

**SUMMARY OF COUNTY COVERAGE INITIATIVES**

<b>COUNTY</b>	<b><u>ALAMEDA</u></b>	<b><u>CONTRA COSTA</u></b>	<b><u>KERN</u></b>	<b><u>LOS ANGELES</u></b>	<b><u>ORANGE</u></b>
<b>PROJECT NAME</b>	Alameda County for Excellence (ACE)	Contra Costa Health Care Coverage Initiative (HCI)	Kern County Camino de Salud Network (CDSN)	Healthy Way LA (HWLA)	Health Care Coverage Initiative (CI)
<b>ANNUAL FEDERAL FUNDING</b>	\$8,204,250	\$15,250,000	\$10,000,000	\$54,000,000	\$16,871,578
<b>ANNUAL COST PER ENROLLEE</b>	\$1,604.85	\$3,180.00	\$4,000.00	\$1,194.00	\$5,784.00
<b>TARGET ENROLLMENT</b>	10,000	9,000	10,000	94,000	17,000
<b>PROJECT FEATURES</b>	<p>1) Focuses on chronic conditions, initially diabetes and CHF</p> <p>2) Primary care at contracted clinics, specialty care at APMC</p> <p>3) A clinical care model for each chronic condition</p> <p>4) Patient care consists of panel, clinical, and case management</p> <p>5) Population management through education and collaboration with CBOs</p>	<p>1) Will build upon CCHP and BHC programs</p> <p>2) Focuses on homeless, college students, parents of kids in Medi-Cal/Healthy Families, first-time mothers, and HIV/TB</p> <p>3) Health Assessment Screening to identify access and care needs</p> <p>4) Addition of community clinics to provider network</p>	<p>1) Developed by COPE Health Solutions and originally used in L.A. County</p> <p>2) Covers outpatient services only</p> <p>3) Phases for enrollment numbers and participating sites</p> <p>4) Contracting with community clinics</p> <p>5) Standardization of care through evidence-based medicine and committee-devised disease management guidelines</p> <p>6) Expanding telemedicine network for rural areas</p>	<p>1) Covers outpatient services only</p> <p>2) Focuses on particular chronic conditions, pre-Medicare age, and chronic users of LACDHS services</p> <p>3) Contracting with private clinics</p> <p>4) After-hours nurse advice line</p> <p>5) Intensive follow-up care management</p> <p>6) Homeless care management planned</p>	<p>1) Will build upon MSI program</p> <p>2) Safety net consists of contracted providers</p> <p>3) Concurrently enroll extra 3,300 people, while converting current MSI enrollees to new program</p> <p>4) 24-hour nurse line and copayments will encourage use of medical home over more expensive/intensive options</p> <p>5) Pay-for-performance incentive program for providers planned</p>
<b>SCREENING SOURCE</b>	MICRS, APMC Wellsoft ER Tracking, APMC self-pay data	Medical records review, point of service contacts, future community outreach	Year 1: KMC ER and inpatient users Years 2-3: also community clinic users	Enterprise Data Repository, PPP clinics, and point of service contacts	Point of service contacts using nine-point Medi-Cal/MSI screening tool
<b>ENROLLMENT PROCESS</b>	One-E App system	Point of service	Point of service	Application mailings and point of service	MSI/CI electronic eligibility system

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<b>MEDICAL RECORDS SYSTEM</b>	Planned enhanced electronic system (e.g., Ref Track)	Electronic system exists, but plans to enhance	Electronic Medical Information System (MIS)	Currently hybrid of electronic and paper; plans to introduce ESS and RPS	Planned enhanced MSI Connect electronic system
<b>MEDICAL HOME</b>	Free standing clinics of ACMC or contracted clinics of Alameda Health Consortium	All providers within CCHP provider network, with plans for contracted community clinics	KMC clinics or planned contracted community clinics	LACDHS health facility with plans to contract PPP clinics	MSI-contracted safety net community clinics or individual primary care physicians
<b>CARE/CASE MANAGEMENT</b>	Focus on cultural competency	Assist in coordination of primary, specialty, and social services	Intensive services for chronically ill and/or frequent users	Follow-up management for those hospitalized	Contracted care management
<b>EVALUATION PROGRAMS</b>	Process and outcome measures for each disease management model	Will use measures such as HEDIS and SF-30; patient satisfaction survey	Specialty care utilization review, Quality Management and Performance Improvement Plan, patient satisfaction surveys	None currently specified	Quality Improvement Committee and disease management models planned
<b>PATIENT COSTS</b>	\$10 copayment	Partnership Fees: \$30-450 per 6 months	Unknown	None	\$5 copayment for non-medical home, \$25 for ER visits
<b>UPDATES</b>	Enrollment to begin on October 1, 2007	Enrollment began on September 1, 2007		Enrollment began on September 1, 2007	Enrollment began on September 1, 2007

