SOCIAL POLICY RESEARCH
ASSOCIATES

Evaluation of the MTSAB-Funded Strategies of the Solano County Health Access Strategic Plan

Final Report

August 9, 2007

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Acknowledgements

Social Policy Research Associates (SPR) would like to thank the numerous individuals who provided us with their insights and cooperation that made this report possible, especially Gina Merrell, Patrick Hughes, and Jacque McLaughlin. We would also like to acknowledge the support of the following individuals: Dr. Chris Cammisa, Helena Chung, Patrick Duterte, Vena Ford, Liz Gibboney, Sandra Gunderson, Nadine Harris, Sarah Jewel, Marcia Jo, Rodney Kennedy, Michael McGlathery, Jackie Moye, Terry Stanley, and Moira Sullivan. We extend our appreciation to all members of the Health Access Committee and the workgroups for their cooperation and assistance.

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Executive Summary

Social Policy Research Associates (SPR) is pleased to present the 2006-2007 report of our Evaluation of the MTSAB-Funded Strategies of the Solano County Health Access Strategic Plan. Our first year of effort has revealed an impressive amount of work being conducted by a wide range of individuals and groups dedicated to improving health access and outcomes among Solano County's most vulnerable populations. This report is designed to speak to our three primary evaluation questions:

1. To what extent are the five Health Access Strategic Plan goals met through the seven MTSAB-funded strategies?
2. What are the outcomes from MTSAB-supported program and system-level activities?
3. What are the key challenges and lessons emerging from program and system-level activities?

In order to answer these questions, we first assess the activities, outcomes, successes, and challenges of each MTSAB-funded strategy thus far, and then provide recommendations for moving forward. We then discuss the extent to which these strategies as a whole are contributing to the realization of the five Health Access Strategic Plan goals.

Health Access Strategy #1: Support the growth and effectiveness of a health access coalition committed to the implementation, modification, and evaluation of this health access strategic plan.

Since the revision of the Health Access Strategic Plan in May 2005, the Health Access Committee's (HAC's) role has been to continue reviewing Plan modifications and approve the MTSAB spending plans; receive updates from workgroups and provide guidance on MTSAB-funded strategies; and connect the work of the strategies to larger Solano Coalition for Better Health (SCBH) and health-related efforts.

Prioritized Outcomes for Strategy #1 for 2006-2007:

1) Active participation on each of the workgroups of organizations whose work is aligned with the workgroup goals/purpose; and (2) SCBH leverages MTSAB funds, develops partnerships and participates in other efforts related to improving health access.

- **Finding #1: SCBH continues to maintain broad participation of partners, but attendance data is inconsistent.** Outdated rosters and inconsistent record keeping on attendance data prevents us from drawing solid conclusions for all groups. For instance, although we can say that an average of 64% of HAC members regularly attended meetings, we cannot provide a similar statistic for all of the workgroups as some of them had no or irregular attendance data and meeting minutes.

- **Finding #2: SCBH generated over $2 million in funding for health access related activities.** Excluding MTSAB funds, SCBH raised $2,196,339 between January 2006 and December 2007 to help support Solano Kids Insurance Program, Healthy Kids, Elimination of Health Disparities in Solano project.
- **Finding #3: SCBH enjoys a wide range of partnerships and works multiple additional efforts related to improving health access.** In 2006-2007, SCBH supported a total of nine committees or workgroups around health access. Thirty-nine organizations (including hospitals, community clinics, health care groups, and education) participated in SCBH committees, workgroups and related efforts to improve health access. SCBH has been involved in a number of additional efforts related to the goals of the Strategic Plan, including: the CMSP Task Force; the Solano County African American Disparities Elimination Project; the Cultural Competence Conference Series; the Safety Net Study; and SCHIP reauthorization.

➢ **<u>Recommendation #1:</u> Improve mechanisms for collecting attendance data and meeting minutes.** Systematic attendance data should be collected at every workgroup meeting, whether in-person or by phone, and stored in a centralized location. Workgroup rosters should also be updated frequently in order to calculate accurate participation rates.

➢ **<u>Recommendation #2:</u> Identify appropriate participants at different stages of the workgroups to measure attendance.** To more accurately calculate the base for attendance, we recommend identifying the *stage* and *types* of participants who are appropriate at various stages. Types of participants include (1) initiative planners, 2) initiative implementators, and 3) resource members.

➢ **<u>Recommendation #3:</u> Continue to capture and connect health access related efforts that are not MTSAB-funded to the Health Access Strategic Plan.** SPR has begun summarizing the number and extent of all SCBH efforts to improve health access in order to assess true gaps in the focus and implementation of the Strategic Plan.

Health Access Strategy #2: Enroll and retain all eligible children and adults in available public or other subsidized plans or Health program(s).

Health Access Strategy #4: Develop programs to pay premiums or share of cost for eligible families where appropriate.

The primary ongoing interventions related to these strategies are the Solano Kids Insurance Program (SKIP) and Healthy Kids Solano (HK). SKIP assists children and their families with enrollment and retention in publicly-funded health care programs. In 2006, SKIP assisted 2,645 individuals to enroll in health insurance, achieving 95% of its goal. SKIP has also provided assistance in *utilizing* health care through follow-up phone calls to families of zero to five year old children. A recent state Outreach Enrollment

Referral and Utilization (OERU) grant will allow SKIP to further expand its enrollment, retention, and utilization efforts.

HK is Solano County's Children's Health Initiative program providing health care to 1,200 low-income county children who are ineligible for either Medi-Cal or Healthy Families. Children are enrolled in HK by SKIP staff and receive benefits through Partnership Health Plan of California and its provider network. From January 2006 to April 2007, SCBH paid $1.4 million in premiums to cover costs for 1,200 children. During the 2006-2007 year, the Enroll & Retain Workgroup spent considerable time discussing fundraising activities to cover HK premiums and developing policies for the HK waiting list.

Prioritized Outcomes for Strategies #2 and #4 for 2006-2007:

1) Targeted children visit their Primary Care Physician (PCP); and (2) Over 95% of children 0-17 in Solano County are insured.

