APPENDIX D

PLANNING GRANT SUMMARIES

March 2005
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**Intervention**

A consortium of six organizations in Los Angeles County collaborated to form Chronic Care Connections (CCC). Planning to develop four, long-term care managed care products to integrate long-term care and acute medical care, CCC was made up of community-based providers, the L.A. Health Care Plan, and SCAN Health Plan, a social HMO.

**Underlying Hypothesis**

Integrating managed care products for acute medical services and long-term care services would result in improved health outcomes and reduced utilization for costly medical services, such as inpatient days and emergency room (ER) visits.

**Project Design**

CCC planned to introduce four, long-term managed care products:

- **Care management only**—a product to enable Medicare HMOs to serve the chronically ill population. This would be targeted to the 380,000 Los Angeles residents who are enrolled in Medicare managed care plans.

- **Care management in conjunction with a social HMO**—a contract with SCAN, a social HMO, which would eventually be broadened to other social HMOs. SCAN would receive a payment for care management and a payment for services. CCC would be a fee-for-service (FFS) payer while it worked out its managed care arrangements. This would essentially be a test product, allowing CCC to “work out the kinks” in the managed care products before it assumes risk. This plan would target the five percent of SCAN enrollees who are dually eligible and are certified as nursing home eligible.

- **Fully integrated product**—a product that integrates acute medical services and Chronic Care Connections’ nursing home facilities and home- and community-based services. This would be targeted to persons who are substantially functionally impaired (defined as needing assistance with at least one activity of daily living [ADL]) and who are eligible for Medicaid or are dually eligible. It was estimated that 25,000 Los Angeles residents would meet this criteria.

- **Subcapitated, subacute product**—a product that would allow care management and fully integrated products to “enter into subcapitated arrangements for Medi-Cal and Medicare risk providers for subacute services. Subacute services are defined as all services that substitute for inpatient days” (CCC 1999). This would be targeted to the 380,000 Los Angeles residents who were enrolled in Medicare managed care plans (CCC 1999).
Project Implementation and Experience

CCC received a planning grant from the California Health Care Foundation (CHCF) to develop a governance structure; decide upon goals, strategies, and types of service delivery arrangements; and create mechanisms for coordinating care across CCC member organizations (CCC 1998). In the implementation phase, CCC sought funding to cover start-up costs, including hiring staff, building information systems and financial infrastructure, and hiring outside consultants for auditing and legal matters (CCC 1999). In July 1999, it submitted an implementation grant proposal, but it was not funded by CHCF. Information is not available on whether this project was funded by other sources.

Timeline of Grant Activities

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<th>Activity</th>
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<tr>
<td>Planning grant begins</td>
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<tr>
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<td>July 1999</td>
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<tr>
<td>Planning grant ends</td>
<td>September 1999</td>
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<tr>
<td>Final financial report submitted</td>
<td>August 2001</td>
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Evaluation Structure

The evaluation plan is detailed in the implementation grant proposal but is not relevant because CHCF did not fund the implementation grant (CCC 1999).
REFERENCES


Intervention

The purpose of this project was to design a new, single-point-of-entry system for the Kaiser Permanente network, called the Senior Care Delivery System (SCDS). SCDS would be run by a local community services agency. All elderly members in Kaiser who required community services would be referred to this agency. SCDS would make referrals to community services and interface with Kaiser Permanente medical providers and community agencies to ensure care coordination.

Underlying Hypothesis

Under the existing system, Kaiser was unable to monitor its patients’ progress and services received in the community once they were no longer receiving acute medical services. As a result, patients often returned for acute medical services “in greater functional decline than before” (Kaiser 1999). Kaiser believed that integrating medical and community-based services outside of the normal acute medical care would result in improved patient outcomes and greater member satisfaction. SCDS would be evaluated on three primary outcomes: (1) access to services; (2) consumer satisfaction; and (3) reduced rates of readmission (Kaiser 1999).

Project Design

The project targeted seniors over age 65 who were receiving care from Kaiser and living in San Diego County.

