Options for Expanding and Sustaining Outreach, Enrollment, Retention and Utilization Projects in Los Angeles County

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For LA Health Action

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The Context for This Report

The implementation of the Healthy Kids program in Los Angeles County was accompanied by funding from First 5 LA and The California Endowment, which was dedicated to outreach and enrollment activities. The program was intended to close gaps in children's health coverage by linking uninsured, eligible children and their families with an appropriate health insurance program for which they are eligible. New state funding for outreach and enrollment activities is designed to continue the expansion of health coverage to the state's remaining uninsured children. Los Angeles County will receive $6.1 million this fiscal year, plus nearly $10 million in each of two subsequent years. These are to be used for sustaining and expanding outreach, enrollment, retention and utilization (OERU) activities for Medi-Cal and Healthy Families. Retention, (keeping eligible children enrolled), and utilization assistance (assisting families in connecting with the health care system), will be increasingly important as Los Angeles moves towards full enrollment of children.

The purpose of this report is to provide recommendations for allocation of these resources. We begin by summarizing estimates of uninsured children by Service Planning Area (SPA) and health district. There are eight Service Planning Areas in Los Angeles County: SPA 1 is the Antelope Valley, SPA 2 the San Fernando Valley, SPA 3 the San Gabriel Valley, SPA 4 the Metro or Central Los Angeles area, SPA 5 West Los Angeles, SPA 6 South Los Angeles, SPA 7 East Los Angeles, and SPA 8 the South Bay including Long Beach.[1] Next, a comparison is made of the dollar investments by SPA, with estimates of the uninsured. We then observe actual enrollments by SPA in the context of the number of uninsured. Finally, we provide recommendations for distributing resources based on these analyses. The study also provides some ideas and a structure or starting point for discussing alternative funding strategies based on some lessons learned.

Uninsured children and families. The 2002-03 Los Angeles County Health Survey (LACHS) provides data on the number of uninsured in Los Angeles County.[2] More recent population-based estimates of the uninsured are currently pending, and a thorough analysis of SPA and health district estimates using the 2005 LACHS will show the effects of more recent outreach and enrollment activities in reducing the number of uninsured children. Until those data are available, we will use 2003 estimates and program data. In 2003, nearly 270,000 children ages 0-17 in Los Angeles County were uninsured, representing 9.5% of all children residing in the county.[3] SPAs 4 (Metro) and 6 (South) have the highest percentage of uninsured children, with approximately 14 and 18% respectively. The lowest is in SPA 3 (San Gabriel Valley) and SPA 5 (West), both with 7%. An analysis by health district shows that the South, Southeast, Central, Northeast and San Antonio Health Districts have the highest rate of uninsured children, while Glendale, San Fernando, Alhambra, Foothill, Bellflower have the lowest, with each having less than 5% uninsured. While these estimates are percentages of children

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[1] See Appendix A for a map of SPAs and health districts in Los Angeles County.
[2] See Appendix B for more information on LACHS 2002-03, as well as other data sources used in this report.
[3] Los Angeles County Department of Health Services, Public Health, Health Assessment and Epidemiology Unit, 2005

residing in these communities without coverage, the largest numbers of children without coverage are found in the West Valley (SPA 2) and San Antonio (SPA 6) Health Districts, each with an estimated 19,000 to 22,000 uninsured children. Several health districts had over 12,000 uninsured, including the Antelope Valley in SPA 1, East Valley in SPA 2, Pomona in SPA 3; Central, Northeast and Hollywood in SPA 4; all the health districts in SPA 6; and Long Beach and Torrance in SPA 8.