- **Finding #1: 100% of children targeted by SKIP reported a visit to PCP within 10 months after enrolling in health insurance.** Of the targeted families (98 children aged 0-5) that SKIP was able to contact for follow-up all three times, 100% reported that their child had visited a doctor at least once during the 10 months since the child became insured. Because of the small number of children included in the data and the fact that the results are self-reported, we cannot easily generalize these results to the larger population. Also, we cannot be sure that the follow-up calls were the primary reason children visited a doctor, though it is certainly likely that the calls contributed to this positive outcome.
- **Finding #2: Solano County has achieved the targeted outcome of over 95% insurance coverage among children 0-17.** Results from the California Health Interview Survey (CHIS) for 2005 show that Solano County continued to maintain a very high percentage of insured children (96%), more than three percentage points higher than the rate for the state as a whole. Results broken down by race/ethnicity reveal that Latino children in Solano County appear to have a significantly lower insurance coverage rate (83%).[1] Insurance coverage results broken down by poverty status reveal that the percentage of the poorest children in Solano County (0-99% of FPL) who were covered by health insurance increased between 2001 and 2005 from 84 to 92%.

➢ **Recommendation #1: Continue SKIP's strong focus on enrolling and retaining Latino children in health insurance programs.** Data suggests that Latinos continue to be less likely than other groups to be insured and thus should continue to be a primary focus of enrollment and retention efforts.

➢ **Recommendation #2: Broaden the data and analysis of utilization in the 2008 report.** When conducting the analysis in 2008 for the first prioritized

[1] At the 95% confidence level, the interval is wide: (68 to 98%), so this result must be viewed cautiously.

outcome ("Targeted children visit their primary care provider"), data should be included on all children followed-up with by SKIP, including follow-up funded by the new OERU grant.

Health Access Strategy #3: Expand behavioral health services at primary care sites and increase linkages to specialty mental health and substance abuse and drug treatment services not provided at these sites.

The primary ongoing activity related to achieving Strategy 3 has been providing an on-site Behavioral Health Consultant (BHC) at primary care clinic sites that serve a high proportion of Medi-Cal clients. The BHC acts as partner to the primary care physician for patients who have co-existing medical and behavioral health issues. During 2006-2007, on-site BHC service provision continued successfully at two county clinic sites. Due to the Behavioral Health/Primary Care Integration (BH/PCI) Workgroup's efforts, MTSAB funding totaling $160,000 was approved for FY 2007-2008 to support Behavioral Health Integration Project objectives (such as an on-site BHC) at two community clinic sites, in addition to the two county clinic sites currently funded.

In addition to the on-site BHCs, the other main activity designed to address the gap in behavioral health services for underserved populations is consultation services for PCPs. The Supervising Mental Health Clinician provides on-demand assistance to PCPs needing advice on how to address their patients' behavioral health issues and successfully obtain county-funded services for eligible clients. One of the BH/PCI Workgroup's focus areas in FY 2006 has been collecting data on PCP requests for behavioral health services.

Another successfully continued workgroup activity is academic detailing. This work is aimed at increasing providers' awareness of behavioral health issues, and informing them about the availability of behavioral health services and how to access those services.

Prioritized Outcome for Strategy #3 for 2006-2007:

1) Increased client use of behavioral health services on-site.

- **Finding #1: The number of visits and unduplicated clients for onsite Behavioral Health Consultants at the two county clinic sites that received MTSAB funding declined between FY 2005-2006 and FY 2006-2007.** The number of visits over the two years declined by 17.5% (235 visits), while the number of unduplicated clients declined by 16.4% (133 clients). We can explain at least some of this decline as due to the decline in visits and unduplicated clients seen by clinician #3. This drop was due to Clinician #3's increasing supervisory responsibilities and less time spent onsite given the hiring of an additional on-site BHC, as well as his increasing responsibilities for providing consult services to primary care providers in the community.

- **<u>Recommendation #1:</u> Assign clear data collection roles and responsibilities.** Tracking progress on client use of on-site BHC services was a difficult process because it was unclear whom was responsible for collecting this data, for how long, or in what form. Moving forward, it will be critical to identify key staff responsible for both data collection and reporting in order to facilitate accurate and timely communication about the workgroup's progress.
- **<u>Recommendation #2:</u> Ensure all data needed for evaluation and planning purposes are being effectively collected and distribute a revised matrix/strategic plan.** For this evaluation, at a minimum, the number of client visits and the number of unduplicated clients seen by BHCs at all practice sites supported by MTSAB funding should be tracked on an ongoing basis. In the broader interest of capturing the progress of the BH/PCI Workgroup on all fronts, we recommend developing a data map that will identify *all* information the workgroup wishes to track; established or planned mechanisms for collecting that data; time points for data collection, the specific data fields where that information is or will be captured; and reports to be generated. We also recommend that the workgroup revise and re-distribute its matrix/strategic plan to reflect changes made during the year and to integrate the outcomes being tracked by this evaluation with other outcomes desired by the BH/PCI Workgroup.

Health Access Strategy #5: Reduce frequent users' inappropriate use of the health care system.

The primary intervention related to Strategy 5 is a small pilot project, successfully launched in FY 2006, which has a full-time mental health clinician assigned to work with frequent users (individuals who use acute services disproportionately due to chronic illness, behavioral health problems and homelessness or near homelessness) who are referred by the project's two partnering hospitals, North Bay and Sutter Solano. The clinician works with these frequent users to link them to a PCP and obtain preventative and ongoing care with the aim of decreasing their inappropriate use of acute services. The Frequent Users Workgroup and the project's mental health clinician also work closely with a number of other organizations that provide services that are critical to decreasing the need for inpatient services by frequent user clients, such as housing, substance abuse and mental health treatment, and disability benefits.

Between April 2006 and March 2007, the project received 48 referrals of frequent user clients. However, only some of these referrals were served by the project as a few refused to participate while others were referred to more appropriate services. In April 2007, the project's clinician reported that she had a case load of 15 clients, 10 of whom she was actively managing.

<u>Prioritized Outcome for Strategy #5 for 2006-2007:</u>

1) Increased Frequent User (FU) client visits to his/her primary care provider.

- **Finding #1: For the 23 FU clients on Medi-Cal who were enrolled in the Frequent Users Program for at least one month between the program's inception and February 2007, 52% increased their number of visits to their PCP six months after their referral to the program as compared to six months prior to referral.** This result means that these clients became at least somewhat more connected to the primary care system via their PCP following receipt of project services.

➢ **<u>Recommendation #1:</u> Continue timely identification of intervention challenges and targeting of key partners.** Workgroup respondents stated that because 2006-2007 was the inaugural year of the Frequent Users Program, most of their time was spent getting the program up and running. As the project enters its second year, the workgroup should continue to shift greater attention to identifying FU client needs and partner organizations that can address those needs.

