December 2007

Senior Care Options Evaluation Phase 2: Member Experience Report of Individual Interviews

Prepared by:

Center for Health Policy and Research (CHPR)
In collaboration with the Center on Aging,
University of Connecticut Health Center

Project Team:

Center for Health Policy and Research
Faith Little, MSW
Richard McManus, MPP, MSW
David Centerbar, PhD

Center on Aging, UConn Health Center
Leslie Curry, PhD
Cindy Gruman, PhD
Julie Robison, PhD

MassHealth Office of Long Term Care
Diane Flanders, RN
Christine Smith
Frances Bochenko

Table of Contents

I. Executive Summary

Background

This is the second of two reports that present findings from Phase II of a process evaluation of member experience with the Senior Care Options (SCO) program in Massachusetts, using data gathered from focus groups and individual interviews. The first report, which detailed the results of the focus groups, was submitted to the Executive Office of Elder Affairs in December 2006. This report presents the findings of individual, in-person interviews conducted with 82 SCO enrollees in three languages (English, Spanish and Portuguese).
The original goals of the SCO Evaluation Phase II were:

1. to evaluate the health care experience of nursing home certifiable SCO enrollees in a consistent, member-centered and culturally sensitive method; and

2. to compare the health care experiences of nursing home certifiable SCO enrollees to enrollees in two other Massachusetts programs that serve similar elders (the Program of All-inclusive Care for the Elderly and the elder Home and Community Based waiver program[1].

The SCO program, an integrated health service delivery model for dually-eligible and Medicaid-only elders, is the result of a partnership between the Centers for Medicare and Medicaid Services (CMS) and MassHealth (the Massachusetts Medicaid program). The SCO program provides a comprehensive package of health care and social support services to help elders maintain health and stay in their own homes. Features of SCO include: coordination and delivery of all acute medical, preventative, behavioral health and long term care services; access to community supports through a partnership with the Aging Services Access Points (ASAPs); and 24 hours a day/ 7 days a week access to a Nurse Case Manager. Three contractors in Massachusetts implement the SCO program: Commonwealth Care Alliance (CCA), Senior Whole Health (SWH) and Evercare. Each of the SCO contractors (SCOs) has its own provider network and service areas within the state. A hallmark of the SCO program is intensive recruitment of enrollees from underserved, culturally diverse neighborhoods.

[1] As noted in the interim Report of Focus Groups, we were not able to achieve this second goal of comparing across types of programs because we experienced unanticipated limitations to the sample size for the SCO group. Therefore, comparisons could not be made across the three program groups. The study design was later adjusted to address this limitation for the individual interviews; more detail on the entire study design is provided in the Methodology section of this report.

Methodology

The Interview Guide was developed in collaboration with a project advisory group consisting of members from CHPR, the University of Massachusetts Medical School and the University of Connecticut Center on Aging. The Interview Guide consisted of six domains:

- Part I: General understanding of the SCO program
- Part II: Access to services and providers and knowledge of benefits
- Part III: Relationship with SCO program staff and involvement in care
- Part IV: Barrier to receiving services
- Part V: Complaints about services or unmet needs
- Part VI: Overall satisfaction/dissatisfaction with the SCO program

A list of 1,202 nursing home certifiable SCO members who had been enrolled in the program for at least six months was obtained from the MassHealth Office of Long Term Care. Reflecting the culturally diverse nature of the SCO population, more than half of these individuals did not speak English. Our study design called for interviews in two other languages besides English; we determined that Spanish and Portuguese, in addition to English, would capture about 80% of the individuals on the eligible list. From the 969 English-, Spanish-, and Portuguese-speaking enrollees on the eligibility list, we randomly selected 296 names to receive an invitation to participate in an interview.

Recruitment letters and follow-up phone calls were made to these individuals. The final sample size was 82 (41 English-speaking, 26 Spanish-speaking and 15 Portuguese-speaking persons). In-person interviews were conducted with each of these 82 enrollees. The Central Massachusetts Area Health Education Center (CMAHEC) collaborated with CHPR to provide translation services for interview materials and experienced Spanish- and Portuguese-speaking interviewers.

Data Analysis

Qualitative analysis was used to identify themes related to member experience with the SCO program. Quantifiable data from the interviews were also analyzed for further descriptive and inferential analysis.

Key Findings

Descriptively, this sample of 82 SCO enrollees had a median age of 79 years. The sample was predominantly female, had an eighth grade education or less, was widowed and lived alone. On average, their self-reported health was “fair.” Major themes regarding member experience that emerged from the analysis were as follows:

1. General understanding of SCO program
    - Most respondents were able to describe the SCO program as their "health care" or "health insurance" plan, indicating that they understand the purpose of the program.
    - Most reported first hearing about the program from a health care provider or from the aging services system.

2. Knowledge of SCO benefits and use of services
    - Self-reported service use indicated nearly 70% of SCO enrollees used at least 3 – 4 services.
    - Non-English CCA members reported using more services than non-English speaking SWH or Evercare members.
    - Only 6.2% of respondents had availed themselves of the 24/7 SCO contact feature.
    - Nearly half of respondents had called 911 or used their Lifeline since becoming enrolled in SCO.

3. Access to and relationship with SCO program staff
    - Many respondents could not identify by name their SCO contact, although it is not clear whether this lack of clarity about a staff contact prevented members from getting the services they needed.
    - Almost all respondents said they trusted the SCO to help them get the help they needed.
    - About half of respondents had a family member involved in making decisions about SCO program services.

4. Barriers to services
    - Most respondents (84%) said they felt they were getting all the services they needed.
    - Nine respondents cited barriers to services, including language differences and difficulty contacting the SCO or their physician.
    - Some respondents were unclear about the range of services available and thus could not answer whether they were getting all services they needed.

5. Concerns and complaints
    - Six out of 82 respondents reported they had been denied a service they asked for. These denied services were: additional hours of personal care assistance, greater access to a doctor, and equipment such as an electric wheelchair.
    - No respondents reported feeling uncomfortable talking to SCO staff about problems with services.