Funding for Outreach and Enrollment

Comparing distributions by SPA. In this section, we compare the level of funding for outreach and enrollment with estimates of uninsured children. This analysis provides some information that can lead to a more equitable or targeted enrollment campaign based on need. Exhibits 1 and 2 compare the distribution of uninsured children in Los Angeles County by SPA with the distribution of spending on OERU and child health insurance enrollments. Exhibit 2 is a graphical depiction of the data in Exhibit 1. Data on spending were derived from allocations to agencies and agency estimates of the percentage of resources they devote to activities in different health districts.[4]

Exhibit 1. A Comparison of Outreach and Enrollment Spending, and Healthy Kids Enrollments by SPA, 2003-2005

SPA	Uninsured Children[1]		OERU Spending[2]		Enrollments[3]	
	Number	Distribution	Number	Distribution	Number	Distribution
1 Antelope Valley	9,000	3%	$304,496	3%	684	2%
2 San Fernando Valley	49,000	18%	$847,757	10%	9021	21%
3 San Gabriel Valley	39,000	14%	$1,362,954	16%	6418	15%
4 Metro	37,000	14%	$1,789,843	21%	7146	17%
5 West	7,000	3%	$332,265	4%	758	2%
6 South	51,000	19%	$1,627,101	19%	7162	17%
7 East	38,000	14%	$1,489,462	17%	5442	13%
8 South Bay	41,000	15%	$951,401	11%	5782	14%
Total	270,000	100%	$8,705,279	100%	42413	100%

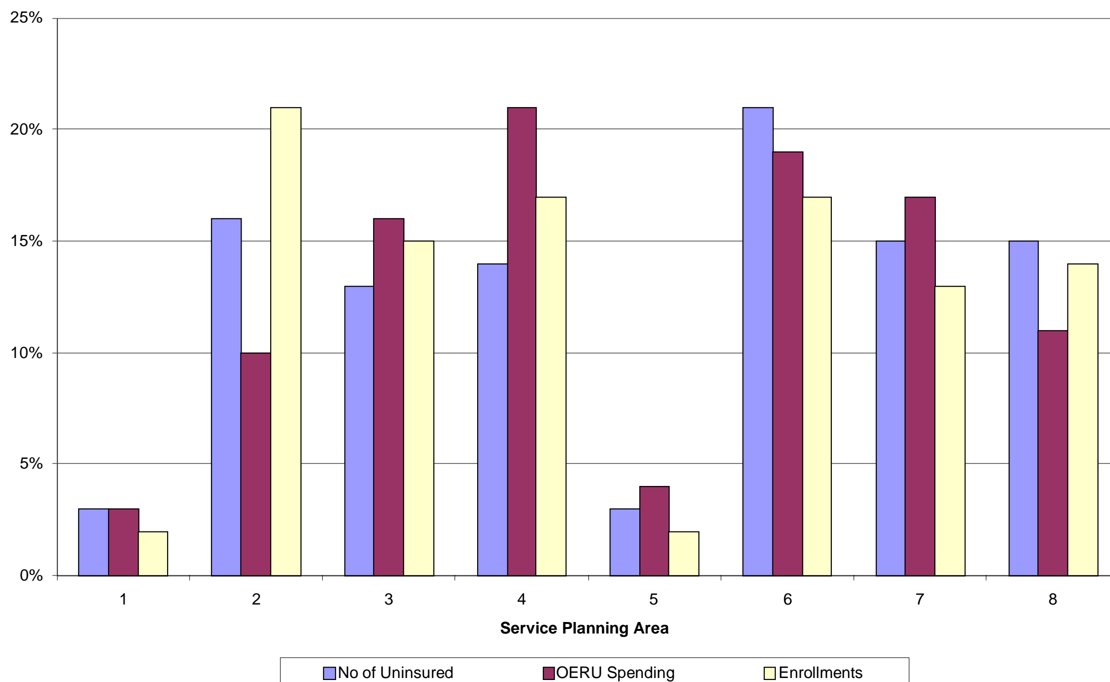
Sources: 1. 2002-03 Los Angeles County Health Survey; 2. Los Angeles County Department of Public Health contracts and The California Endowment grants; and 3. Confirmed Healthy Kids enrollments, CHOI database. These percentages represent the distribution. For example, 3% of all uninsured children reside in Antelope Valley

However, these disproportionate funding allocations have not led to proportionate numbers of enrollments. For example, while SPA 2 has a smaller allocation of spending (10%) relative to its share of the uninsured (16%), it generated 21% of the Healthy Kids

[4] Step by Step Report, March 2006.

enrollments. SPA 8 generated 15% of the new enrollees, about proportionate to its share of the uninsured, although it receives about 11% of the resources. Smaller but still disproportionately higher number of enrollments relative to spending also occurred in SPAs 3 and 4. However, a disproportionately smaller number of enrollments came from SPA 6, which has 21% of the uninsured and 19% of the funding, but generated 17% of new enrollments in Healthy Kids. Similarly, SPA 7 has 15% of the uninsured and 17% of the funding, but generated about 14% of the new Healthy Kids enrollments.

