AGENDA

11:30am – 12:00pm  Tour of CEI San Leandro PACE Center
12:00pm – 12:30pm  Lunch
12:30pm  Welcome
12:30pm – 2:00pm  PACE 2.0 Growth Initiative
2:00pm – 4:00pm  Rate Setting and Cost Effectiveness
4:00pm – 4:30pm  Other Business
4:30pm  Adjourn

Attachments
A. Summary of Strategic Planning Session 02.01.2018
B. NPA PACE 2.0 Project Summary and summary of Institute for Healthcare Improvement Model

Board Members
- AltaMed PACE, Maria Zamora
- Brandman Centers for Senior Care, Molly Forrest
- CalOptima, Arif Shaikh
- Center for Elders’ Independence, Linda Trowbridge
- Fresno PACE, Abe Marouf
- InnovAge, Beverley Dahan
- On Lok Lifeways, Eileen Kunz
- Redwood Coast PACE, Joyce Hayes
- San Diego PACE, Kevin Mattson
- St. Paul’s PACE, Cheryl Wilson
- Sutter SeniorCare PACE, Christie Brown O’Hanlon
Summary of Strategic Planning Session
February 1, 2018

What do you consider top challenges/opportunities for CalPACE within the next year:

- Rates
- Legislator Changes in 2018 CAQ election
- Growth
- PACE voice vis a vis other big players
- Demonstrating cost effectiveness
- Workforce shortages and salary competition
- Statewide PACE visibility campaign
- Leverage PACE 2.0
- Collaborations with like organizations (eg. Association of Local Health Plans)

Based on a forced choice exercise, the above were clustered and prioritized into these top two areas:

1. Demonstrating cost effectiveness as the basis for addressing rates and rate methodology – can Moore grant be utilized to fund this effort?
2. Growth of PACE in California – Leverage PACE 2.0 to spur growth; can one of the 2.0 Collaboratives focus on best practices for growth; should California have its own collaborative on growth? Start by setting an ambitious growth goal for California.

Next Steps: The Board will review and refine these two priorities at its February 22 Strategic session.
PACE 2.0: Adapting and Disseminating PACE to Serve
High Need, High Cost Populations

Executive Summary

The Program of All-Inclusive Care for the Elderly (PACE) serves one of the health care delivery system’s most challenging high need, high cost populations – low income, frail, older adults. PACE provides these older adults with an age friendly health system that supports their ability to live at home, have their care needs met, and enjoy a high quality of life. Recent enactment of the PACE Innovation Act allows for PACE to serve a wider range of high need, high cost adults through one or more pilots. For example, in addition to low income, frail, older adults, PACE could serve people with physical, intellectual or developmental disabilities, severe and persistent mental illness, or end stage renal disease. While the legislation authorized payments to PACE pilot organizations for service delivery, it did not fund the development of PACE model adaptations for new populations or dissemination strategies related to these new opportunities. The development of these adaptations and strategies, combined with increased operational flexibility proposed by federal regulators, is required to set the stage for an exponential, rather than linear, rate of PACE growth.

With the goal of supporting PACE’s exponential growth from 40,000 to 200,000 individuals, the PACE 2.0 project sets forth a plan for adapted PACE models to serve a wider range of adults with high needs and high costs, inclusive of but not limited to PACE’s current focus population of low income, frail older adults. PACE is a comprehensive, community-based care model that integrates preventive, primary and acute care with services and supports across the full range of care settings, including at home. As care providers, PACE organizations bring access and expertise to meeting the needs of the high need, high cost older adults they serve. Further, the direct care relationship that PACE interdisciplinary team members have with the people they serve results in person centered, timely and effective needs assessment, care planning and care delivery. The strong evidence basis for the quality and cost-effectiveness of the
PACE care model supports the value of extending PACE to a greater number of frail older adults and a wider range of high need, high cost populations.

Extending PACE 2.0 services will require adapting the care model’s essential strengths to (1) meet the unique needs of different high need, high cost subpopulations and (2) support accelerated growth and access. The PACE 2.0 project provides the foundation for achieving these goals. The project will estimate by high need, high cost subpopulation the number of people an adapted and more broadly disseminated PACE 2.0 model could serve. Using this estimate, the project will develop dissemination strategies for achieving exponential growth in PACE 2.0 services across a range of scenarios. These scenarios will consider (1) the scope and type of high need, high cost subpopulations served (2) the PACE model adaptations required, (3) competing programs and services and (4) the impact of current and potential state and federal policy constraints.