SCDS would focus on five categories of services including:

- **Outreach and linkage**—screening, referrals, and telephone contact to keep seniors connected to the health care system;

- **Ambulatory care**—a wide variety of health care services for those who are healthy and those who require monitoring; examples include services provided in a health care facility and in adult day care;

- **Home care**—formal and informal home care, such as skilled nursing or housekeeping services;

- **Wellness and health promotion**—activities such as health education classes, and social and support groups; and

- **Housing**—arranging for assisted living facilities when needed (Kaiser 1999).
Project Implementation and Experience

The project team consisted of representatives from the Kaiser Permanente Continuing Care Service Department, the University Center on Aging, and the Community Aging network. In the planning phase of this project, the project team met weekly. Topics discussed included designing the new system of care, determining what services SCDS would provide, how to measure outcomes, and costs of long-term sustainability. The team conducted some initial surveys of members to determine their needs and explored financing options.

The project team planned for a second phase of the project, which would have been funded by an implementation grant from PEMC. Activities in the second phase would have included identifying a nonprofit organization to operate SCDS, implementing the program with an initial group of 1000 seniors and evaluating the results.

The second-cycle implementation grant for this project was not funded. Information on whether this project was eventually funded by other sources is not available.

Timeline of Grant Activities

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<td>October 1999</td>
</tr>
<tr>
<td>Final financial report for planning grant submitted</td>
<td>August 2000</td>
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</table>

Evaluation Structure

This is not applicable because the implementation grant was never funded. The planned evaluation is detailed in the implementation grant proposal (Kaiser 1999).
REFERENCES

**Intervention**

This project linked community health advocates (CHAs) with frail elders in the Hispanic American and Filipino American communities in San Diego. CHAs performed a number of activities, including acting as spokespersons and patient advocates, translators, and health educators. CHAs served the health plan by training staff and translating materials; they served patients and their families by acting as advocates in their interactions with the health plan.

**Underlying Hypothesis**

The purpose of the project was to test the hypothesis that “access to health care by minority older people is related to their participation in a multicultural program” (Stanford and Du Bois 1999).

**Project Design**

This project used its planning grant in the first round of funding to develop a telephone-screening tool to identify at-risk seniors who might benefit from case management services. The project translated materials into Spanish and Tagalog and developed incentives to encourage seniors to participate. It also standardized procedures and protocols for the CHAs (Stanford and Du Bois 1999).

In July 1999, the investigators submitted a proposal for a second-round implementation grant to launch the program, which would serve 500 subjects—250 in an intervention group and 250 in a control group—and to evaluate the outcomes of these activities (Stanford and Du Bois 1999). Although the CHCF decided not to fund the larger implementation, the investigators submitted a proposal in December 1999 for a smaller pilot test, which was funded as a second-cycle planning grant (Stanford 1999).

In the pilot project, 84 Hispanic American elders and 47 Filipino American elders in the San Diego area agreed to participate. The study ended with 41 Filipino Americans and 53 Hispanic Americans, for an attrition rate of 28 percent (Du Bois 2002). Seventy-seven percent of study participants had an annual incomes under $9,999, and 78 percent were eligible for both Medicare and Medicaid (Du Bois 2002). The pilot study did not include a control group.

**Project Implementation and Experience**

CHAs, which were bilingual and bicultural (Filipino or Hispanic), conducted assessments and provided care management services to participants over the four-month study period. Unpaid volunteers, also bilingual and bicultural, conducted baseline and follow-up interviews and did community health education (Du Bois 2002). The evaluation assessed which of the
CHA services seniors used most often as well as changes in health status from the beginning of the project period to the end.

Project partners included the Chicano Federation and the Union of Pan-Asian Communities. The former is sustaining the project by incorporating care management services into its activities and is seeking additional funding for these activities. The latter is not continuing the CHA program but is continuing separate care management activities.

**Timeline of Grant Activities**

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<tr>
<td>Planning grant begins</td>
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<td>Pilot test proposal submitted</td>
<td>December 1999</td>
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<tr>
<td>End of project period</td>
<td>January 2001</td>
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<td>Final report submitted</td>
<td>July 2002</td>
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**Evaluation Findings**

The evaluation sought to determine which CHA services participants used most frequently and whether the services affected health outcomes, including social activities, bodily pain, quality of life, consumer satisfaction, primary access, and ability to do daily tasks.

*Services most frequently used.* These included advocacy for patient rights and needs, referral to other providers, community health education, and classes on health topics. The services used least were problem-solving regarding insurance benefits, forms assistance, family education, social and recreational activities, and telephone calls (Du Bois 2002).

*Effects on daily activities.* The reported “difficulty in performing usual daily activities inside and outside the home because of physical and emotional health” improved significantly for both the Filipino American and Mexican American population. Because the change was observed in both groups, the investigators concluded that it must have been the result of either the intervention or an unobserved factor present in both populations. Since the investigators knew of no other such factor, they concluded that the change was the result of the intervention (Du Bois 2002).