Exhibit 2. A comparison of the distribution of uninsured outreach and enrollment spending, and Healthy Kids enrollments by SPA, 2003-2005

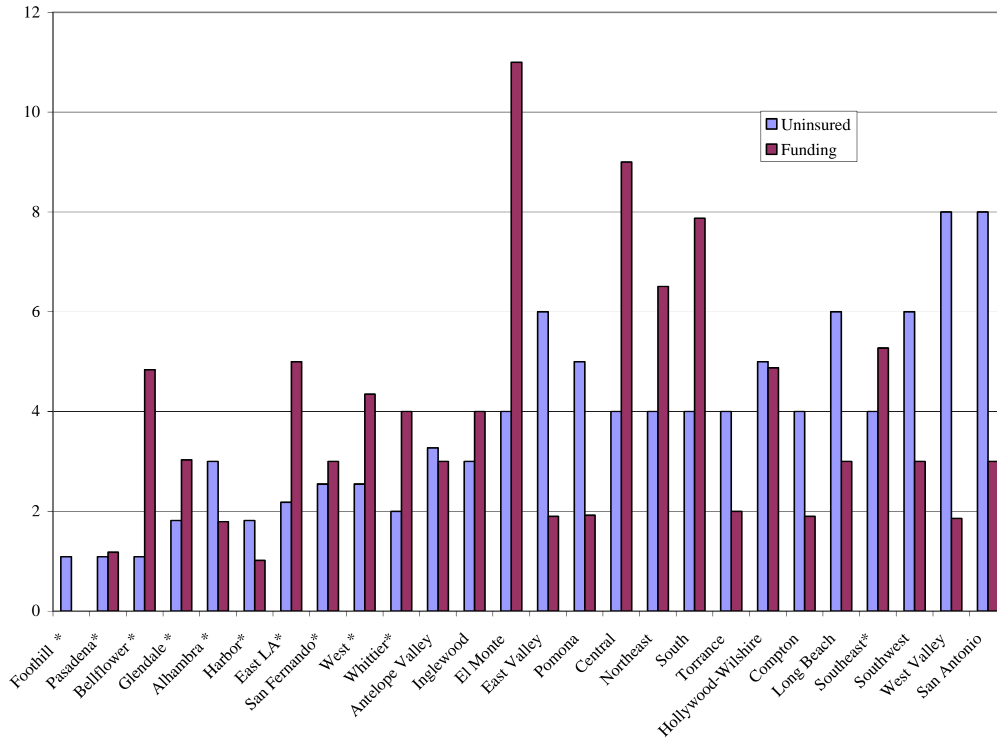


From July 2003 to June 2005, $8.7 million was invested in outreach and enrollment-related activities, excluding funds for training, technical, and administrative support provided by the Los Angeles County Department of Public Health (LA DPH).[5] These funds come from First 5 LA and are administered by LA DPH as contracts with 16 agencies, 12 of which provide full scope OERU services. Two, for example, provide training or advocacy and problems solving and technical assistance. They also include grants from The California Endowment to 14 different organizations some of which are

[5] On May 30, 2006, the Los Angeles County Board of Supervisors approved separating Public Health from the Department of Health Services, creating a new Department of Public Health (LA DPH). In July 2006, LA DPH was formed, which includes the Children's Health Initiatives program that oversees L.A. County's OERU efforts.

the same 12 funded by Los Angeles County. In comparing the distribution of the uninsured with the distribution of spending for outreach and enrollment, note that current allocations in SPAs 2, 6 and 8 are lower than their share of the uninsured while SPAs 3, 4, and 7 receive a disproportionately larger amount of funding.