<b>COUNTY</b>	<b><u>SAN DIEGO</u></b>	<b><u>SAN FRANCISCO</u></b>	<b><u>SAN MATEO</u></b>	<b><u>SANTA CLARA</u></b>	<b><u>VENTURA</u></b>
<b>PROJECT NAME</b>	Safety Net Access Program (SNAP)	Health Access Program (HAP)	Access and Care for Everyone (ACE)	Valley Care Coverage Initiative (VC)	Access Coverage Enrollment Program (ACE)
<b>ANNUAL FEDERAL FUNDING</b>	\$13,040,000	\$24,370,00	\$7,564,172	\$20,700,000	\$10,000,000
<b>ANNUAL COST PER ENROLLEE</b>	\$4,000.00	\$2,415.00	\$3,602.00	\$3,325.00	\$1,608.00
<b>TARGET ENROLLMENT</b>	5,000	15,600	2,100	12,500	12,500
<b>PROJECT FEATURES</b>	<p>1) Will build upon CMS program, but be run as a separate project</p> <p>2) Will contract with safety net providers for services</p> <p>3) Focuses on diabetes, hypertension, and other related conditions</p> <p>4) Disease management based on Project Dulce model</p>	<p>1) Will transition enrollees from participation in Sliding Scale Program</p> <p>2) Enrollees will participate in San Francisco Health Plan</p> <p>3) Enhanced health promotion and education</p> <p>4) Will utilize SFHP evaluation/management resources</p>	<p>1) Pilot program for Blue Ribbon Task Force</p> <p>2) Will build upon WELL program</p> <p>3) Will use successful features from Healthy Kids program</p> <p>4) Open access model to improve patient experience</p> <p>5) Utilize chronic care management models, initially for diabetes</p>	<p>1) Based on shared responsibility model</p> <p>2) Will adopt successful features used in Children's Health Initiative</p> <p>3) Available health education classes and chronic disease management programs</p> <p>4) Contracting with Santa Clara Independent Physicians Association</p>	<p>1) Focus on families with young children, low-wage workers, farm workers, older persons, homeless individuals, and those with mental illnesses</p> <p>2) Enrollees eligible to use Discount Self-Pay Program for non-covered services</p> <p>3) Incentives for enrollees and providers to focus on primary and preventive services</p> <p>4) Small Employer-Based Enrollment Program, especially for agriculture sector</p>
<b>SCREENING SOURCE</b>	Point of service contacts from safety net providers, ERs, and Indian Health Centers	Current users of Department of Public Health services	Individuals who continue to attempt to access county health services; chart review at participating clinics	Community outreach and point of service contacts	Community outreach and current users of safety net services
<b>ENROLLMENT PROCESS</b>	Application criteria verified by County Eligibility Worker	Transition current Sliding Scale participants to HAP	One-E app system	Point of service	Point of service

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<b>MEDICAL RECORDS SYSTEM</b>	Records kept at medical homes; plans for electronic system	Records maintained by medical homes	Planned enhanced electronic system	Currently hybrid of electronic and paper records; planned electronic system	Existing electronic system
<b>MEDICAL HOME</b>	Contracted community clinics	Identified members of the safety net and participants in SFHP	SMMC clinics and RFHC	Providers within the SCVHHS and IPA	Ventura County HCA clinics and Clinicas del Camino Real
<b>CARE/CASE MANAGEMENT</b>	Focus on culturally-sensitive assistance	Will utilize SFHP resources	Redesigned chronic care models	Intensity of management based on case severity	Preventive and Care Management Program (CMP) and Individual Service Plan (ISP)
<b>EVALUATION PROGRAMS</b>	Coordinated by Administrative Services Organization	Will utilize SFHP's Utilization Management and Quality Improvement Programs	Outcome evaluation via HEDIS measures; process evaluation via patient survey	Coordinated by the Valley Care Utilization Management Committee and Quality Assurance Department	Coordinated by Utilization Management Program using standards such as NCQA/HEDIS, JCAHO core, and CMS measures
<b>PATIENT COSTS</b>	None for covered benefits	Monthly fees and service copayments based on sliding scale	\$300 annual fee	Sliding scale	Unknown
<b>UPDATES</b>	Enrollment to begin on November 1, 2007		Enrollment to begin on September 17, 2007	Enrollment began on October 1, 2007	