*Social activities.* A significant improvement was found in “social activities with family, friends, neighbors, and groups” due to physical and emotional health for the Mexican American population only (Du Bois 2002).

*Bodily pain.* There was some evidence that bodily pain decreased for both groups, but this was not statistically significant (Du Bois 2002).

*Quality of life and self-report of health.* This was measured by changes in functioning in instrumental activities of daily life (IADLs). The evidence suggested that improvements in IADLs were more the result of changes in quality of life than in direct response to case management services provided through the intervention (Du Bois 2002).
Consumersatisfaction and consumer knowledge. The study did not find evidence of greater consumer satisfaction or knowledge as a result of the CHA services (Du Bois 2002).

Primary access. The study found that seniors who reported a need for prescription medications were more likely to seek care management services (Du Bois 2002).
REFERENCES


Intervention

The purpose of the planning grant was to support the development of a new system of care for seniors to link acute-care services and long-term care services. The system was developed by the Senior Care Alliance, a coalition of 17 organizations in Sonoma County formed specifically for this intervention. The organizations included a Medicare managed care plan and several medical groups, hospitals, and community-based organizations.

Underlying Hypothesis

Frail seniors would benefit from and experience improved health outcomes from coordinated medical, long-term care, and community services.

Project Design

The project developed a new system of care in which participating seniors would receive coordinated care as a result of partnerships developed by the Medicare managed care plan, providers, hospitals, and community-based services. Care managers already employed by the participating organizations would work with physicians and link seniors to available community services. The alliance would also provide telephone information, referral services, and educational services to seniors and was planning to develop an integrated data collection and reporting system (Redwood 1999).

The program, initially designed to target 1,000 Medicare managed care enrollees at Health Plan of the Redwood, was expected to grow to cover all Medicare-Medicaid dual eligibles and eventually all Sonoma County seniors.

Project Implementation and Experience

The alliance met regularly as of January 1999. In the planning phase, it focused on building trust among member organizations, developing the conceptual model, and identifying roles and responsibilities of each organization (Redwood 1999). In June 1999 Redwood Health Services submitted a proposal to CHCF for a second-cycle implementation grant (Redwood 1999).

The implementation grant proposal was not funded, and both Redwood Health Services and the Health Plan of the Redwoods are now bankrupt. Information on whether project activities were continued or funded by another organization is not available.
## Timeline of Grant Activities

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<td>October 1998</td>
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<tr>
<td>Implementation grant submitted</td>
<td>June 1999</td>
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<tr>
<td>Planning grant ends</td>
<td>September 1999</td>
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<tr>
<td>Final financial report for planning grant submitted</td>
<td>August 2001</td>
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## Evaluation Structure

The evaluation structure is outlined in the implementation grant proposal but is irrelevant because the grant was never funded.
REFERENCES


Intervention

This project supported the development of VitaLink, a care management program that would coordinate medical services, community-based services, and fitness programs for frail elders. VitaLink was developed by a coalition formed by a Medicare managed care plan, a group of primary care physicians, and a community-based senior program.

Underlying Hypothesis

Integrating medical and community services and promoting a senior fitness program would result in improved health outcomes. Specifically, it would result in fewer hospitalizations, hospital days, emergency room visits, and long-term nursing home placements as well as lower health care costs (VitaLink 2001).

Project Design

In the VitaLink program, participating seniors would receive an initial screening and assessment. They would then be enrolled in the Huntington Senior Care Network Support Services, which integrates medical services with community services and provides access to physical fitness activities (VitaLink 2001).

The project planned to target 1,000 seniors over the age of 65 who reside in the community (as opposed to nursing homes), who are members of PacifiCare/Secure Horizons Medicare managed care plan, and who have primary care physicians in the Huntington Medical Foundation (VitaLink 2001). It was expected that 500 participants would be in the intervention group, which would receive VitaLink services, and that 500 would be in the control group.

Project Implementation and Experience

In the planning phase, the VitaLink coalition met to determine the roles and functions of members, to develop and clarify the program model, to assess organizational capacity, and to design the evaluation structure (VitaLink 1998).