6. Overall satisfaction/dissatisfaction
    - While most respondents were very general in reporting what they liked about the SCO program ("I like that they take good care of me"), specific features of the program that some cited as particularly liked included: free medication, help to family caregivers and a specific person who had been especially helpful to them.
    - Thirteen respondents named something specific they did not like about the SCO program, including wait time for doctor appointments, lack of choice in providers, problems contacting the SCO and specific problems with certain providers, such as transportation.

Conclusions and Recommendations

For the most part, SCO enrollees in our sample were quite happy with the program, the services they received and the personnel who provided them. Aspects of the SCO program that might benefit from follow-up included: clarifying points of contact with the SCO program so that members know who to call if they have a question; increasing awareness of the 24/7 nature of the SCO program; and addressing some perceived barriers to services. Further research could center on study of the "community well" SCO population, an exploration of family caregiver experiences with the program, and further study of non-English-speaking SCO member experiences.

II. Introduction

This report serves as the second of two reports that present findings from Phase II of a process evaluation of member experiences with the Massachusetts Senior Care Options (SCO) program.[2] The goal of Phase II of the project was to learn about enrollees' experiences in the program, using data gathered through focus groups and individual interviews. In December 2006, an interim report of focus groups was submitted which detailed findings from a focus group held with members of the SCO program as well as focus groups with two other comparison programs. This interim report details findings gathered from individual interviews with 82 SCO enrollees. A summary Final Report that captures the high level elements from each interim report will be submitted as the third deliverable of the SCO Evaluation Phase II.

The original goals of the Senior Care Options Evaluation Phase II were:

1. to evaluate the health care experience of nursing home certifiable SCO enrollees using a consistent, member-centered and culturally sensitive method; and

2. to compare the health care experiences of nursing home certifiable SCO enrollees to enrollees in the Program of All-inclusive Care for the Elderly (PACE), and enrollees in the elder Home and Community Based waiver program (HCBS).[3]

This report of individual interviews first discusses the background, goals and objectives of the Senior Care Options program. Second, it details the study methodology for developing the interview guide, identifying and recruiting participants, conducting the interviews, and analyzing the data. Third, it presents study findings. Finally, it provides recommendations for further study of the Senior Care Options program.

III. Background

The Senior Care Options (SCO) program is an integrated health program for dually-eligible and MassHealth-only elders in Massachusetts. The program is the result of a partnership between the Centers for Medicare and Medicaid Services (CMS) and MassHealth (the Massachusetts Medicaid program). The purpose of the SCO program is to provide a comprehensive package of health care and

[2] Our Report on Phase I of the project, submitted in September 2005, presented findings related to enrollment and disenrollment in the SCO program, using information from a literature review, interviews with key informants and an analysis of enrollment and disenrollment data.

[3] As noted in the interim Report of Focus Groups, we were not able to achieve this second goal of comparing across types of programs because we experienced unanticipated limitations to the sample size for the SCO group. Therefore, comparisons could not be made across the three program groups. The study design was later adjusted to address this limitation for the individual interviews; more detail on the entire study design is provided in the Methodology section below.

social support services to help elders maintain health and stay in their own homes. The SCO program features highly individualized care plans with features including:

- Coordination and delivery of all acute medical, preventative, behavioral health and long term care services
- Flexible, creative benefits not routinely available in traditional plans
- Access to a full range of community supports through a geriatric services support coordinator, in collaboration with Aging Services Access Points
- 24/7 access to a Nurse Case Manager
- Part D covered with no deductibles or co-pays
- Centralized enrollee records
- Accountability to both CMS and the state of MA

Three contractors in Massachusetts implement the SCO program, delivering and coordinating services through a comprehensive network of health and social service providers. Each SCO contractor (referenced hereafter as "SCO") employs a slightly different recruitment and service delivery model although the key program features noted above are the same across all three contractors. Recruitment strategies for the three SCOs include grassroots recruitment at community centers, senior housing, primary care physician offices, and other community-based efforts.

Enrollees are free to choose any of the three SCOs; however, availability of some of the programs is geographically limited to certain areas of the state. Commonwealth Care Alliance (CCA) recruits its members through several large primary care groups and Community Health Centers. CCA's primary service area is Greater Boston, the North Shore and the Springfield area. Senior Whole Health (SWH) is an independent healthcare network that includes several hospitals in Eastern, Central and Southeastern Massachusetts. Its service area is primarily Boston, Worcester, and Southeastern MA. Evercare, a subsidiary of United Health Care, has a broader service area than the other two SCOs and includes metro Boston, the North Shore, Merrimac Valley, Springfield, and central MA, including Worcester.

The SCOs are continually expanding their provider networks and service areas within the state. A hallmark of the SCO program is intensive recruitment of enrollees from underserved, culturally diverse neighborhoods. The individual interviews that are the subject of this report were intended to elicit information regarding member experiences for this very diverse group of frail elders with multiple health and social service needs.

IV. Methodology

A brief recapitulation of the methodology for the focus groups is necessary before proceeding to a discussion of the individual interviews (see Report of Focus Groups for more detailed information). The focus group results were intended to serve as indicators of topics to explore in the interviews, and our experiences in defining eligibility criteria and developing recruitment strategies for the interviews were shaped by our early experience in arranging and conducting the focus groups.

The original study design called for 9 focus groups to be conducted with SCO enrollees (3 groups for each of the 3 SCOs). The purpose for this number of groups was twofold: 1) to acquire adequate data for analysis; and 2) to be able to compare the SCO groups with other similar state programs (the PACE and HCBS waiver programs). However, the exclusion criteria we established for the SCO focus groups limited the number of participants to such an extent that only one SCO focus group could be convened, consisting of only three members. This was primarily due to the large number of non-English speaking SCO members and to the large number of members who were judged by SCO staff to be incapable of participating in a focus group situation. As detailed in the Focus Groups report, we were able to successfully recruit and conduct three focus groups each for the PACE and Waiver groups, but the lack of representation for the SCO groups meant we were not able to compare findings from the focus groups across the three types of programs as we had originally planned.

In order to avoid the same problems with insufficient sample size with the individual interviews, we altered our eligibility and recruitment strategy for the interviews as detailed below. This study was originally approved by the UMass Medical School Institutional Review Board (Docket Number 11949). Amendments reflecting changes in the methodology were also approved by the IRB as the study progressed.