Exhibit 3. A comparison of the distribution of spending for outreach and enrollment by health district with distribution estimates of uninsured children, ages 0-17, 2003



Health districts. We conducted a similar analysis for spending by health district (Exhibit 3). The East (SF) Valley and West (SF) Valley health districts in SPA 2, Pomona in SPA 3, San Antonio in SPA 7 and Torrance in SPA 8 have a disproportionately large number of uninsured relative to their share of spending. For example, in the East Valley, about 2% of the outreach dollars are spent there while the districts have 4% of the county's uninsured. San Antonio receives only about 2% of the total funds invested in outreach and enrollment, even though it has about 8% of the county's uninsured. Conversely, El Monte, East LA and Central health districts receive a disproportionately higher amount of funding relative to the share of uninsured. El Monte and Central have approximately 4 and 5% of the uninsured respectively, but each receives nearly 10% of outreach and enrollment dollars. Please note that health districts average about 300,000 people and estimates of the uninsured, while the best available, are derived from small samples of respondents living within those districts. Many of these estimates are unstable, and thus some caution is urged in drawing conclusions based on these estimates.

Exhibit 4. Healthy Kids Enrollment

SPA	Healthy Kids Enrollments	Medi-Cal Enrollments	Healthy Families Enrollments	Total Enrollments	Total Enrollments per 1,000
		1.4	1.0	2.4	
1 Antelope Valley	684	958	684	2,326	258
2 San Fernando Valley	9,021	12,629	9,021	30,671	626
3 San Gabriel Valley	6,418	8,985	6,418	21,821	559
4 Metro	7,146	10,004	7,146	24,296	656
5 West	758	1,061	758	2,577	368
6 South	7,162	10,027	7,162	24,351	477
7 East	5,442	7,619	5,442	18,503	487
8 South Bay	5,782	8,095	5,782	19,659	479
Total	42,413	59,378	42,413	144,204	531

Medi-Cal enrollments are estimated at 1.4 per every Healthy Kid enrollment. Healthy Families enrollment is calculated as 1 per every Healthy Kids enrollment. Source: CHOI database.

Enrollments

In this section we analyze how the number of enrollments varies as a percentage of the estimated number of uninsured children in those health districts (Exhibit 4). In Los Angeles County, over 42,000 children have been enrolled in Healthy Kids. We estimate that every Healthy Kids enrollment yields nearly 2.4 additional enrollments in either Medi-Cal or Healthy Families.[6] Thus, in Los Angeles County, over 144,000 children have been enrolled in some health insurance program since the inception of the Healthy Kids program. SPA 2 (San Fernando Valley) has the highest number of enrollees, with an estimated 31,000 Healthy Kids, Healthy Families, and Medi-Cal enrollees, followed by SPAs 4 (Metro) and 6 (South), each with over 24,000 new enrollees.

Enrollments per 1,000 uninsured. While the above analyses show total volume of enrollees, they do not show them as a function of need. Countywide, 531 children were enrolled per 1,000 uninsured children. Variations in this rate across SPAs range from 258 enrollees per 1,000 uninsured children in SPA 1 (Antelope Valley) to a high of

[6] This estimate is based on follow-up calls to those enrolled through LA DPH and The California Endowment-funded contactors and recorded in the CHOI database.

nearly 656 enrollees per 1,000 uninsured children in SPA 4 (Metro). Thirteen districts surpassed the countywide rate of 154 Healthy Kids enrollees per 1,000 uninsured children. The lowest rates were found in Torrance, Whittier and Antelope Valley, each with fewer than 100 enrollees per 1,000 uninsured children. The highest rates were found in the Bellflower (SPA 7), Foothill and Pasadena (SPA 3) Health Districts, where there were more than 270 enrollees per 1,000 uninsured children, and 215 enrollees per 1,000 uninsured in the Inglewood district (SPA 8). There is more confidence in SPA rates of enrollments per 1,000 uninsured than in rates at the health district level due to small sample size that was described earlier.