➢ **<u>Recommendation #2:</u> Secure better information on the referral process.** The Workgroup has not fully explored the difference in number of referrals among hospitals. It may be due to (1) different screening techniques, (2) different client bases by region, (3) the number of staff at the hospitals, and 4) different referral criteria being used by staff. The Workgroup needs to collect additional information regarding the referral process to understand whether hospital discharge staff are aware of the Frequent Users Program and its eligibility criteria.

➢ **<u>Recommendation #3:</u> Obtain more detailed and accurate information on frequent users.** The Workgroup has already suggested that ethnicity, gender, length of time in the County, and current location be added to the Frequent Users caseload log. Such information would allow the Workgroup to track the program's effectiveness with different types of clients. Adequate recording of frequent user data may require more time than the clinician has available, and therefore, the Workgroup might consider allocating support staff resources to go toward frequent user data collection.

➢ **<u>Recommendation #4:</u> Secure better access to confidential client data for evaluation purposes.** To facilitate improved analyses for the purposes of evaluation, the County, PHC, and partnering hospitals should work out an agreement to provide the evaluators and other appropriate parties with access to individual client data with identifiers.

Health Access Strategy #6: Increase the availability of dental services.

The primary interventions related to Strategy 6 are: (1) increasing oral health prevention efforts in Solano County through a public health campaign designed to raise awareness of the importance of oral health care; and (2) increasing access to oral health treatment services through a Gap Fund that provides oral health services to un- and under-insured children, care coordination, and linkages to comprehensive health insurance. With regard to the first intervention, the public health campaign RFP was released in spring

2007; interviews with finalists were scheduled for late June, with an award likely being made by the end of FY 2006. Information on the second intervention is detailed below.

Other key accomplishments of the Oral Health Workgroup during FY 2006 were the completion of the Oral Health Care Strategic Plan and the pilot program at Mare Island Elementary School that screened 292 children for oral health services as well as created a fund for emergency dental care.

Prioritized Outcome for Strategy #6 for 2006-2007:

1) Gap Fund is operational and a Care Coordinator is providing care coordination.

- **Finding #1: Fiscal protocols for the Gap Fund were approved in Spring 2007 and a limited number of children may receive oral health services from the Gap Fund by the end of FY 2006.**
- **Finding #2: A temporary care coordinator was hired in late spring 2007.** The permanent care coordinator position, pending final approval, has yet to be filled.

➢ **Recommendation #1: Clarify age group of oral health treatment target group.** While the targeted age group of uninsured and underinsured children being targeted for oral health treatment and coordination may be clear to Workgroup members, it would be helpful to have it formally documented for a wider audience in an updated plan that reflects approved MTSAB spending for the Oral Health Workgroup for FY 07. Clarifying the age group will also help ensure that our evaluation tracks and analyzes all data of interest for 2007-09.

Health Access Strategy #7: Address beliefs, attitudes, knowledge, and experiences that negatively impact appropriate utilization of health services.

The Community Education Workgroup provides oversight for all activities undertaken as part of Strategy 7. Throughout 2006 and during the first few months of 2007, the Workgroup focused on developing plans for an intervention to provide health education services to the African American community in Solano County. Staff from Solano County and SCBH, with early assistance from the Workgroup, began a Request for Proposals (RFP) process to select a grantee who would carry out this intervention.

Prioritized Outcome for Strategy #7 for 2006-2007:

1) Grantee is funded and beginning program implementation.

- **The RFP that was issued in February 2007 was cancelled and no grantee was selected**. The Workgroup issued an RFP on February 14, 2007 for its Health Promotion and Education Campaign. Potential contractors and vendors submitted proposals, but were notified by the Health and Social Services Department in late March that the County had cancelled the RFP. Due to the development of a different scope of work for the new RFP, we do not expect to

be able to use the outcomes that were originally prioritized for evaluating this strategy. There are no recommendations at this time.

Assessment of MTSAB-funded Strategies on Strategic Plan Goals

We conclude by assessing the contributions of the seven strategies on the five goals of the HASP (our first primary evaluation question), and providing some overarching successes, challenges and recommendations.

Goal 1. ***Increase the % of Solano County residents consistently enrolled in health insurance or other health programs.***

- Strategies 1, 2 and 4 have likely had a major role in keeping the percentage of children ages 0-17 with health insurance close to 100%.
- Strategy 2 (SKIP) is also beginning to focus more and more on retention, and thus is contributing to keeping children consistently enrolled.
- No funded strategies focused on assisting large numbers of adults with enrollment or retention in health insurance.

Goal 2. ***Create a primary care based comprehensive system of health care that is integrated, financially sustainable, & has a strong infrastructure.***

- Six of the seven funded strategies contributed to Objective a of Goal 2, *increasing the capacity, efficiency and coordination of the primary care system in Solano County.*
- Both Strategy 3 (expand Behavioral Health services) and Strategy 5 (Frequent Users) contributed to Objective b of Goal 2 (*expand integrated behavioral health services at primary care sites and increasing linkages of specialty mental health and substance abuse and drug treatment services not provided at these sites).*
- Strategy 1, via the efforts of SCBH and the CMSP Task Force, contributed to Objective c of Goal 2 (*increase the availability of medical specialty care services)*.
- Strategy 6 (Oral Health) began to contribute to Objective d of Goal 2: *increasing the availability of dental services* over the past year.

Goal 3. ***Increase appropriate utilization of health services by Solano's racially and ethnically diverse population.***

- Strategy 2, via SKIP services, contributed to Objective a of Goal 3: *assuring that services throughout the healthcare system in Solano County are made available to all patients in a language they can understand.*
- Strategy 1, via the Cultural Competence Conference Series co-sponsored by SCBH contributed to Objective b of Goal 3: *increasing the cultural sensitivity and competency of key personnel throughout health system*.

- Strategies 2 and 6 both carried out activities in 2006-07 related to Objective c of Goal 3: *providing informational and educational materials that are easy to understand in all appropriate languages*.
- Strategies 6 and 1 began efforts in 06-07 related to objective d of Goal 3: *addressing beliefs, attitudes, knowledge and experiences that negatively impact appropriate utilization of health services*.

Goal 4. Decrease logistical barriers which prevent appropriate utilization of the healthcare system by Solano County residents.

- Strategies 1, 3, and to some extent Strategy 6 involved activities that are likely to have *assured that there are adequate primary care services located throughout Solano County* (objective a)
- Strategy 5, in a small, but critical way, has *decreased transportation barriers which prevent residents from timely healthcare*. (objective b)

Goal 5. Advocate for policies and actions that increase access to healthcare for low-income, uninsured, and other vulnerable populations.

