote their interests.
- Vermont: Adding criteria to an existing annual state quality award for nursing facilities that required the use of best practices for recruitment and retention of DCWs; establishing a similar industry award for home care, but without the financial incentive. Through a related grant, Vermont also created a direct care worker association.

3. <u>As Atlantic exits from this set of grants over the next few years, where is it leaving the field? How can the field in general build on the achievements to date?</u>

BJ/BC is over, but the need for a continuing focus on the quality of jobs and care of direct care workers is not. Throughout our evaluation, we have heard from the field that Atlantic's focus on this group is exemplary and critical, and should continue. One point made by the BJ/BC evaluation team is that work with DCWs is needed across settings, not just in nursing homes. One corollary is that the work of DCWs is relevant not just in the context of long-term care (although that is where the bulk of this workforce is employed) but also in the context of caring for frail, vulnerable elders who receive high levels of medical care, both inpatient and outpatient. This means that the quality of their

work can influence the overall effectiveness not only of the long term care system, but the health care system in its entirety.

As Atlantic moves forward with its more policy-oriented agenda, we recommend that it continue to pursue improvements in the quality of work and care for DCWs. They may also prove to be a compelling voice about the reality of life for elders with multiple chronic conditions, as they are, as their title implies, in direct contact with them, often in their homes, and see the difference better care can make for them.

4. What lessons have we learned from the experience of the grantees in pursuing their objectives? Who are the target audiences for these learnings?

The target audience for these lessons is Atlantic Philanthropies and its current and future grantees that work on policy, especially through collaborative efforts such as coalitions.

Lesson One: It may not be wise to engage the same grantees and coalitions for purposes of policy development and advocacy on the one hand, and direct service improvement on the other.

This is unfortunate. One would wish that those working on policy could be "close to" those working on practice improvement. However, it takes a special set of skills, perhaps even a special orientation to the world, to do policy development and especially policy advocacy. It is probably not accidental that four of the five BJ/BC grantees put off their policy work in favor of work on practice.

Lesson Two: Coalitions do not start of fully capable of taking on complex policy analysis and advocacy tasks; they have to develop over time.

For the most part, projects were putting together coalitions only when their grant began. There is considerable evidence that (1) coalitions take a good deal of time, often years, to actually "coalesce" and (2) their development can be problematic if they are given tasks to undertake that are not commensurate with their current stage of development. Policy development and advocacy is probably one of the most demanding and "advanced" tasks to give a coalition, particularly when its membership has little experience with each other, does not have much experience individually in the policy arena, and furthermore has some fundamentally not just different, but conflicting interests. This was certainly the case for most of the coalitions in the BJ/BC program. Even given five years, these coalitions were largely not ready for the complexities of defining achievable policy objectives, generating policy rationales, building relationships with policy makers, and then going through the grinding process of monitoring the policy making process.

Lesson Three: Multi-stakeholder coalitions take even longer, if they are ever able, to come to consensus on truly "disruptive" policy changes. Even coalitions made up of allies with the same interests can find it difficult to reach consensus not only on objectives but on strategy, tactics, and who gets the blame/credit.

Many of the BJ/BC coalitions had a very difficult time navigating the problems that arose when industry representatives became worried that direct care worker associations were going to lead to direct care work unions. In reality, improving the jobs and the training of DCWs will not happen without money, potentially a lot of money. Providing a true "career ladder" with higher pay for more experienced workers would cost money; providing benefits to these low-wage workers could in some cases nearly double their compensation; providing training costs money; creating infrastructure for credentialing costs money; improving the management of the agencies where they work and in their direct supervision would also cost at least some money. It would take quite a massive campaign to convince the public and the legislatures that it would be worthwhile to spend this kind of money, especially in the context of a health care system that is already incredibly costly and getting more so each year.

We are not suggesting that policy change in this arena be ignored. We are suggesting that a more strategic approach needs to be pursued through which the public begins to realize the price we are paying for low-quality direct care workers and further recognizes that when we provide dignity and a living wage and benefits to DCWs the retention rates do go up, training that is offered makes a difference, and the health and quality of life of patients improves.

APPENDIX A

GRANTS COVERED IN THIS REVIEW

List of Human Capital Projects Reviewed

ID #	CATEGORY	PROJECT TITLE	ORGANIZATION NAME	START DATE	END DATE
12568	Scholarship and Fellowship Award Programs	The Paul Beeson Physician Faculty Scholars in Aging Research Program	American Federation for Aging Research	7/1/2004	6/30/2009
14726	Scholarship and Fellowship Award Programs	Renewal of the Paul Beeson Career Development Award in Aging Research	American Federation for Aging Research	4/1/2007	3/31/2012
14198	Scholarship and Fellowship Award Programs	T. Franklin Williams Awards for Junior Faculty	Association of Subspecialty Professors	7/1/2006	6/30/2012
10379	Scholarship and Fellowship Award Programs	Jahnigen Career Development Awards	American Geriatrics Society	7/1/2002	6/30/2008
14058	Scholarship and Fellowship Award Programs	Jahnigen Career Development Awards -- Renewal	American Geriatrics Society	7/1/2006	6/30/2011
13135	Scholarship and Fellowship Award Programs	Postdoctoral Gerontological Scholar Awards	American Academy of Nurses	10/1/2004	9/20/2009
16379	Scholarship and Fellowship Award Programs	Postdoctoral Gerontological Scholar Awards	American Academy of Nurses	12/5/2008	12/5/2013
16671	Training Programs	Institute for Geriatric Social Work	Boston University School of Social Work	12/5/2008	12/5/2013
15864	Training Programs	Building a Stronger Workforce for an Aging Society	Boston University School of Social Work	9/1/2007	1/31/2009
15861	Training Programs	Increased Competency of Practicing Nurses through CE	New York University College of Nursing	10/1/2007	12/31/2010
14277	Training Programs	Improving Geriatric Skills of Family Physicians	American Academy of Family Physicians Foundation	3/12/2008	3/12/2011
11719	Model programs	Improving Internists Management of Geriatric Conditions Through Practice Redesign	American College of Physicians (and RAND)	7/1/2006	12/31/2008
15193	Scaling proven model	Nurses Improving the Care of Healthsystem Elders (NICHE) Capacity Expansion	New York University - College of Nursing	4/1/2007	8/31/2012
16807	Scaling proven model	Nursing Home Collaborative Business Planning	Sigma Theta Tau International Foundation for Nursing	12/5/200	8/16/2009
14266	Infrastructure Development	Transforming Human Services to Older Adults	Alliance for Children and Families	4/1/2007	3/31/2012
15687	Infrastructure Development	Integrating Geriatrics into the Specialties of Internal Medicine: Moving Forward from Awareness to Action	Association of Subspecialty Professors	7/1/2008	12/31/2010
12203	Policy Development & Advocacy	Evaluation of Better Jobs/Better Care Initiative	Penn State University	11/01/03	4/30/07