Across the range of scenarios, the project will develop both a scale and spread strategy for achieving broader PACE 2.0 dissemination. In large population areas, the scale strategy looks to establish PACE 2.0 organizations that serve a high number of people. For smaller population areas, the spread strategy looks to establish a larger number of PACE 2.0 organizations serving significantly more communities than currently served. A modified spread strategy that addresses rural areas will also be specified. To propel PACE 2.0 growth under these strategies, the project will communicate its findings and share its resources with current or prospective providers; state and federal policy makers; and potential partners interested in contracting for PACE 2.0 services.
Applying the Institute for Healthcare Improvement

Breakthrough Collaborative Model to PACE

The National PACE Association (NPA) launched the PACE 2.0 project this past August with support from The John A. Hartford Foundation and the West Health Policy Center. The initiative is designed to expand access to Programs of All-Inclusive Care for the Elderly (PACE) for complex high-need, high-cost populations across the country. The two-year grant funded initiative will chart a course for exponential PACE growth, from approximately 40,000 participants served today to 200,000 participants.

A chief component of the project will involve adapting the Institute for Healthcare Improvement’s (IHI) Breakthrough Collaborative Model (BCM) to test and apply strategies for growing existing PACE organizations by increasing net monthly enrollments and market penetration levels. The origins of BCM date back to 1994 and it was initially conceived by Paul Batalden, MD. In developing the model, Batalden and other members of IHI’s leadership sought to create a structure that would support organizations in their endeavors to generate “real, system-level changes that would lead to dramatic improvements in care.”¹ The main premise of BCM is to use subject matter experts to guide and engage Collaborative participants in rapidly testing and implementing change.

In applying BCM to the PACE 2.0 project, NPA anticipates developing up to three distinct Collaboratives, one of which could be specifically focused on California PACE organizations. NPA will identify five to fifteen subject matter experts, with expertise in enrolling eight to fourteen participants monthly or in achieving a high level of market penetration (20% or more), to guide Collaborative members. The experts will function as PACE faculty. The faculty will participate in the Collaborative and will assist in creating content to support non-faculty participating members identify and test small scale changes to increase net monthly enrollment rates. Collaborative members will be expected to commit between six and fifteen months to participate and test strategies. A vital factor in ensuring the success of the Collaborative will require members to openly share their strategies and experiences.

Over the course of the commitment, participating organizations will take part in about three separate Learning Sessions, during which they will come together to learn about and discuss strategies to significantly increase net monthly enrollment. Each organization will be expected to send three team members to attend these one to two day in-person sessions. In between the Learning Sessions, members will return to their programs and share the information they learned, then test and implement small-scale changes through what is known as Action Periods. During the Action Periods, participating organizations will adopt the Model for Improvement,

which was developed by Associates in Process Improvement, to test and implement changes to grow monthly enrollment rates. The Model will guide participants in addressing the following three questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

In performing tests of change, Collaborative participants will engage in Plan-Do-Study-Act (PDSA) cycles as indicated below:

I. Plan: plan the test/observation;
II. Do: try out the test on a small scale;
III. Study: set aside time to analyze the results; and
IV. Act: refine the change, based on what was learned from the test.

During the second and third Learning Sessions, ample time will be devoted to allowing members to share more with each other as they present on the various strategies they tested and discuss outcomes as well as refinements in approaches.

While in-person Learning Sessions are critical pieces of BCM, virtual communication also will be expected. The Collaborative will include regular conference calls, online dialogue, written updates and web-based meetings to facilitate shared learning and improve enrollment strategies.

Throughout the entire Collaborative process, senior leadership at participating organizations will serve as Champions. These Champions will guide, support, and encourage the improvement teams. They will ultimately bear responsibility for the work performed.

NPA would like to launch the first Breakthrough Collaborative in 2018 with programs in California. A sample timeline of events is depicted on page three.

At the conclusion of BCM, NPA intends to disseminate the successful strategies/tools to help support exponential growth in PACE across the nation.

Please feel free to contact Peter Fitzgerald or Sam Kunjukunju for more information.
Sample Breakthrough Collaborative Timeline

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<td>04/18</td>
<td>05/18</td>
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<tr>
<td>Develop Framework for Change</td>
<td>Launch Learning Session 1</td>
<td>Launch Learning Session 2</td>
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