- Strategy 1, through its support of HAC, SCBH and the Health Access Strategic Plan, is the primary strategy that contributed to Goal 5 in FY 06-07.
- Strategies 2 and 4 both involved activities related to Goal 5.

Overall Successes and Challenges

- **Most strategies were fully implemented**. By the end of the year, most of strategies had at least begun implementation of planned interventions and activities. In addition, most had or were planning to expend all of their MTSAB funding. Given the significant challenges related to implementing new and innovative projects, this is an important achievement.
- **SCBH, HAC and the four of the workgroups continued to effectively coordinate implementation of the strategies.** Although attendance was not as high for some groups as hoped, the fact that all of these groups, staffed by volunteers, continued to meet on a regular basis to oversee the efforts of particular strategies reflects the underlying strength of the coordination among health care partners in Solano County and the dedication of numerous staff.
- **Where data were available and accurate, it often showed impressive results.** Particularly in the case of Strategies 2 and 4, the data highlight the effectiveness of health access-related programs in the county such as the Solano Kids Insurance Program.
- **Putting structures in place to expend funding was sometimes extremely challenging due to the County's strict requirements for procurement and hiring of staff or contractors.** During fiscal year 2006-2007, two of the newest funded strategies (6 and 7) had some difficulty in implementing structures to expend allocated MTSAB funding. Because funding that is not expended by

June 30 is not automatically carried over into the next fiscal year, these problems may mean fewer resources focused on these strategies and their target populations.

- **Developing and sustaining new projects has been challenging.** Determining how to best manage, fund, and collect appropriate data for new projects has been challenging for several of the newer strategies.
- **Identifying available, accurate, and appropriate outcomes and data sources for a few of the strategies has been challenging in this first year of an external evaluation**. Despite carrying out a participatory process to identify the most appropriate outcomes to track, the prioritized outcomes for two of the strategies had to be changed and a few may need further revisions. For some of the strategies (particularly Strategy 3), we also had difficulty identifying appropriate and accurate data sources. However, these kinds of challenges are typical for the first year of an evaluation of relatively new interventions.

Overall Recommendations

- **Continue to increase the focus on health care utilization and consider focusing more on adults.** Due to the county's continuing success in achieving nearly 100% insurance coverage for children, in the future, HAC and the enroll and retain workgroup should continue to increase their focus on utilization. Without the latter, we cannot expect to see improved health status among the county's children. In addition, at some point, it might be appropriate to shift to a focus on increasing the percentage of adults with health insurance.
- **Consider whether there are more expedient means of distributing funds to appropriate service providers or grantees.** Due to the issues related to expending money for new projects, MTSAB, HAC, SCBH and the County might want to consider whether there are more expedient means of distributing funds to appropriate service providers or grantees so that valuable MTSAB resources and time do not slip away. A major question for the County to consider is, are there alternative mechanisms for regranting the funds while still maintaining close County oversight and involvement?
- **Workgroup and HAC members should continue to work closely with the evaluators.** Because of the challenges of identifying and accessing appropriate and accurate data sources, particularly for new interventions and activities, it will be important over the next year for evaluator staff and workgroup and HAC members to continue to work closely to ensure the evaluation is able to proceed smoothly, becoming less formative and more summative as we move forward.

INTRODUCTION

Social Policy Research Associates (SPR) is pleased to present the 2006-2007 report of our Evaluation of the MTSAB-Funded Strategies of the Solano County Health Access Strategic Plan. Our first year of work has revealed an impressive amount of work being conducted by a wide range of individuals and groups dedicated to improving health access and outcomes among Solano County's most vulnerable populations. This report presents the many successes, and identifies some challenges as a springboard for further discussion and action.

Background

Health access issues, particularly those concerned with low-income and vulnerable populations, have long been a priority within Solano County. The Solano Coalition for Better Health (SCBH) has been addressing such issues for nearly twenty years. In 2000, the Solano County Board of Supervisors approved the use of the county's Master Tobacco Settlement Agreement (MSA) funding to achieve two goals: (1) improve access to health care for low income, uninsured, and other vulnerable populations, and (2) reduce the rates of use of alcohol, tobacco and other drugs. Solano County's efforts to meet this first goal—specifically through its Health Access Strategic Plan—is the primary focus of our evaluation and this report.

Development of the Health Access Strategic Plan (HASP, or the Plan) was led by the Health Access Committee (HAC)—one of the primary committees under SCBH since 1998. The first Plan was approved in 2002; the second, three-year Plan was adopted in 2005. While SCBH and the county are committed to promoting health and wellness of all residents, the Plan specifically targets low-income, uninsured and other vulnerable populations residing in Solano County. All residents with incomes at or below 300% of the Federal Poverty Level are considered low-income.

The Plan is guided by three core principles: (1) people need a way to pay for health care or they may not seek treatment when needed; (2) a primary care-based delivery system offers the best chance for disease prevention, early diagnosis and treatment, and comprehensive integrated services; and (3) in addition to a payment source and a delivery system, other practical, cultural, linguistic and psychosocial barriers must be addressed to ensure full access to health care.

With these principles as a foundation, the Plan is aimed at the ultimately desired outcome of universal access to primary care services for Solano County's low-income, uninsured and other vulnerable residents and improved health status. Toward this end, the Plan outlines the following specific goals:

Exhibit 1: Health Access Strategic Plan Goals

1. Increase the percentage of Solano County residents that are consistently enrolled in a health insurance plan or other health program(s).
2. Create a primary care based comprehensive system of health care that is integrated, financially sustainable, and has a strong infrastructure.
3. Increase appropriate utilization of health services by Solano's racially and ethnically diverse population.
4. Decrease logistical barriers that prevent appropriate utilization of the healthcare system by Solano County residents**.**
5. Advocate for policies and actions that increase access to health care, support healthy behaviors and healthy communities.

The *vehicles* for realizing these goals are the seven MTSAB-funded strategies, as well as the Solano Coalition for Better Health, HAC and its five workgroups charged with implementing the strategies. Listed below are the seven strategies, and their corresponding workgroup.