During this phase, the project leadership and organization changed significantly. In the planning grant, Southern California Health Care System’s Medical Value Plan (MVP) was listed as the participating managed care plan, and Southern California Health Care Systems was the lead agency (VitaLink 1998). By the time the implementation proposal was submitted, MVP was replaced by PacifiCare/Secure Horizons. Additionally, in the implementation grant proposal, Southern California Health Care Systems was no longer listed as a project partner. Instead, the proposal was submitted by the Huntington Senior Care Network on behalf of the Southern California Health Care System (VitaLink 2001). Gretchen Brickson at Huntington Hospital (an affiliate of the Southern California Health Care System) replaced Judy Pierson at Southern California Health Care Systems as project director.
The coalition submitted a proposal for an implementation grant to CHCF in August 2001, a year after the due date, but CHCF did not provide any further funding. Information on whether project activities continued with other funding is not available.

**Timeline of Grant Activities**

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<td>Planning grant begins</td>
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<tr>
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<td>October 1999</td>
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<tr>
<td>Implementation grant proposal submitted</td>
<td>April 2001</td>
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</table>

**Evaluation Structure**

The evaluation structure is outlined in the implementation proposal but is not relevant because CHCF did not fund the implementation grant (VitaLink 2001).
REFERENCES

Brickson, Gretchen. Cover letter to Jan Eldred for implementation grant proposal, April 26, 2001.

Eldred, Jan. Note to PEMC evaluation staff stating that final report was submitted a year late. [No date.]


VitaLink. “Program for Elders in Managed Care.” Planning grant proposal submitted to CHCF May 1, 1998.
Intervention

This project was a joint venture of the Contra Costa County Area Agency on Aging and the Contra Costa Health Plan (CCHP), which is a division of the County Health Services department. Many home- and community-based services are available in Contra Costa County, but seniors in managed care plans are often not aware of them. The purpose of this project was to plan and develop a new system of care, called Coordinated Care for Seniors (C^2FS), that would provide targeted case and disease management to at-risk seniors enrolled in CCHP’s Medicare managed care plans. The plan was to expand to other Medicare managed care plans in Contra Costa County once C^2FS was established.

Underlying Hypothesis

Providing targeted case and disease management for at-risk seniors in Medicare managed care plans would result in better health outcomes, reduce inappropriate use of medical services (including emergency rooms), and improve clients’ quality of life and satisfaction with the health plan.

CCHP enrollees were expected to benefit the most from these services because they are among the most elderly, are the frailest, and have the lowest income of all California Medicare managed care plan enrollees, according to Health Care Finance Administration (CCC 1999). About half the CCHP members are dual eligibles, and CCHP has more racial and ethnic minorities than any other California Medicare managed care plan (CCC1999).

Project Design

Under the proposed program, all CCHP members who are enrolled in Medicare managed care (about 845) would be screened to determine if they might benefit from case management services. It was expected that about 25 to 30 percent (about 235 seniors) would be identified as needing case management services (CCC 1998).

Seniors so identified would then be assessed to determine what types of services would be most beneficial to them. They would also be linked to a variety of services, including “health education, medication management, home delivered meals, transportation, home modification, respite care and caregiver support and 24-hour medical consultation” (CCC 1999). C^2FS would also have an emergency fund to cover the costs of necessary nonmedical services for those who could not afford them and would develop a database to track the services received by seniors.

CCHP care managers planned to serve as C^2FS care managers. CCHP care managers serve all Contra Costa County residents who need services, not just CCHP plan members. Under C^2FS, the care managers would shift their focus to C^2FS participants. The size of the caseload for CCHP case managers would be consistent with the caseloads prior to C^2FS.
Project Implementation and Experience

In the planning phase, CCC assembled the coalition of community partners and developed the plans for C²FS. A 17-member community advisory committee met regularly, and the project consulted with more than 50 medical and social service professionals, more than 100 Medicare managed care enrollees, and others in the community. As all first-cycle planning grants, the project was originally scheduled to end in September 1999, but the project partners asked for and received a no-cost extension until December 1999 (Yee 1999).

In July 1999, the project partners submitted a proposal to CHCF for a grant to implement the new system of care, but this grant was not funded. Information on whether this project was later funded by other sources is not available.

Timeline of Grant Activities

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<td>No-cost extension granted for planning grant</td>
<td>September 1999</td>
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<tr>
<td>Planning grant ends</td>
<td>December 1999</td>
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<tr>
<td>Final financial report submitted</td>
<td>October 2000</td>
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Evaluation Structure

The evaluation plan is detailed in the implementation grant proposal but is not relevant because the implementation grant was not funded (CCC 1999).
REFERENCES


Intervention

CalOPTIMA, the county-organized health system for Orange County, California, provides services to more than 35,000 members who are dually eligible for Medicare and Medicaid, 75 percent of whom are over age 65. CalOPTIMA also provides Medicare supplemental coverage, including premiums and deductibles, and pays for prescriptions and nursing home room and board costs for these members (CalOPTIMA 1999).