A. Eligibility, Identification and Selection of Participants

For the interviews, as with the focus groups, we received from the MassHealth Office of Long Term Care a list of SCO enrollees who met two key eligibility criteria. The first criterion was that members be enrolled at least 6 months in the program, in order for them to have sufficient experience with it.[4] The second criterion was that the members be nursing home certifiable, in order to be comparable to the focus groups. As previously noted, the reason we recruited only nursing home certifiable enrollees was because the original study design called for comparison across the PACE and Waiver programs, which include these types of clients. We ultimately were not able to make such a comparison

[4] With the focus groups, the time criterion was three months because at that point, the program was newer and had fewer long term members.

due to the low numbers in the SCO focus group. One change we would recommend for future research on the SCO program would be to include other types of enrollees, such as community-dwelling individuals who do not meet nursing home level of care. This recommendation is discussed in more depth later in this report.

The list of nursing home certifiable SCO members who had been enrolled for at least six months totaled 1,202 individuals at the time we received the list in February 2007. The list reflected the culturally diverse SCO population; more than half of the individuals on the list did not speak English. From this list, we next determined the spoken languages of these 1,202 SCO enrollees. Our study design called for interviewing individuals in two other languages besides English. Languages represented in the SCO population included Spanish, Portuguese, Russian, Haitian Creole, Cape Verdean Creole, Vietnamese and Chinese, as well as English. We determined that the two languages that would represent the most non-English speaking SCO enrollees were Spanish and Portuguese; recruiting from these two languages plus English enabled us to capture over 80% (969) of the individuals on the eligible list.

Thus the English-, Spanish- and Portuguese-speaking SCO enrollees who were nursing home certifiable and enrolled in the program for at least 6 months numbered 969 individuals. From this pool, we drew our sample for interviewing. We stratified the list into the 3 SCOs and by the three languages chosen for interviews. Based on this stratification, we then randomly selected names of 296 SCO members who were invited to participate in an interview. Table 1 details this sample selection process.

Table 1: Sample Selection of Eligible SCO Enrollees for Interviews

Eligible SCO Interview Sample				
SCO	**Spoken Language**			
	English	Portuguese	Spanish	Total
CCA	149	2	124	275
Evercare	160	19	96	275
SWH	236	139	44	419
TOTAL	545	160	264	969
Random Sample Sent Invitation Letters				
	English	Portuguese	Spanish	Total
CCA	40	0	40	80
Evercare	43	19	39	101
SWH	61	35	19	115
TOTAL	144	54	98	296

B. Recruitment of Participants

We mailed recruitment letters to 296 randomly selected enrollees, approximately four times as many enrollees as we needed in order to complete our target of 80 interviews. (Experience with the focus group recruitment showed that about one out of every 4 people we contacted resulted in a study participant.) We then followed up these letters with telephone calls to schedule interviews.

Recruitment phone calls and interviews were conducted in the primary language spoken by the SCO enrollee. The SCO project lead and a project associate made the calls to English-speaking enrollees. The project lead, a Masters level social worker, conducted all the English language interviews. Recruitment calls to Spanish- and Portuguese-speaking enrollees were made in the primary language of the enrollee by interviewers who were trained as medical interpreters and who also had experience working with elders in various health settings. These same individuals conducted the Spanish- and Portuguese-language interviews.

The Central Massachusetts Area Health Education Center (CMAHEC) hired the four Spanish- and Portuguese-speaking interviewers and handled payment issues. Before study recruitment began, all interviewers attended a 3-hour training session conducted jointly by CHPR and CMAHEC that familiarized interviewers with the Interview Guide, reviewed the study protocols, including informed consent procedures, and emphasized the challenges of conducting interviews with frail elders.

A total of 82 randomly selected eligible enrollees were ultimately scheduled for interviews. During the recruitment telephone call, we completed the final level of eligibility screening of potential participants. The following criteria meant the person would not be eligible for an interview:

- Could not hear well enough to understand the caller on the telephone.
- Could not understand the caller for what appeared to be cognitive reasons.

In addition to these criteria, many of the 296 randomly selected eligible enrollees who received a recruitment letter were not ultimately interviewed for a variety of reasons, such as individuals' inability to participate in an interview due to poor health or hospitalization, or our inability to contact with them via telephone (e.g., no answer, phone disconnected, moved). Further, we did not need to contact about one quarter (76) of these individuals because we achieved our target number of interviews before reaching their names on the list. (These are identified in Table 2 as "Reserve Interviewee Pool – Contact Not Required".) The final disposition for the 296 enrollees receiving letters, including those enrollees who were not interviewed, is listed in Table 2. We obtained a response rate of

37% based on the ratio of number of completed interviews (82) to number of people we contacted (or attempted to contact) by telephone (220).

Table 2: Final Disposition of Enrollees Contacted By Letter

Final Disposition	n	%
Completed Interview	82	27.7
Reserve Interviewee Pool - Contact Not Required	76	25.7
Unable To Contact	60	20.3
Enrollee Unable To Complete	52	17.6
Enrollee Declined Interview	18	6.1
Excluded: Language	4	1.4
Moved	3	1.0
Deceased	1	0.3
Total	296	100.0

All interviews were conducted in the respondents' homes from July 30 through October 15, 2007. Informed Consent was obtained in writing from all respondents before the interview took place. Interviews were tape recorded (except in cases where the participant did not want to be recorded) and interviewers took extensive notes. Interviews lasted an average of 45 minutes. At the conclusion of the interview, respondents were paid a $50 cash stipend in appreciation for study participation. Notes from each interview were carefully reviewed, and information provided on the tape that was not present in interview notes was recorded on the interview form. Interviews were not transcribed because of the prohibitive cost.

In the case of the foreign language interviews, the interviewers tape-recorded the interviews, took detailed notes, and then typed up a detailed summary of each interview in English. The typed interview summaries were then provided to CHPR for data analysis.

C. Data Collection Tool

The Interview Guide for the individual interviews was developed in collaboration with a project advisory group consisting of members from CHPR, the University of Massachusetts Medical School and the Center on Aging at the University of Connecticut. The Interview Guide incorporates the question domains developed for the focus groups, as well as some additional questions that, through analysis of the focus groups, emerged as themes to be explored in the interviews. A copy of the Interview Guide is provided as Appendix A.