Although there is a wide range in rates, it is not clear if these differences are accounted for by differences in efficiencies and productivity of the contracted agency, or by differences in the costs of mounting different types of strategies. For example, door-to-door, or individual or family-based strategies which are likely to be more expensive approaches compared to those targeting school children, patients in the waiting of clinics or those waiting in WIC sites where multiple contacts can be made in a relatively shorter period of time. At best this analysis suggests that a more careful assessment of agency productivity and selection of strategy within the region be conducted. There may be locations where a more expensive and perhaps less productive enrollment strategy is warranted especially if agencies are trying to find and enroll more isolated and less accessible families who may be more resistant to government-sponsored health programs. Additional studies are needed to provide more information about what accounts for differences in productivity and effectiveness.

Recommendations

Geographic distribution. We recommend that Los Angeles County continue to try to accomplish somewhat proportionate funding based on the estimates of the uninsured. Los Angeles County may want to establish a new formula once both 2005 California Health Interview Survey (CHIS) and LACHS data are available for analysis. However, we suggest some reallocation as follows:

- **SPA 1 Antelope Valley.** The unique needs of this community suggest the continuation of funding at the current level. Given the geographic dispersion of the population in the area and the rural nature of many communities, funding should be targeted to very rural communities where families are more isolated and harder to reach, and therefore are less likely to come in contact with community institutions such as churches and schools. An effort to expand the rate of enrollment from the current 76 per 1,000 uninsured to the county average of 154 per 1,000 uninsured should be undertaken.
- **SPA 2 San Fernando Valley.** West Valley Health District had a large number of uninsured children (an estimated 20,000), yet is under-funded with an estimated $156,000 spent on OERU or $7,836 per 1,000 uninsured. While over 4,000 children have been enrolled in this community with an additional 10,000 enrolled in Healthy Families and Medi-Cal, an expansion of outreach in this community could yield as many as 10,000 additional children. We recommend shifting resources within SPA 2 from San Fernando and Glendale Health Districts to the West Valley Health District.
- **SPA 3 San Gabriel Valley.** Total funding distribution for SPA 3 seems adequate, although funding could be expanded in the Pomona Health District, which is currently under-funded relative to its share of the uninsured.
- **SPA 4 Metro.** Within SPA 4, spending per 1,000 uninsured in the Central Health District is about twice that of other communities in SPA 4. A review of strategies in this SPA is suggested to better understand the unique challenges in these communities and determine how productivity can be improved. SPA 4 includes the communities of Central Los Angeles, which has many homeless families, some of whom live in hotels. A targeted approach to these families is suggested.
- **SPA 5 West.** No changes are recommended in the distribution or allocation of funding in this community.
- **SPA 6 South.** Compton Health District is currently home to about 5% of the county's uninsured children, yet has only 2% of the funding for outreach and enrollment. While additional funds to Compton is suggested, additional analyses of currently funded agencies and strategies within SPA 6 are suggested in order to determine the most effective use of any expansion dollars in this community.
- **SPA 7 East.** The San Antonio Health District is under-funded relative to its share of the uninsured. We recommend that within SPA 7, resources should be reallocated away from Bellflower and Whittier and towards San Antonio, which has more that 8% of the county's uninsured children but only 2% of the resources.

- **SPA 8 South Bay.** No changes are recommended in the distribution or allocation of funding in this community. However, it is recommended that additional investigation be done to understand the low productivity rate in the Torrance Health District.

Types of Strategies

It should be noted that broad screening tools including media-based messages, participation in health fairs, development of flyers, and other screening strategies may be less useful now that insurance has expanded so dramatically for children. Rather, we suggest focusing on strategies that are likely to find harder-to-reach families, and refocus on retention and utilization assistance. This is also a time to experiment with less-known strategies, including working with employers, focusing more on families, and linking outreach and enrollment with other policy initiatives.

Targeting families and pre-screening adults for ORSA. The Los Angeles outreach and enrollment efforts are family focused; that is, CAAs work with all family members by linking each to an appropriate source. We strongly recommend that the focus on families be continued, if not strengthened by created family enrollment packages that include enrollment assistance for children eligible for public programs, adult programs and linkages to provider-based programs. The establishment of the adult enrollment module recently announced by the National Health Foundation is a very important and useful tool for assisters working with families with uninsured adults. The support of other training initiatives that have approached enrollment from a more comprehensive and family orientation, such as that implemented by the Maternal and Child Health Access is also highly recommended. Another suggestion would be enabling CAAs to pre-screen individuals for Los Angeles County's ORSA and PPP programs. Pre-screening could facilitate access to primary care by reducing the administrative obstacles to care. We also suggest linking enrollment to health insurance programs with the County's PPP program by linking outreach and enrollment contracts with PPP contracts. This will enhance the continuity of coverage options for all family members.