- Strategy 1: Support the growth and effectiveness of a health access coalition committed to the implementation, modification, and evaluation of the health access strategic plan. (Health Access Committee)
- Strategy 2: Enroll and retain all eligible children and adults in available public or other subsidized plans or health program(s). (Enroll & Retain Workgroup)
- Strategy 3: Expand behavioral health services at primary care sites and increase linkages to specialty mental health and substance abuse and drug treatment services not provided at these sites. (Behavioral Health/Primary Care Integration Workgroup)
- Strategy 4: Develop programs to pay premiums or share of cost for eligible families where appropriate. (Enroll & Retain Workgroup)
- Strategy 5: Reduce frequent users' inappropriate use of the health care system. (Frequent Users Workgroup)
- Strategy 6: Increase the availability of dental services. (Oral Health Workgroup)

- Strategy 7: Address beliefs, attitudes, knowledge, and experiences that negatively impact appropriate utilization of health services. (Community Education Workgroup)

About the Evaluation

In August 2006, Social Policy Research Associates (SPR) was contracted by Solano County to conduct a formative and summative evaluation. Under the direction of the Master Tobacco Settlement Advisory Board (MTSAB) Evaluation Subcommittee, SPR's overarching objective has been to assess the success of the MTSAB-funded strategies being carried out by the HAC and its five workgroups in achieving the Plan's goals listed above. Our primary evaluation questions are as follows:

1. To what extent are the five Health Access Strategic Plan goals met through the seven MTSAB-funded strategies?
2. What are the outcomes from MTSAB-supported program and system-level activities?
3. What are the key challenges and lessons emerging from program and system-level activities?

The 2006-07 year represents the first year of a formal, external evaluation. One of SPR's major tasks for this first year was to create a detailed plan for evaluating the effect of the MTSAB strategies on the HASP from 2006 to 2009. Once this plan was submitted and approved in spring 2007, we proceeded with a concentrated data collection and analysis phase just prior to submitting this first evaluation report. We describe these first year tasks in more detail below.

First Year: Developing the Evaluation Plan

SPR carried out a participatory process to identify the outcomes and indicators to track within our evaluation. We began this process in the fall 2006 by interviewing the chairs of the HAC and each of the five workgroups. We also reviewed key documents, such as minutes from HAC and workgroup meetings, strategic plans, and previous evaluation reports. Based on this background information, we developed draft logic models and potential outcomes for each workgroup. We then held meetings with each of the workgroups to collaboratively review the draft logic models and prioritize which outcomes to track. Our next step was to work with workgroup chairs and key stakeholders to develop indicators with concrete data sources for each of the prioritized outcomes. We concluded this comprehensive process by working with the HAC to finalize and further prioritize the outcomes of all workgroups for the evaluation.

The results of this last step are shown below in Exhibit I-2.

Exhibit 2:
Table of MTSAB-Funded Strategies and Prioritized Outcomes

MTSAB-Funded Strategies	Prioritized Outcomes 2006-2009
Strategy 1: Support the growth and effectiveness of a health access coalition committed to the implementation, modification and evaluation of the health access strategic plan.	• Solano Coalition for Better Health leverages MTSAB funds, develops partnerships and participates in other efforts related to improving health access (2006-2009) • Active participation on each of the workgroups of organizations whose work is aligned with the workgroup goals/ purpose (2006-2009)
Strategy 2[1]: Enroll and retain all eligible children and adults in available public or other subsidized plans or health program(s). **Strategy 4:** Develop programs to pay premiums or share of cost for eligible families where appropriate.	• Targeted children visit their primary care physician (2006-2007) • Over 95% of all children 0-17 in Solano County are insured (2006-2007) • Increase in children and families assisted with enrollment who are insured 14 months after initial enrollment (2007-2008) • Increase in percentage of public elementary schools with 100% health insurance coverage (2007-2008) • Healthy Kids Solano (or any similar/replacement program(s)) is fully funded with sustainable funding sources (2008-2009) • Children assisted by SKIP increased their school attendance rates (2008-2009)
Strategy 3: Expand behavioral health services at primary care sites, and increase linkages to specialty mental health and substance abuse and drug treatment services not provided at these sites.	• Increased client use of behavioral health consultant (BHC) services on-site (2006-2007) • Increased linkages between on-site behaviorists and primary care physicians (2007-2008) • Increased number of sites with on-site behaviorists (2008-2009)
Strategy 5: Reduce frequent users' inappropriate use of the health care system.	• Increased number of client visits to his/her primary care provider (2006-2007) • Fewer and shorter client "administrative" or "avoidable" hospital stays (2007-2008) • Frequent user clients receiving ongoing substance abuse and/or mental health services (2008-2009)
Strategy 6: Increase the availability of dental services.	• Gap Fund is operational and a Gap Fund Coordinator is providing care coordination (2006-2007) • Increased number of uninsured/underinsured children receiving needed urgent oral health treatment (2007-2009) • Increased number of uninsured children served by care coordinator linked to comprehensive health insurance, including dental insurance (2007-2009)

[1] Because Strategies 2 and 4 are closely related and are both overseen by the Enroll and Retain workgroup, we have opted to treat the two strategies as a set and have developed outcomes and indicators that relate to both.

MTSAB-Funded Strategies	Prioritized Outcomes 2006-2009
Strategy 7: Address beliefs, attitudes, knowledge, and experiences that negatively impact appropriate utilization of health services.	• Grantee is funded and beginning program implementation (2006-2007) • Increased knowledge by education program participants about diabetes, the role of the physician, the role of the health care system, and the role of the individual related to diabetes (2007-2008) • Behavior changes that result in positive health outcomes related to diabetes for African Americans involved in health education effort (2008-2009)

After the preceding outcomes were finalized in collaboration with the HAC, we prepared a formal three-year evaluation plan that outlined our evaluation questions and design, and then presented a detailed data collection and analysis plan for evaluating each of the prioritized outcomes.[2] For each prioritized outcome, we articulated the relevant timeframe, indicators, data sources and collection process, and analysis plan. Finally, the evaluation plan also included our budget, list of deliverables, timeline and staffing.

First Year: Data Collection & Analysis

The submission of our evaluation plan launched a short data collection and analysis phase for the first year—from March to June 2007. For the first year, the focus of the evaluation was primarily formative, as several of the strategies had only just begun implementation. As a result, a number of the outcomes tracked this first year were process-oriented. The first year was also concerned with finalizing new data collection instruments as well as collecting baseline data for many outcomes.

We relied on a wide range of data sources to inform this report. Specific data collection plans differed across strategies, but common data sources included:

- Review of key documents, such as attendance data, meeting minutes, program records, and financial records.
- Formal telephone interviews and less formal communications with over fifteen workgroup chairs, county staff and other key stakeholders for this round of data collection.
- Review of evaluation interview data from Fall 2006.
- Database queries.
- Quantitative data extraction from external sources such as CHIS.