This project supported CalOPTIMA in its plans to develop a managed care plan for dually eligible members that would integrate medical services with long-term care services (CalOPTIMA 1999). It was expected that this plan would be better able to manage Medicare and Medicaid costs and provide better coordination of care, which would result in improved health outcomes for members.

Underlying Hypothesis

Implementing care management for the dually eligible population would result in improved access to preventive services, reduce the unnecessary use of inpatient services, and lower the risk of requiring long-term care (CalOPTIMA 1999).

Project Design

CalOPTIMA planned to develop a managed care plan that would serve its 35,000 members in Orange County who are dually eligible for Medicare and Medicaid. About 75 percent of this population is over age 65 (CalOPTIMA 1999).

Project Implementation and Experience

CalOPTIMA received a $75,000 planning grant from CHCF in the first round of PEMC funding and committed $155,000 of its own funding in the first year.

The planning process had three major components:

- **Assess demographics and health care utilization.** CalOPTIMA developed a database on dually eligible members that integrated Medicare, Medicaid, and CalOPTIMA cost and utilization data.

- **Conduct focus groups with providers, dually eligible members, and families.** CalOPTIMA sent 235 questionnaires to providers, provider organizations, and community service organizations to assess needs. Five focus groups were also conducted with members and families from May through July 1999. CalOPTIMA also made presentations to community organizations.
• **Develop a managed care plan for dually eligible members.** CalOPTIMA began assessing similar managed care plans in Minnesota, Wisconsin, and Texas to examine how these programs were designed and implemented (CalOPTIMA 1999).

In July 2000, CalOPTIMA decided not to continue plans to develop the managed care plan for dual eligibles, given the instability in the Medicare managed care market. CalOPTIMA was also concerned about the medical cost risk profile of dually eligible members, given that it is already at risk for all of Medicaid services for its members (CalOPTIMA 2000).

It is uncertain as to whether state Medicaid policy played a role in CalOPTIMA’s decision to discontinue the development of the managed care plan. This move was not identified as a concern in the planning grant proposal or in later progress reports and funding requests. Barriers that were identified included developing a database linking Medicare and Medicaid records, expanding CalOPTIMA’s network of services to serve this population, and obtaining federal waiver approval (CalOPTIMA 1999). The project’s subcontractor, JEN Associates, Inc., completed the linked database in July (CalOPTIMA 2000).

In November 1999, CalOPTIMA submitted a request to CHCF for a second planning grant and additional funding for the Home and Community Care Program, which would provide care management services to 770 frail seniors. The CHCF funding would have supported outreach activities and staff hiring for the program (Richardson 1999). CHCF did not approve this funding.

CalOPTIMA instead used their own funding to begin a Home and Community Care Program in FY 2000-2001, which would coordinate care for 770 frail members (Richardson 1999). This program, part of a larger CalOPTIMA project—Senior Select and Long-Term Care Program (in place since 1998)—is intended to provide access to community-based services to reduce the need for nursing home services (CalOPTIMA 2000).

### Timeline of Grant Activities

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<tr>
<td>Planning grant begins</td>
<td>October 1998</td>
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<tr>
<td>Second planning grant proposal submitted</td>
<td>July 1999</td>
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<tr>
<td>Additional funding requested for Home and Community Care Program</td>
<td>November 1999</td>
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<td>July 2000</td>
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<tr>
<td>Final financial report submitted</td>
<td>June 2001</td>
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</table>

### Evaluation Findings

Not relevant for this planning grant.
REFERENCES

CalOPTIMA. “Grant Progress Report and Proposal to the California HealthCare Foundation Program for Elders in Managed Care.” July 14, 2000.

CalOPTIMA. “CalOPTIMA Planning & Research Initiative for Dual Eligibles.” Second-round planning grant proposal submitted to CHCF July 1, 1999.

Intervention

Community Health Group (CHG) is a health service plan with more than 65,000 members who are Medicaid enrollees in California. Many of these enrollees also have Medicare, but because CHG does not have a Medicare contract, it does not have information on the health services received by members under Medicare (CHG 2001). The result is a fragmented system of care for these frail elders.