The Interview Guide consisted of six parts, as follows:

- Part I: General understanding of SCO program and how respondent became enrolled
- Part II: Access to services and providers, and knowledge of range of benefits
- Part III: Relationship with SCO program staff, and involvement in own care
- Part IV: Barriers to receiving services
- Part V: Complaints about services or unmet needs
- Part VI: Overall satisfaction/dissatisfaction with the program

D. Data Analysis

Data obtained from SCO member interviews were collected and analyzed using both qualitative and (where possible) quantitative analyses. The primary purpose of the interviews was to describe the variety of SCO member experiences. For this qualitative description and analysis, interview responses and accompanying interviewer notes were entered into a data file allowing responses to be sorted in a variety of ways to extract recurring themes. We used an established approach developed for qualitative analysis (LaPelle, 2004). This process involves using content analysis and thematic analysis to extract emergent categories of responses, and to identify and count the frequency of instances of categorically-consistent responses and reoccurring themes within domains established in this case by the interview question topics.

Quantifiable data from the interviews were also entered into a data analysis package (SPSS, version 15.0) for further descriptive and inferential analysis. From these data, we were able to describe both demographic characteristics of the interview respondents, and quantifiable data from post-coding of categorical responses of member experiences. The findings from both the qualitative and quantitative analyses are described in detail in the next section of the report.

V. Findings

This section reports findings from the 82 interviews conducted with SCO enrollees in three languages. The findings are reported in two sections: a) description of study participant characteristics; and b) major themes regarding member experience with the program. As noted above, part of this analysis included post-coding categorical data to reflect quantifiable aspects of member experiences.

A. Description of Study Participants

The descriptive characteristics of the 82 SCO members interviewed are presented in this section. Table 3 details the number of interviews conducted for each SCO and in each language. Half of all interviewees spoke English as their

primary language. The remaining half was comprised of Spanish-speaking (32%) and Portuguese-speaking (18%) individuals.

Table 3: Final SCO Enrollee Interviews by Language

Final Enrollee Interviews				
	English	Portuguese	Spanish	Total
CCA	11	0	12	23
Evercare	13	5	9	27
SWH	17	10	5	32
TOTAL	41 (50%)	15 (18%)	26 (32%)	82

Where possible when discussing study findings below, member characteristics were compared both across SCO providers and spoken language. For comparisons across language, Spanish- and Portuguese-speaking members were combined into a single group (Non-English speaking) due to sample size. Statistical tests of continuous variables were conducted using two-way analysis of variance (ANOVA); categorized variables were analyzed using the Chi-square test ($X^{2)}$. There were no reliable differences by provider or language unless otherwise noted.

Table 4 details age and gender of study respondents. The average age of members at interview was 78.2 years (*SD* = 7.58). Approximately two-thirds of the sample was between the ages of 70 and 85 years. Overall, 83% of the sample was female.

Table 4: Age and Gender of Sample

Age (median = 78 yrs)	**n**	**%**
< 70	12	15.0
70 - 74	15	18.8
75 - 79	17	21.3
80 - 84	22	27.5
85 - 89	8	10.0
> 89	6	7.5
Total	80	100.0
Gender	**n**	**%**
Female	68	82.9
Male	14	17.1
Total	82	100.0

Table 5 details education levels of the respondents. More than half of the interviewees reported having an eighth grade education or less. About 30% of the sample had completed high school or more. Education level differed between English-speaking and non-English-speaking enrollees, such that more English-speaking enrollees reported having completed some high school or above compared with non-English-speaking enrollees, X^2 (1*df*) = 28.94, $p < .001$.

Table 5: Education Level of Sample: English vs. Non-English

Education	English		Non-English		All	
	n	%	n	%	n	%
8th grade or less	12	29.3	36	87.8	48	58.5
Some high school	5	12.2	5	12.2	10	12.2
Completed high school/GED	10	24.4	0	0.0	10	12.2
Some college	7	17.1	0	0.0	7	8.5
Four year college or more	7	17.1	0	0.0	7	8.5
Total	41	100.0	41	100.0	82	100.0

Marital status and living arrangement are detailed in Table 6. Not surprisingly, slightly more than one-half (56.1%) of interviewees were widowed.
Nearly two-thirds of interviewees (63.4%) reported they lived alone. However, it was often the case that members who "lived alone" actually resided in individual apartments or room units within a collective community residential setting, such as assisted living residences or faith-based retirement community settings.

Table 6: Marital Status and Living Arrangement

Marital Status:	n	%
Widowed	46	56.1
Single	18	22.2
Married	9	11.1
Divorced / Separated	8	9.9
Total	81	99.3
Living Arrangement:	**n**	**%**
By yourself	52	63.4
With adult child	13	15.9
With spouse	11	13.4
With other relative(s)	4	4.9
With others (unrelated)	1	1.2
Total	81	98.8

Note: Totals for individual table sections may sum to < 82 because of sporadic missing data.

Self-reported health status is detailed in Table 7. On average, enrollees' reported health was "fair" (*M* = 2.10, SD = 1.05). Over 70% of people interviewed reported their current state of health as either "fair" or "poor". English-speaking members reported their health as being significantly better (between "fair" and "good"; *M* = 2.49, *SD* = 1.14) than did non-English-speaking members (between "poor" and "fair"; *M* = 1.71, *SD* = .78), *F*(1, 76) = 13.12, *p* = .001. This difference remained when age, gender, and education were included as statistical covariates[5].

Table 7: Self-Reported Health

Coding	Status Of Health (self-reported)	English		Non-English		All	
		n	%	n	%	n	%
5	Excellent	2	4.9	0	0.0	2	2.4
4	Very good	6	14.6	2	4.9	8	9.8
3	Good	11	26.8	2	4.9	13	15.9
2	Fair	13	31.7	19	46.3	32	39.0
1	Poor	9	22.0	18	43.9	27	32.9
	Total	41	100.0	41	100.0	82	100.0

B. Member Experiences with the SCO Program

This section of the report details the themes that emerged from the qualitative data. In addition, responses to some questions that had originally been intended for qualitative analysis lent themselves to post-coding into categorical formats useful for quantitative analysis. For example, a number of interview questions elicited somewhat closed-ended, yes/no responses, despite our attempts to prompt further elaboration. Useful categories of responses emerged in many such instances.