Clinics and health centers. Provider-based outreach and enrollment strategies are an important source of enrollment activities. So far, over 41% of enrollments come from community-based provider organizations. Among agencies involved in outreach and enrollment, over a quarter found that outreach or enrollment activities in the waiting rooms of clinic and health centers were the most effective strategies for identifying and enrolling families. Providers, especially community clinics, carry the trust of individuals who use these services as a source of health care. Many families use community clinics for general primary care, preventive services, and referrals to more specialized or hospital-based care. Thus these individuals are already in the health care system and will benefit from enrollment, especially those who need services beyond what primary care clinics can offer. Expanding outreach and enrollment by adding additional slots at community clinics is a cost-effective alternative to new start-ups. In addition, other clinics or similar provider organizations can be added to the current list of outreach and enrollment sites. Of particular importance is the placement of staff to assist in such efforts in LA DPH and Los Angeles County Department of Health Services (LA DHS) ambulatory care sites, especially public health clinics and comprehensive health centers.

These placements would be especially effective if these sites could be designated provider sites for Healthy Families and Healthy Kids. Provider-based enrollments would also allow staff to link enrollment with the establishment of a medical home; some clinics have enrolled a child and set up the first appointment at the same time.

Hospital-based sites. While hospital use is low for children, emergency room use remains somewhat high and could provide an important source of new enrollments for uninsured children. We recommend expanding the number of CAAs in hospital emergency departments, outpatient departments, and inpatient wards. Many hospitals have on-site eligibility workers for Medi-Cal, and county facilities have Patient Financial Workers. These individuals can be trained to complete the appropriate enrollment forms, or alternatively, work with newly placed CAAs who can provide management and follow-up for newly-enrolled families. Adding certified staff to assist with enrollment at hospital sites would create a more comprehensive team of workers assisting the enrollment process.

Coupling with the state Coverage Initiative. Los Angeles County should also determine how to couple the expansion of outreach and enrollment with its plans under the California Medi-Cal Coverage Initiative. It could for example, link enrollment of children with efforts to identify and enroll adults who meet specified conditions, such as a diagnosis for a particular health condition (diabetes or asthma), some other criteria defined by utilization (e.g., a frequent user of health services), or a social condition (e.g., homeless). Linking the two initiatives makes sense if a system is in place for cross-training enrollment staff for both initiatives and if resources were in place for a seamless approach to enrolling both adults and children.

Schools. Schools have enrolled many children, and several studies have shown the benefit of school-based enrollment. Because of this, some work with Los Angeles Unified School District (LAUSD) as well as several other school districts should continue. LAUSD's CHAMP office has recently completed an analysis of schools with relatively high numbers of uninsured students, which include those defined as *provisional.* These schools historically have upwards of 90% or more of their students qualifying for free lunch. Because of the large number of families in these schools who are living near or below the poverty level, outreach campaigns directed at these and other similar LAUSD schools are likely to yield new enrollments. An analysis of other school districts with potentially large number of low-income children could also yield many more uninsured children eligible for these programs.

It is further recommended that the role of the certified enrollment staff be re-examined. There is a benefit to having more certified application staff at the schools. Certified assisters not only provide valuable resources for enrolling families, but they also form critical linkages for families experiencing problems in enrolling. In addition, their role will become important in the retention process, and in assisting families establish linkages to a medical home and utilize health services. On-site enrollment staff will allow some continuity in their work with schools and families in the larger community. Providing them with broader responsibilities, including health education and health promotion, community outreach and referrals, and other types of support services will allow communities to see these staff as filling a broad health-related need in the community.

Finding and enrolling harder-to-reach families. Individual assistance, enrollment, and retention efforts can be placed at locations with vulnerable populations. These would especially be beneficial in targeting homeless families. Sites would include shelters serving homeless families, outreach sites and drop-in centers. These centers will provide much needed linkages to health coverage in an environment where services are also linking families to other needed services, especially housing and food assistance, health services, mental health, and drug and alcohol dependence services.