The original intent of the planning grant was to support the development of a Medicare managed care plan for the population dually eligible for Medicare and Medicaid. CHG believed that a consolidated health care delivery system would be better able to identify at-risk seniors and provide them with the services they need (CHG 2001). However, CHG chose not to go through with the plans for developing the managed care plan, in part because significant changes were taking place in the California Medicare managed care market during the grant period, and health plans were pulling out of the market. Instead, CHG used the planning grant funds to develop tools for identifying at-risk seniors and protocols for case management and home assessments. To develop and test these instruments, CHG partnered with two community health centers, two adult day centers, and one organization that provides in-home services.

Underlying Hypothesis

Community-based service centers lack the tools needed to identify at-risk seniors. Developing screening and assessment tools targeted to center needs would help them to identify and serve at-risk seniors and would improve coordination of care.

Project Design

The following screening tools and protocols were developed in consultation with the participating senior centers.

- **A screening tool to identify health care needs.** This tool was tested on 30 seniors in the San Ysidro Health Center (SYHC), a community health center that serves a primarily Hispanic population. The results of the screening were compared to participants’ medical charts. The screener identified not only findings consistent with the medical charts for falls, medication, nutrition, and incontinence but also a significantly greater number of seniors with depression than were identified in medical charts.

- **An in-home assessment tool.** This was tested through in-home visits to 18 high-risk seniors. It was found that in-home assessments were beneficial to and well received by seniors.
• **Care management protocols.** These were developed for patients at high risk for the following conditions: incontinence, depression, undernutrition, medication noncompliance, and functional impairment (CHG 2001).

**Project Implementation and Experience**

The participating community service centers assessed the tools’ effectiveness. As noted, the screening tool was tested with 30 seniors, and the in-home assessment tool was tested with 18 seniors.

Although the planned Medicare managed care plan will not be implemented, the screening and assessment tools and care management protocols are being implemented by the San Ysidro Health Center.

**Timeline of Grant Activities**

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<td>August 2000</td>
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<tr>
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<td>June 2001</td>
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<tr>
<td>Final report submitted</td>
<td>November 2001</td>
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**Evaluation Structure**

Not relevant for this planning grant.
REFERENCES


**Intervention**

LifeLong Medical Care, along with the Alameda Alliance for Health (the Alliance) and the Centers for Elders Independence, formed a coalition to develop a Medicare managed care plan that would serve the population dually eligible for Medicare and Medicaid. The goal was to improve service delivery and care coordination for this population. The group planned to develop a program similar to, but more flexible and “consumer friendly” than, the PACE demonstrations (Lynch 2001a).

The Alliance, an HMO already serving the Medicaid population, was planning to apply to CMS to implement a Medicare managed care plan. The planning grant from CHCF supported a feasibility study for the development of this managed care plan. The Alliance subcontracted with Levine Healthcare and Milliman USA to develop the business plan and conduct the actuarial analysis (Lynch 2001b). The Robert Wood Johnson Foundation and The California Endowment also supported this project.

**Underlying Hypothesis**

Seniors in Alameda County who are dually eligible for Medicare and Medicaid would benefit from improved coordination of services in a new Medicare managed care plan.

**Project Design**

The feasibility study assessed the managed care environment in Alameda County and examined other similar programs serving the dually eligible population nationwide, including Elder Health in Baltimore, Maryland. Two models were developed: (1) a “no-frills” Medicare-only plan that would serve low-income elders; and (2) a comprehensive Medicare/Medi-Cal plan that would provide prescription coverage and transportation services without co-pays for health care services (Alliance 2001). The business proposal assessed financial outcomes in four possible scenarios: best case; worst case; most likely; and most likely if there was a slow startup.

**Project Implementation and Experience**

Based on the results of the feasibility study, the Alliance is continuing with planning activities, although it has not yet decided whether to apply to CMS to implement a Medicare managed care plan (Lynch 2001c). As a Knox-Keene–licensed HMO, the Alliance would have to submit a request to the California Department of Managed Health Care to expand its license to serve this population (Alliance 2001).
**Timeline of Grant Activities**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning grant begins</td>
<td>January 2000</td>
</tr>
<tr>
<td>Planning grant ends</td>
<td>October 2001</td>
</tr>
<tr>
<td>Final report submitted</td>
<td>November 2001</td>
</tr>
</tbody>
</table>

**Evaluation Structure**

Not relevant for this planning grant.
REFERENCES