The following discussion of findings is organized by question/theme as they were asked in the interview guide.

1. General understanding of SCO program and how respondents became enrolled

The first two questions in the Interview Guide asked respondents how they would describe the program in general and how they originally became a member. The goal of these questions was to discover whether enrollees generally knew what

[5] The estimated marginal means for each language group after statistically controlling for these covariates were: English-speakers, *M* = 2.50; non-English-Speakers, *M* = 1.70)

the "SCO program" was and were able to relate how they ended up enrolling. Nearly all (80) respondents provided a response to the question asking them to describe the SCO program. Of these, 21 described it specifically as their *"health care"* or *"health insurance"* plan. Others described the program in more functional terms, e.g.: *"They provide transportation to the doctor. The nurse comes here. . . A helper comes to stay with me. . ."* (R 052, Spanish). A few respondents responded to the question in terms that indicated how much they liked the program, but this still indicates they generally knew what the program was about, e.g.*: "Very, very good. Better than MassHealth."* (R 166, Portuguese). One respondent did not recognize the name of the SCO when the interviewer referred to the program, but did indicate understanding of the services she received from them (R 019, English).

Although there were a variety of ways in which SCO members recalled initially becoming aware of the SCO program, over half reported learning of the program either through their doctor or nurse, or because someone from the SCO or aging services system visited to tell them about the program. (This sort of grassroots recruitment is a hallmark of the SCO program.) About 12% reported learning of the program from someone they knew, such as a family member or friend. Table 8 details the ways in which respondents said they heard about the SCO program.

Table 8: Respondent's Introduction to SCO Program

How Respondent Found Out About SCO Program	n	%
Doctor or Nurse	25	30.5
Someone Visited (SCO, Elder Services, etc)	23	28.0
A Family Member	6	7.3
MassHealth	6	7.3
Don't Know	6	7.3
No Response	6	7.3
Someone I Know (Not Family)	4	4.9
Other	4	4.9
Advertisement	2	2.5
Total	82	100.0

2. Knowledge of range of SCO benefits and use of emergency services

Part II of the interview guide focused on respondents' knowledge of the range of services they already received or could obtain, and also whether they knew that they could contact SCO staff 24 hours a day, seven days a week, rather than dialing 911 in a situation that might not be a true emergency.

First, we asked members what services they were currently receiving from the SCO program and then followed up with questions regarding continuity and cooperation of people providing services. Nearly all respondents listed a number of services they said they received, as detailed in Table 9 below. Over three-quarters of members reported using homemaker and medication services, and over half also reported using transportation, visiting nurse, meals, personal care, and dental services. Nearly 70% of members reported currently using at least 3 to 4 of the eight services. Only seven respondents said they did not receive any services at all, either because they said they didn't need the help or because family members provided whatever they needed. We found that non-English-speaking CCA members reported using more services than did non-English speaking members at SWH or Evercare.

This service utilization data must be interpreted with caution however, and we report it for descriptive purposes only. Interviewers did not have SCO data to verify individual interviewee service utilization, and the reported data were acquired based on follow-up probes at the discretion of the interviewers. Because clients were not consistently and systematically asked if they were currently using each of the eight services, sporadic or even systematic missing data limited the usefulness of this measure, and statistical tests were therefore not considered appropriate with these data. We cannot rule out that collection methods may have differed across interviewers, and thus across language.

Table 9: Self-reported Service Utilization

Services (number and % reporting use)*	n	%
Homemaker	60	76.9
Medications (delivery or other assistance)	53	75.7
Transportation	41	60.3
Visiting Nurse	37	62.7
Meals	31	60.8
Dental Care	27	55.1
Personal Care	25	58.1
Doctor Visits	7	16.7

Number Of Above Services Being Utilized	n	%
No Services	7	8.6
1 - 2 Services	19	23.5
3 - 4 Services	33	40.7
5 - 6 Services	20	24.7
7 - 8 Services	2	2.5
Total	81	100.0

Note: Totals for individual table sections may sum to < 82 because of sporadic missing data.
*Individual enrollees may have been using services from more than one category.

For respondents who answered the follow-up questions regarding consistency and cooperation, almost all of them indicated that the same person comes every week, that they know ahead of time who is coming, and that the person does what they want them to do.

Two questions probed whether respondents had used traditional emergency services (e.g., 911, Lifeline phone alert) while members of SCO. The first question asked: *"Since you have been in [SCO], did you ever have a medical emergency where you need to call 911 or (use your Lifeline button - if you have one)?"*

Nearly half of the respondents (47%) who answered the question said they had dialed 911 or used their Lifeline since they had become enrolled in the SCO program. The second question asked members: "*Since you have been in [SCO], did you ever call [SCO] on weekends or evenings?"* A very small number (5) of individuals responded that they had called the SCO on an evening or weekend about an urgent matter, with several reporting that they did not know that this was an option. Since a key feature of the SCO program is 24/7 response availability for members, it is important to note that most members have not availed themselves of this option. It is not possible to know from the data whether this is because they have not needed the 24/7 access, or just don't know about its availability. Table 10 shows use of emergency and urgent services by respondents

Table 10: Emergency and Urgent Service Use

Emergency or Urgent Service Use	n	%
Have Made Emergency Calls (to 911 or Lifeline)	38	46.3
Have Made Evening or Weekend Calls to SCO	5	6.1

Note: Totals for individual table sections may sum to < 82 because of sporadic missing data.