Door-to-door or neighborhood outreach is indeed expensive as an outreach strategy. The door-to-door approach is useful only if coupled with outreach efforts to identify potential enrollees through other means. Such neighborhood efforts could be an important strategy for retention, and utilization assistance as well.

Improving quality and access within a managed care environment. We recommend developing quality improvement initiatives aimed at improving compliance with specific clinical standards and benchmarks for child health. These would expand on existing studies funded through the evaluations. However, we suggest focusing on quality improvement, including achieving standards of care in utilization of key clinical services such as dental care, immunizations, well-child examinations and referrals for specialty services for chronic illnesses.

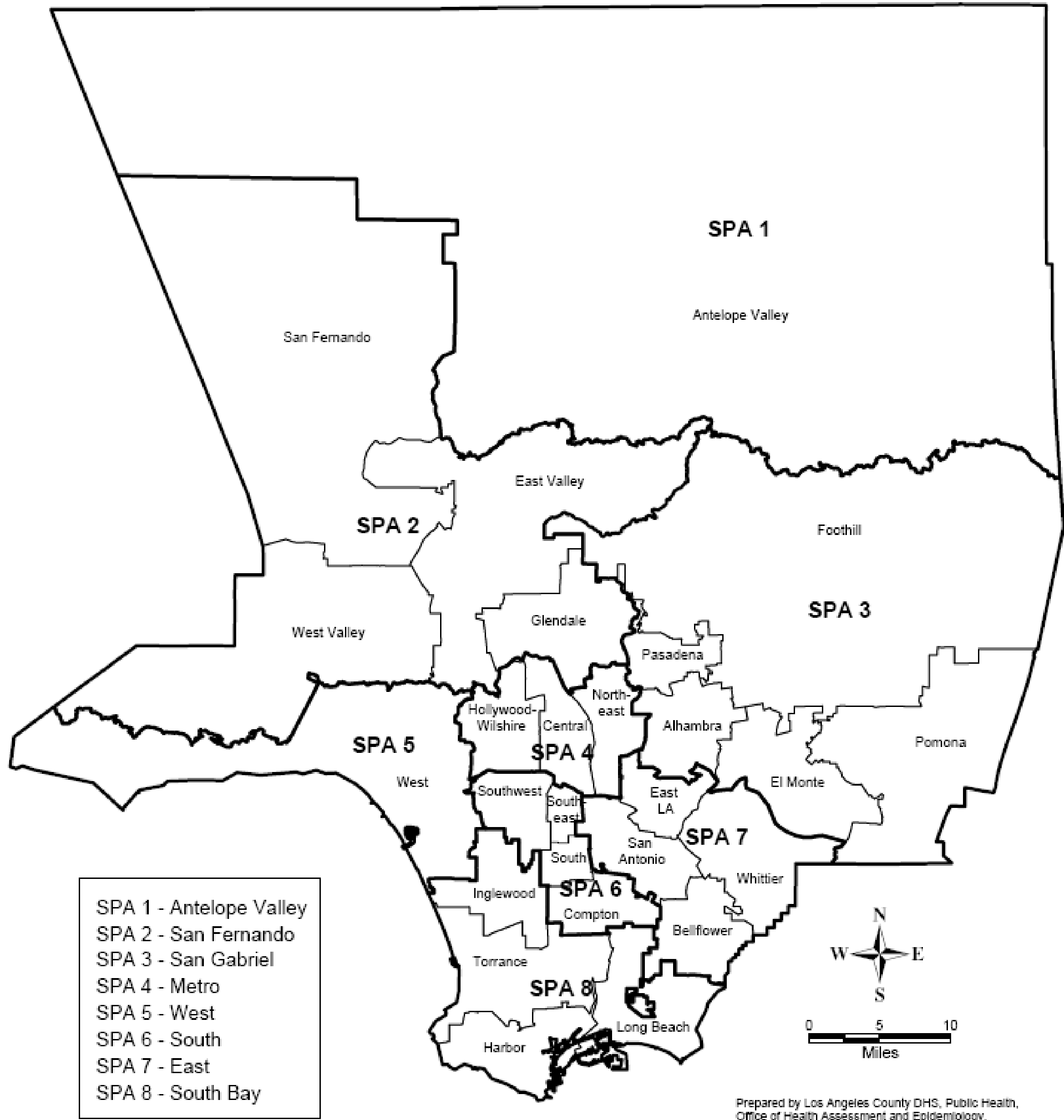
Technology. We recommend the continuation of efforts to merge the CHOI database with *One-e-App*. This will provide a seamless system for managing enrollments and evaluating the effects of outreach and enrollment activities. The continued deployment of *One-e-App* in schools and other similar settings is recommended. In spite of the high costs and problems in set-up, many counties are beginning to see the benefit of *One-e-app*, which expedites the enrollment process and provides good management tools for enrollment staff.