As testimony to the formative nature of a number of strategies, we discovered a number of challenges in obtaining the necessary data for our analysis. While specific challenges will be discussed in their respective sections, overarching challenges

[2] See Evaluation Plan for Evaluation of the Solano County Health Access Strategic Plan. (April 2007)

included incomplete or unavailable data, and unclear or infeasible data sources. In addition, the compressed three-month timeframe of our data collection for the first year posed an additional challenge in scheduling interviews with respondents and obtaining necessary data.

Overview of this Report

The remainder of this report is concerned with magnifying the activities, expenditures, successes and challenges of implementing and evaluating each MTSAB-funded strategy thus far. We do this primarily with an eye toward the strategy's prioritized outcome(s) for 2006-07. However, each section also provides an overview of the strategy's activities and progress as a whole—even those that are not the explicit focus of the evaluation—as well as a set of recommendations concerned with strategy implementation and/or evaluation issues. We begin with an examination of Strategy 1, which, in many ways, serves as the foundation of all other MTSAB-funded strategies, since it is concerned with the very health of the coalition dedicated to fostering the implementation of the Health Access Strategic Plan. We next discuss Strategies 2 & 4 in tandem, since their work is inextricably intertwined and both are overseen by the Enroll & Retain Workgroup. Following are the individual discussions of Strategy 3 (Behavioral Health), Strategy 5 (Frequent Users), Strategy 6 (Oral Health), and Strategy 7 (Community Education).

We conclude the report with the implications of the individual strategies' progress for our larger research question—the extent to which strategies are contributing to the realization of the five Health Access Strategic Plan goals. As part of this discussion, we highlight key successes, as well as perceived gaps and emerging challenges. It is our hope that this final section will serve as a formative check point, and an impetus for further discussion among all those dedicated to improving health access and outcomes in Solano County.

HEALTH ACCESS STRATEGY #1 *Support the growth and effectiveness of a health access coalition committed to the implementation, modification, and evaluation of this health access strategic plan.*

The implementation of strategies to increase access to healthcare for the low income, uninsured and vulnerable Solano County residents requires the sustained commitment of multiple partners and significant systems change. Since its inception in 1988, The Solano Coalition for Better Health has worked to promote the participation of the key county leaders in healthcare, especially executive officers or their equivalents for each of the major providers. This engagement is designed to support leaders in affecting changes to both their individual systems and to the broader community system which impacts health. The Coalition's work is shaped by the multiple committees that it supports.

The Health Access Committee (HAC) of the Coalition is the body that is tasked with developing, monitoring, and developing recommendations to modify the Health Access Strategic Plan, adopted by both the Coalition and the County Board of Supervisors. The Health Access Committee includes representatives of all of the major components of the healthcare delivery system and continues to be the central and critical source of leadership, coordination of MSA workgroups, and resource development for health access activities.

Ongoing Activities Related to Strategy 1

Since the HAC revised the Health Access Strategic Plan in May of 2005, its role has been more of a monitoring function. This workgroup has continued reviewing modifications to and adoption of recommended MSA spending plans, receiving updates from workgroups, giving guidance to MTSAB-funded strategies, and connecting the work of the MTSAB-funded strategies to health reform initiatives and Coalition- and Health Access-related activities (e.g., safety net study, health care for homeless initiative, etc.) In 2006-07, the Executive Director of SCBH and chairs of the workgroups played key roles in facilitating and reviewing the development of MSA workgroup logic models and identification of prioritized outcomes for tracking and evaluation.

Exhibit 1-1. MTSAB Budget and Expenditures for 2006-07 for Strategy 1[1]

	Recipient	Approved Budget	Expenditures as of May 31, 2007	Percentage Expended
Strategy 1: Health Access Coalition	SCBH	$100,000	$56,251	54%

[1] This chart captures expenditures paid out by the County as of 5/31/07 and does not reflect claims submitted for services during May. Workgroups have until June 30, 2007 to expend allocated funds and do not submit claims to the County for June until July. Therefore, complete expenditure data will not be available from the County until after the end of the 2006-07 fiscal year (August 2007).

For fiscal year 2006-07, $100,000 was budgeted to SCBH for activities related to Strategy 1 in support of other strategies. As of May 31, 2007, the 2006-07 Financial Status Report shows that only 54% of this funding had been expended. However, by the end of June 2006, the Coalition will have expended the entire $100,000. For this reported fiscal year, the Coalition provided professional and staff support to the HAC, Enroll and Retain, Oral Health, and Community Education Strategies.

Outcomes

Prioritized Outcomes for Strategy 1 for 2006-2009[2]

1) Active participation on each of the workgroups of organizations whose work is aligned with the workgroup goals/ purpose.

2) Solano Coalition for Better Health leverages MTSAB funds, develops partnerships and participates in other efforts related to improving health access.

Results for 2006-2007

Outcome (1) Active participation on each of the workgroups of organizations whose work is aligned with the workgroup goals/purpose.

Indicators:

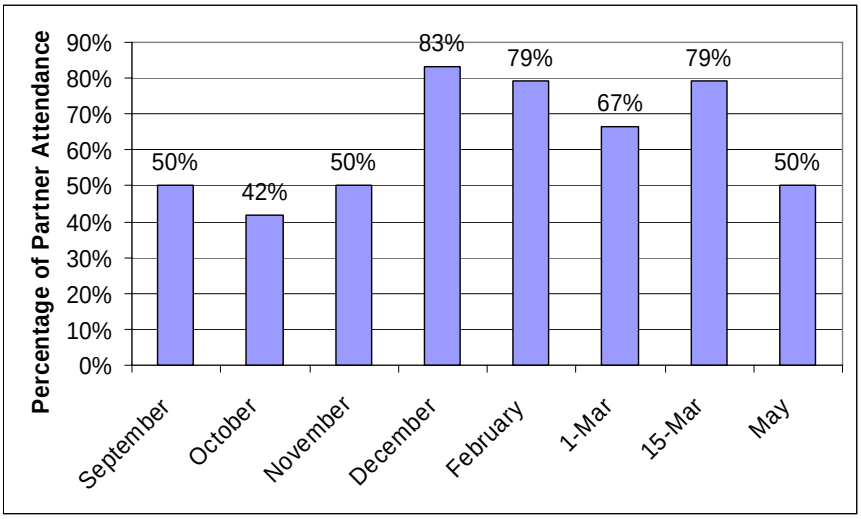
1. ***Workgroup Attendance over a 12-month period by partner organizations for each workgroup.***
2. ***Partner organization participation in workgroups over a 12-month period.***

- **Workgroup Attendance and Participation**
  - **Health Access Committee**. Over the eight HAC meetings that occurred in 2006-07, an average 64% of the members or 15 members attended on a regular basis. Exhibit 2 details invited partners' participation in the HAC meetings. It should be noted that while the HAC meetings were scheduled to occur once every two months, the committee met more often with two meetings in March for FY 2007 budget planning purposes. The Health Access Committee included representatives from the following organizations: Partnership HealthPlan of California, Solano County, United Way of the Bay Area, La Clinica de La

[2] Strategy 1 has the same two outcomes for each of the three years of the evaluation.