3. Access to and relationship with SCO program staff, and involvement in decision-making about care

Part III of the Interview Guide explored members' experiences and interactions with SCO program staff. One key question we asked was: *"Who is the person at the SCO that you turn to first when you want to ask about your services or things you need?"* We wanted to know whether SCO enrollees knew whom to call at the SCO if they had a question or concern. Most respondents (71 out of 82) provided a first and/or last name of someone at the SCO whom they said they contacted when they had questions. (The other 11 were not able to provide any name at all, either because they could not recall the name at the time of the interview or did not know it.) We then sought to confirm with each SCO whether the names that members provided us were, in fact, people working for the SCO. Of the 71 respondents who provided us with the name of someone they contacted when they had questions, we were able to confirm that 41 of these

names were actual SCO staff. For the other 30 names respondents gave us, it is not possible to know who these "SCO contacts" really were. An important feature of the SCO program is formalized collaboration with the Aging Services Access Points (ASAPs) who provide an array of services to SCO enrollees. With that fact in mind, it is quite possible that the names that were not verified as "SCO staff" were instead ASAP staff, such as case manager or home health aides. Since most respondents felt they were getting the services they needed, perhaps the question of whether or not they know who to contact (i.e., the name of their "SCO contact") is less important than whether they know how to contact the SCO when necessary. Nevertheless, it should be noted that some respondents could confidently identify someone they would call if they had a question or concern about their SCO services, while others could not.

Probe questions for Part III centered on whether the respondent's preferences were considered in decisions around help and services needed and whether anyone from the SCO talked to them about available services and asked what they needed. For the most part, respondents felt the SCO had involved them in decisions about services and listened to their preferences. Typical of the mostly positive responses, one respondent said:

> "*Yes, I'm involved in choosing the best services for me. Everyone is very kind. Very often they ask if I need more services. . .*" (R 165, Portuguese).

Part III also asked two questions specifically designed to explore whether the respondent trusted the SCO to answer questions, get them the help they needed, and, in general to "be on their side." All 77 of the people who responded to this question said they did indeed trust the SCO to listen to them and help them get what they needed.[6]

Typical of responses to the question about trust are the following:

> "*With all my heart.*" (R 028, English).
>
> "*They don't do anything behind your back – very honest."* (R 134, English).
> "*Yes, they listen, they show respect, they care.*" (R 169, Portuguese).

One respondent, noting the importance of understanding her language, said: *"I feel very comfortable with them; besides, they speak my dialect."* (R 290, Portuguese).

The final question in Part III asked: "*Is anyone in your family involved in deciding about or working with you on the services you get from the SCO?*" Of 79 SCO

[6] The "trust" question was included at the request of a colleague at UMass Medical School whose research has focused on the patient/physician relationship, including aspects of trust. The wording of the question we used in our interview guide came directly from a scale developed by Dugan, Trachtenburg and Hall (2005).

members responding, 47 said they had a family member who was involved in helping make decisions related to their SCO plan. In one case, the respondent noted that the SCO program pays for a family member to provide care:

> "*They pay for my daughter to take care of me. She comes two and a half hours in the morning every day, Monday through Sunday. She does everything that I need her to do.*" (R 247, Spanish).

4. Barriers to receiving services

Part IV explored possible barriers that SCO enrollees may have encountered in getting the services they needed (such as language barriers, rules that limit services, or staff who might have been difficult). The questions were: "*Do you think you are getting all the services you need from the SCO?*" and "*Is there anything keeping you from getting the services you need from the SCO?*"

Eighty four percent of respondents said they felt they were getting all the services they needed from the SCO. Nine respondents said they had encountered barriers to services. The barriers noted were: language differences with program staff; difficulty contacting the SCO; and difficulty accessing their doctor. Examples included:

> "*They are hard to reach.*" (R 211, English).

> "*When I go to the doctor – she's Indian - she is hard to understand. But my care manager interprets.*" (R 225, English).

Responses of those who felt they were getting everything they needed were generally very positive:

> "*They're perfect. Couldn't be more perfect. . .*" (R 028, English).

However, others cited specific needs that were not yet being met by the SCO:

> "*I want a scooter and am working on that.*" (R 012, English).

> "*I need someone for more hours during the day. We have to pay for someone to come the other hours [that SCO services don't cover]. I can't be alone. . .*" (R 052, Spanish).

A few respondents, when thinking about whether they felt if they were getting all the services they needed found this difficult because of a lack of awareness of what might be available:

> "*I don't know the list of services that are available. I don't know what I'm missing because I don't know what is available.*" (R 207, English).

5. Concerns and complaints about services and unmet needs

Part V of the Interview Guide focused on member experience when they had a problem or concern about their services. We wanted to know what happened when SCO members had a problem or concern about their services, how comfortable they were with voicing complaints to their care manager, and whether there had ever been a situation where the person had been denied a service they asked for. Six respondents said they had been denied a service they had asked for. Services that respondents reported were denied to them included: additional hours of PCA, greater access to doctor, an electric wheelchair, a walker with wheels, transportation, and support socks. No respondents reported feeling uncomfortable talking to SCO staff about problems with services; for the most part this was not applicable because the majority of, respondents had no complaints.

6. Overall satisfaction/dissatisfaction with the SCO program

The last part of the Interview Guide elicited responses regarding overall quality and satisfaction with the program. For the question: "*What do you really like about the SCO program?*" 78 people responded in some way. From these, several specific categories emerged. About half the respondents (41) responded to this question in a very general way, noting how much they liked the program, but not citing specific reasons. Typical of such responses were:

> "*I like that they take good care of me.*" (R 046, Spanish)
>
> "*I can live my life the way I want.*" (R 015, English)
>
> "*I like everything!*" (R 165, Portuguese).

In some cases, respondents were more specific about the things they liked. Twelve individuals cited the free medication they received as being the thing they liked most. Twelve responded by naming a specific person from the SCO program who had been helpful to them (e.g., nurse, homemaker or doctor). Two respondents remarked how helpful the program had been to their family caregivers. One respondent's daughter, who was present for the interview, commented:

> "*It's a great service. I wouldn't be able to continue to care for her at home without the SCO program.*" (R 030, English).

Said another respondent:

> "*It's an excellent program. Very, very good. My daughter recommends the program to everybody.*" (R 054, Spanish).

Three respondents said the thing they liked best was that the program saved them money (or was free). Two respondents cited the dental coverage as their favorite feature.