Employer-based approaches. We recommend pilot projects aimed at using employers for enrolling children into health plans. A partnership with selected businesses, such as the Latino Chamber of Commerce, existing employer-based projects, the United Way of Greater Los Angeles, and the Los Angeles Area Chamber of Commerce, would provide a linkage to businesses that could develop and implement innovative projects.

Conclusion

In conclusion, an analysis of various data on uninsured children, expenditures for outreach and enrollments, and enrollments suggests some modification in the funding formula. It also suggests some reallocation within SPAs by targeting of resources in health districts that have special needs or that are perhaps under funded relative to need, as well as focusing on strategies that are likely to find harder-to-reach families, and refocusing on retention and utilization assistance. We also recommend the continuation and in some cases expansion of clinic and other type of provider-based strategies. Innovation in the establishment of new strategies or approaches is suggested especially involving employers, the use of technology and understanding the impact on the quality of care is also recommended. Further investment in policy analyses, training and evaluation should be considered.

Appendix A. Los Angeles County Service Planning Areas (SPAs) and health districts



Appendix B. Data sources

Los Angeles County Health Survey. The Los Angeles County Health Survey (LACHS) 2002-2003, is a biennial population-based telephone survey using a random digit dial sampling of over 8,000 households in Los Angeles County. Estimated numbers of uninsured children ages 0-17 were calculated from the LACHS. An algorithm was developed by that assigns on a random basis transfers respondents with zip codes that are crossed by health district or SPA are proportionate to the percent of the zip code residents who live within the SPA or health district. This allows estimates of uninsured children to be derived in smaller geographic areas; however, because of small sample size, many of these estimates are unstable at the health district level, and thus authors urge some caution in interpreting these findings and drawing conclusions at the health district level.

CHOI Database. In conjunction with their partnership with First 5 LA, LA DPH developed the purpose-built Children's Health Outreach Initiatives (CHOI) Database system to enable contractors to document their activities carried out under the First 5 LA-funded outreach and enrollment effort. CHOI captures an array of information on outreach, enrollment, utilization, and retention activities. LA DPH provided data on outreach contacts and applications completed by the contractors from July 2003 through June 2005. Data was entered into CHOI by zip code and then an algorithm developed by LA DPH was used to convert enrollment data by zip code into health districts

LA DPH administrative data. LA DPH provided information on funding that was awarded to each contractor from July 2003 through June 2005. Because funding was allocated by agency, not health district, and because contractors serve multiple health districts, an online survey was administered to the contractors asking them to estimate the percentage of their activities spent in each health districts. The estimates were then used to approximate the distribution of funding across health districts for each contractor. Funding from LA DPH contracts plus The California Endowment grants for each health district were calculated based on agency contact and grant awards. These were then applied to estimates of percentage effort in each health district based, on a survey of each agency.

L.A. Care Health Plan data. To examine actual enrollments into the Healthy Kids program, data was received from L.A. Care Health Plan, the local health plan administering the program, on children enrolled in the program by zip code. Enrollment data reflect a count of children ages 0-18 enrolled in Healthy Kids by health district as of May 2006. The algorithm developed by LA DPH was used to convert enrollment data by zip code into health districts. Enrollment totals are not exclusive to children assisted by the contractors.