Raza, NorthBay Healthcare, Sutter Health, Solano Medical Society, Youth & Family Services, and Planned Parenthood.

Exhibit 1-2. Health Access Committee: Percent of Partner Attendance By Month



- **Enroll and Retain.** Because this workgroup has done much work over the previous year related to the transition from CalKids to Healthy Kids Solano, it has decreased the number of in person meetings and conducts most work via emails and conference calls. This workgroup is waiting to see what happens at the state level with the Children's Health Initiative. However, it still maintains a core group of committed members from H&SS, First 5 Solano, and SCBH who attended almost most meetings in 2006-07.[3]
- **Behavioral Health/Primary Care Integration**. Workgroup meeting attendance by some key stakeholders was characterized as sporadic. Meeting minutes from six meetings show a 33% attendance with an average of 10 participants per meeting. Attendance by physicians and substance abuse partners was noted as particularly sporadic or poor.
- **Frequent Users.** Because of the recent implementation of the Frequent Users project, the Frequent Users Workgroup was very active in 2006-07. This workgroup met seven times with an average of 45% attendance with 11 participants attending on a regular basis. The workgroup met monthly and formally

[3] Because Enroll and Retain does not keep formal minutes or attendance records, we have only anecdotal information on attendance for this workgroup.

recorded its minutes. Regular participants included the Frequent User Project's clinician, as well as representatives from H&SS, Sutter Solano Medical Center, North Bay Hospital, and more recently, representatives from local emergency and transitional housing organizations.

- **Oral Health**. In 2006-07, this workgroup participant list included 37 members from 12 partner organizations. A number of interviewees observed that several dentists have volunteered to serve on the Oral Health Workgroup and have shown consistent attendance. All members have been described as fairly engaged, specifically citing La Clinica, Head Start and Smile 'n Style. The Chair attributes the active level of attendance to the fact that "people are really energized about this issue."[4]
- **Community Education**. No attendance data available.[5]

Please also see the discussions of the other strategies in this report for more information on workgroup attendance and participation.

Data Sources and Limitations

- Data for this outcome was collected through interviews with the Executive Director of SCBH, the Chair of HAC, and through review of key SCBH and HAC documents, including SCBH's annual financial report/audit and the Executive Director's monthly reports. To gain additional insight into the operations of individual workgroups, we interviewed the chairs of workgroups with ongoing interventions or activities,[6] as well as other key staff, such as the Director of the Solano Kids Insurance Program.
- As noted, we were not able to obtain any (or an adequate level of) attendance and meeting summary data for the Enroll and Retain, Oral Health or Community Education Workgroups. In addition, our calculation of attendance rates relied on a roster of participating agencies and individual representatives obtained in September of 2006. As old and new participants cycled on and off the workgroups, the roster was not necessarily updated; therefore, the information may not accurately reflect the base or totals over time.

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[4] We were only able to obtain meeting minutes for three of the meetings; and have determined that the data is too limited to provide a percentage attendance for this workgroup.

[5] Because Community Education Workgroup does not keep formal minutes or attendance records, we had no information on attendance for this workgroup.

[6] The chair of the Community Education Workgroup was not interviewed because that strategy's primary intervention is currently on hold.

Outcome (2) SCBH leverages MTSAB funds, develops partnerships, and participates in other efforts related to improving health access.

The Coalition has undertaken many efforts outside of its work with HAC and the MTSAB-funded workgroups. The supporting information presented for the following two indicators describes the extent of fund leveraging and activities that also contribute to promoting health access for Solano residents.

Indicators

1. ***Amount of funding generated by SCBH, excluding MTSAB funds, over a 12-month period.***

- Excluding MTSAB funds, SCBH generated more than $2 million in funding between January 1, 2006 and December 31, 2007. The specific sources of this funding are as follows:[7]
  - **$822,000** from MediCal ($415,000), First 5 ($120,000), United Way ($65,000), State OERU (DHS) ($217,000), and foundations ($5,000) for **Solano Kids Insurance Program (SKIP)**.
  - **$750,000** from First Five ($170,000), The California Endowment ($200,000), Solano County Match ($150,000), Business Partners ($100,000), and Blue Shield ($125,000) for **Healthy Kids**.
  - **$317,000** from The California Endowment ($173,000), United Way ($67,000), Coalition Partners ($67,000), and Champions Event ($10,000) for the **Elimination of Health Disparities in Solano** project.
  - **$72,000** from United Way ($16,000), Solano County Clinic ($40,000), La Clinica ($8,000), CMC ($8,000) for **Pharmacy Assistance**.
  - **$65,600** in affiliate fees from partners.

- These other funding sources are significant as they are funds raised and leveraged from public and private sources to address a number of gap areas. Also, it is important to put the MSA dollars into perspective. Within Solano County, the MSA funds represent a small percentage of the total funding in health access and health care services. For example, Appendix B contains an initial summary of the County's health access and service promotion efforts that total at least $19 million dollars.[8] This is in comparison to the annual $1.45 million available for MTSAB-funded strategies in 2006-07.

2. ***Number and extent of partnerships SCBH is involved in related to improving health access over a 12-month period.***

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[7] This data is based on the 2007 Solano Coalition for Better Health 2007 budget (Feb 2007) based on funds raised in 2006. See also Strategy 2 for more information on leveraged dollars.

[8] Source: The Solano County Health Strategic Plan from 2005-2008.

In 2006-07, SCBH supported a total of nine committees or work groups, which included 180 committee/work group members representing approximately 39 organizations. Of these, six are MSA-supported groups; the remaining committees include the Community Clinic Alliance, Disparities Strategic Planning Committee, and the Disparities Community Leaders Workshop. The SCBH Board includes 18 representatives from 13 different organizations, of which almost all have representatives in the MSA workgroups. Appendix A includes a full list of the 39 organizations (county, hospitals/medical centers, community clinics, funding agencies, heath care groups, education, etc.) who participated in SCBH committees and workgroups and related efforts to increase health access in Solano County.