Respondents were then asked: "*What don't you like about the SCO program?*" Only 13 respondents named something they did not like about the SCO program. Dislikes included:

- Wait time for doctor appointments or at doctor's office (3)
- Low pay for personal care attendants or other help (3)
- Lack of choice of dentist (1)
- Lack of ability to deal with doctors directly (1)
- Hard to reach (1)
- Problem with transportation (1)
- Problem with medication (confused about bubble pack) (1)
- Problem with delivery of supplies (1)
- "*They're a bunch of snoops.*" (1)

The final interview question was: "*Is there anything you would change about the SCO program if you could?*" Ten respondents identified something they would change; three of these had already mentioned the same concern in Question 17 (what they don't like). For the seven others who responded to this question, changes they would make were:

- More transportation available (to doctor, hairdresser, stores) (3)
- More doctors or dentists to choose from on the plan (2)
- Someone to run errands for them (1)
- Different person for home care (didn't like current worker) (1)

C. Study Limitations

As noted above, the study was focused on nursing home certifiable SCO members. Therefore the sample did not reflect the variety of functional levels of the SCO population as a whole. Consequently, many in our sample may have been more limited in their ability to fully comprehend the SCO program and communicate a clear understanding of their relationship to the program and their experiences with it in much detail or depth.

Responses to interview questions were not as rich as we had anticipated. It was anticipated that most interview responses would be more open-ended, lending themselves to more extensive qualitative analysis. In an effort to make the questions easier for these elders to respond to, many question formats were relatively close-ended and thus elicited only short answers, even when prompts were used. Responses tended to be very brief, often only "yes" or "no", and it was difficult for members to elaborate on their experiences, even with extensive

prompting. Because these open-ended responses were so brief, extensive qualitative analysis was not possible.

There were many missing data points because not all interviewees answered all questions. This limited our ability to analyze and interpret these non-responses in relation to responses from other members.

Although some member experience data yielded categorical (yes - no) responses allowing us to post-code responses categorically for analysis, these analyses must be interpreted with caution. Because these questions were not originally designed to elicit quantitative data and responses were not obtained from all interviewed members, these analyses were post-hoc and may not be representative of the entire sample.

A comparison of the respondents in this study to the full population of SCO enrollees and to the MassHealth elder population would have enriched our data analysis. Unfortunately, it was not possible to obtain this type of comparison data for the current study. Thus it is difficult to generalize the findings from our small SCO sample.

VI. Conclusions and Recommendations

A. Conclusions

Findings from 82 interviews about member experience with the SCO program were, for the most part, very positive. Most SCO enrollees in our sample were quite happy with the program, the services they received, and the personnel who provided them. Typical comments were:

> "*The program for me is fantastic. They help me with everything*." (R 053, Spanish).
>
> "*Very kind people; caring all the time*." (R 167, Portuguese).

Aspects of the SCO program that respondents particularly liked were free medications and SCO personnel who were especially helpful. One respondent said she liked the dental care the best (however, others cited poor access to dental care as their only complaint with the program).

The fact that every respondent who answered the "trust" question trusted the SCO to provide needed services and listen to their preferences is also a very positive indication of the solid nature of the relationship of SCO program with its clients. The majority of respondents (64) said they were getting all the services they needed, hence among respondents this is another indication that the program is fulfilling its objective of providing a comprehensive package of services to its members. However, these reports about met needs may be limited

by the degree to which members are aware of what services are available, and how to request such services.

Several issues did emerge that indicate the need for some follow up in order to clarify or correct the few problems that were mentioned. First, some respondents did not know whom to contact at the SCO if they had a question or concern about their services. It may be helpful to members if the SCOs were to reinforce their contact procedures with clients periodically to ensure that SCO enrollees understand how to contact the SCO if there is a problem. Since members report that from their perspective they are getting needed services, knowledge about how to make contact may be more crucial than whether or not members can recall the name of a specific individual.

The number of respondents who had called the SCO on evenings or weekends was very low (6.1%), and a few respondents indicated they didn't know about the 24/7 access. This is another area that may bear reinforcing by the SCOs, in order that clients can avail themselves of this very useful aspect of the program. Greater awareness of the 24/7 service might potentially also decrease the number of 911 calls made by members to the extent that any of these calls may have been non-emergency in nature.

While only 11% of respondents noted barriers to receiving services, these would be important to investigate further. Despite the fact that the SCOs are supposed to be communicating with members in their own languages, four respondents indicated problems with a language barrier. One respondent commented:

> "*The nurse only speaks a little bit of Spanish so she comes when my granddaughter is here.*" (R073, Spanish).

Another respondent said:

> "*My care manager does not speak Portuguese, she brings an interpreter. But the interpreter is from Brazil, therefore I do not understand her well.*" (R 166, Portuguese).

Some English-speaking respondents also noted the reverse: that their homemakers or other SCO personnel did not speak enough English to communicate with them effectively.

Six respondents reported being denied services they felt they needed. These perceived denials of service included additional PCA hours, greater access to their doctor, and equipment such as an electric wheelchair, walker or support socks, or transportation. While these numbers were small, they reflect perceived unmet needs for services, so it may be important that clients be well-informed of the full range of services offered, and the reasons why some desired services may not be covered through the relationship with the SCO.

Thirteen respondents said they did not like some aspects of the SCO program. The dislikes were varied and included wait time at doctor's offices, low pay for personal care attendants, lack of choice in medical providers, difficulty contacting the program, and feeling that the program was overly intrusive.

B. Recommendations for Future Research

The following are recommendations for further evaluation of the SCO program:

1. Exploration of experiences of members who are "community-well". The limitations of our sample, which was confined to nursing home certifiable members who represent only about half of the SCO population, meant that our respondents were probably more frail and more functionally impaired than their community-well counterparts, and thus our sample was not representative of the entire SCO population. For study of the non-frail SCO population, we would develop a new Interview Guide with questions that would address the different functional status and needs of this group.

2. Exploration of the experiences of family members. A number of family members were present during interviews. Others responded to recruitment phone calls and cited some of their thoughts. Further study of how the SCO program affects family caregivers would be useful.

3. Further study of members speaking other languages would be helpful. We captured 80% of the nursing home certifiable SCO population with our sample of English, Spanish and Portuguese speaking members. However, a considerable number of enrollees speak other languages such as Russian and Haitian Creole and their views deserve to be captured as well.

4. A more systematic study of the ways in which diverse populations are served by the SCOs might be valuable. We noted some differences in member characteristics across language groups (e.g., self-reported health). The delivery of services to these populations, given the challenges of potential language barriers and other cultural factors, may be worthy of additional research to better understand the challenges and successes in serving these diverse SCO populations.

In conclusion, based on the findings from the 82 interviews, the Senior Care Options program is well-liked by most of its members, provides comprehensive and needed services and is generally well understood. Improvements could be made in clarifying SCO contact points, and in providing some services that members identified as still needed. Further research on SCO enrollees who are "community well", on family caregiver experiences, and on other non-English speaking members would be useful.

References

LaPelle, N. R. (2004). Simplifying qualitative data analysis using general purpose software tools. *Field Methods*, *16(1)*, 85-108.

Dugan, B., Trachtenberg, F. & Hall, M. (2005). Development of abbreviated measures to assess patient trust in a physician, a health insurer, and the medical profession. *BMC Health Services Research*, *5(64).*

Appendix A: Interview Guide

SCO Phase II: Member Experience
Individual Interview Guide

Thank you for agreeing to talk with me today about your experience with the Senior Care Options (SCO) program. My name is _____ and I am interviewing SCO members like you to find out how the program is working for you. I understand you get your health care from (Commonwealth Care Alliance, Evercare or Senior Whole Health), and that's what we will be talking about today.

Demographic Questions

1. What is your date of birth? _____

2. Gender (just fill out, don't ask them):

   _____ Female
   _____ Male

3. Is your marital status:

   _____ Married
   _____ Widowed
   _____ Divorced/separated
   _____ Single

4. How many years of education have you completed?

   _____ 8th grade or less
   _____Some high school
   _____Finished high school/GED
   _____Some college
   _____4 year college or more

5. Do you live:

   _____ By yourself
   _____With your spouse
   _____With your adult child
   _____ With other relatives
   _____ With others not related to you

6. In general, would you say your health is?

   _____ Excellent
   _____ Very good
   _____ Good
   _____ Fair
   _____ Poor

Part I: Introductory Questions (How they got started with the SCO program)

First, let's talk about how you got started with _____ (name of SCO).

1. Could you describe the _____ (SCO) program to me?
   Probe: If you were describing it to your friends, what would you say?

2. How did you end up becoming a member of _____ (SCO)?
   Probes:
   - What in particular interested you about _____ (SCO) when you first heard about it?
   - Was anyone in your family involved in signing you up for _____ (SCO)?

Part II: Access to Services, Continuity of Providers and Understanding of Benefits

Now let's talk about the services you are getting from _____(SCO).
(NOTE: Interviewer will have list of current services the individual is getting in order to probe as needed.)

3. What kinds of services are you getting from _____ (SCO)?
   Hopefully the participant will start to list the services he/she gets.
   Probe as appropriate for each service:
   - Does the same person come every week?
   - Do they tell you ahead of time who is coming?
   - Did they tell you how long you would be getting this service?
   - Does the person do what you want them to do?

If they don't volunteer list of services, probe:
- Does someone from _____ come in to help you around the house? What does s/he do for you?
- What do you do when you need transportation somewhere? Does _____ help you get to doctor appointments and other places you need to go?
- Does someone from _____help you get your medications?
- Do you receive dental care from _____?

(PART II Continued)

4. Since you've been in _____ (SCO), did you ever have a medical emergency where you needed to call 911 or (use your Lifeline button - if you have one)?

Probes:

- Can you tell me about a time when you called 911?
- What happened?

5. Since you have been in _____ (SCO), did you ever call _____ (SCO) on weekends or evenings?

Probes:

- Can you tell me about a time when you called _____ (SCO) on the weekend or at night?
- What happened?

Part III: Involvement in Care Planning, Access to and Relationship with Care Manager or Other Program Staff

Now let's talk about how decisions are made about the health care and services you get from _____ (SCO), and how you feel about the people from the program who work with you.

6. Who is the person at _____ that you turn to first when you want to ask about your services or things you need?

Probes:

- Does someone from _____ (SCO) talk to you about your health and what you need?
- Does anyone from _____ (SCO) tell you what help and services are available to you?
- Do you help decide what services you will get?
- Do you tell them things you like and don't like?
- Do they listen to that?

7. Do you trust _____ to answer your questions and get you the help you need?

8. Do you feel that people at _____ (SCO) are on your side?

Probes:

- That they listen to you
- That they respect you and your wishes

9. Is anyone in your family involved in deciding about or working with you on the services you get from _____ (SCO)?

Part IV: Barriers to Service

Now let's talk about anything that you feel might be stopping you from getting the services you need from _____ (SCO).

10. Do you think you are getting all the services you need from _____ (SCO)?

11. is there anything keeping you from getting the services you need from _____ (SCO)?

Probes:

- People at (name of SCO)
- Language barriers
- Rules that limit services (Are there services or things _____ doesn't provide or that aren't covered?)
- Do they explain why you can't have that service?

Part V: Concerns/Complaints/Problem Resolution/Unmet Needs

Now let's talk about what happens when you have a problem or a concern about the services you get from _____.

12. When you have a question or concern, what do you do?

Probes:

- Who do you talk to or call?
- Does someone get right back to you?
- Does someone fix the problem?
- Can you describe a time when this happened?

(NOTE: Interviewer will have name of care manager and other key names to prompt as needed.)

13. How do you feel about talking to _____ (your care manager) about any problems you might be having with your services?

14. Has there been a situation where you were told you couldn't have a service that you asked for?

Probe:

- What happened?

15. Have you ever had a concern or complaint about your services that you didn't tell _____ about?

Probes:

- Can you tell me more about that?
- What was it that you did not talk about?
- Why did you feel you couldn't talk about this?

Part VI: Overall Quality and Satisfaction with program

Now let's talk about how you feel about _____ (SCO) overall.

16. What do you really like about _____ (SCO)?

17. What don't you like about _____ (SCO)?

18. Is there anything you would change about _____ (SCO) if you could?

For more information, please contact
Faith Little at (508) 856-8529.

222 Maple Avenue, Higgins Building, Shrewsbury, MA 01545-2732
Tel. (508) 856-7857 Fax. (508) 856-4456
www.umassmed.edu/healthpolicy healthpolicy@umassmed.edu