3. ***Number and extent of other efforts (committees, advocacy, etc.) SCBH is involved with related to improving health access over a 12-month period.***

In addition to staffing the Health Access Committee and its affiliated workgroups, SCBH has also been involved in a number of other efforts related to the goals of Health Access Strategic Plan. These activities are organized by relevant strategic plan goals below:

Efforts related to Strategic Plan Goal 2

"Creating a primary care based comprehensive system of health care that is integrated, financially stable, and has a strong infrastructure."

- **The CMSP Task Force** has been focusing in the past year on several tasks related to promoting access to specialty care for CMSP recipients. These include:
  - Utilizing pro-bono specialists in established primary care clinics.
  - Enlisting the support of certain specialists at Kaiser Permanente to provide specialty care for CMSP recipients.
  - Working with H&SS to submit a proposal to the Federal Bureau of Primary Care to add specialty services to their scope of services eligible for reimbursement.
  - Working with H&SS to assist hospitals to provide "step-down" care for hospitalized clients to decrease the number of days CMSP recipients spend in the hospital.
- Other Goal 2 related efforts undertaken by SCBH in 2006, included:
  - Assisting La Clinica in getting their dental clinic up and running.
  - Providing support for community medical centers to increase access for low income residents in Vacaville.

Efforts related to Strategic Plan Goal 3

"Increase appropriate utilization of health services by Solano's racially and ethnically diverse population."

- **Solano County African American Disparities Elimination Project**: Beginning in 2004, the Coalition refocused its energy to eliminate racial and ethnic disparities in health status. Based on its initial research, SCBH is concentrating on addressing the health disparities that adversely affect African American residents of Solano County. The goals of the project include:
  - Increase individual behaviors which positively contribute to personal health and wellness
  - Increase the role of the extended family and community (schools, church and neighborhood) in supporting personal behaviors
  - Improve the quality of care received by African American residents
  - Increase the number of public and private policies and practices which create and support healthier environments and promote positive personal health behaviors for African American residents.

  To achieve these goals, the Disparities Project has adopted the following strategies:

  - *Strengthen and create partnerships with the community to address disparities in health status*. In 2006, activities related to this strategy included organizing the first annual Champions for Healthy African Americans, a community celebration in February 2006 attended by 250 community members which celebrated existing efforts improve the health and wellness of African Americans in Solano County. The Disparities Project also conducted interviews and discussions with 70 African American community leaders.
  - *Educate the community about the impacts of disparities and approaches to improve health outcomes.* Activities carried out in 2006 related to Goal 3 included making presentations on the project at seven community events and presentations; making 15 presentations to African American organizations or at other community gatherings; authoring seven newspaper articles promoting wellness in the African American community; and distributing 2,000 copies of educational materials at community events.
  - *Develop a community-based and community supported strategic plan to address disparities in health status*. During 2006 and early 2007, a planning team of 31 community residents and healthcare providers worked for 18 months to develop a strategic plan for the Disparities Project. A draft plan was presented to the community in February 2007.
- **Cultural Competence Conference Series.** In conjunction with several other organizations, including First 5 Solano County, Baby First, the Solano County Public Defender's Office, Black Infant Health, and Family Violence Prevention, SCBH hosted a conference to increase the competency of healthcare and other professional staff to provide more effective and culturally competent care. The conference, "Strengthening Partnerships and Skills to Reduce Inequities Among Residents of Solano County," was held May 2007 in Suisun City.

Efforts related to Strategic Plan Goal 5

"Advocate for policies and actions that increase access to health care, support healthy behaviors and healthy communities."

- **Safety Net Study**: The issues discussed by the CMSP Task Force surfaced concerns about the strengths and weaknesses of the healthcare safety net serving Solano county residents. To research and analyze these concerns, SCBH was tasked with carrying out a study of the current safety net that would also serve as a component of the SB 697 health assessment required to be completed by hospitals in 2007. The goal of this study was to give providers a better understanding of how they and others are contributing to the safety net. As of May 2007, a draft version of this report had been completed and was being reviewed by the SCBH Executive Committee.
- **Influence on Statewide Children's Health Initiative (CHI), SCHIP reauthorization, and the Governor's Health Plans:** The Coalition has worked to rally key stakeholders around a number of key state and national proposals and legislation. Sample activities included generating 150 media articles a year on health access & health issues and 90 presentations and contacting U.S. congressional and senate representatives to request support for the reauthorization of SCHIP and reauthorization at a rate that will fully support SCHIP.
- **Pre-natal care.** SCBH worked in partnership with PHC to ensure that there are adequate numbers of health providers who work on the issue of pre-natal care.

Data Sources and Limitations

- The data sources for this outcome include workgroup minutes (which included attendance) for each meeting, interviews with SCBH's Executive Director, the SCBH's 2007 budget, the SCBH annual report, and the 2007-1012 Strategic Plan of the Solano County African American Disparities Elimination Project.
- Because this evaluation is focused on the MTSAB-funded activities, the Coalition was the primary source of this data. It was not possible for us to track in great detail all of SCBH's other activities although they relate to the Health Access Strategic Plan. Comprehensively tracking activities outside of the Strategic Plan would entail resources beyond the scope of this evaluation.

Conclusion

The Coalition and the Health Access Committee continues to play key roles in supporting and coordinating the other MTSAB-funded strategies as well as leveraging funds from other public and private sources. In addition, the partnerships created by the Coalition since 1988 remain strong. Following is a summary of successes and challenges related to Strategy 1:

Successes

- **The Coalition continues to maintain broad participation of partners.** According to the Executive Director of SCBH, higher-level leaders of partner agencies have continued to actively engage in the SCBH Board and MSA workgroups because they are seriously committed to improving the health of residents of Solano County. In addition, the partners participate because (1) there is a strong framework presented in the

Health Access Strategic Plan for this work; (2) partner agencies are getting additional funding; (3) efforts are made to use their time wisely as volunteers, and (4) among the newer workgroups, there is much energy and focus on the presenting health issues.

- **The funding raised and leveraged and the many efforts by the Coalition continue to be strong.** For the Coalition's 2007 health access-related work described earlier, a total of $2,196,339 has been secured. The Coalition and its members have been effective in continuing to raise funds for a variety of projects, including the new work to address Health Disparities with a total of $317,000 for this project.

Challenges

- **Attendance seems to be low for some of the workgroups.** Compared to FY 05-06, average attendance seems to have declined for a number of the workgroups. The chairs of the workgroups cited a variety of reasons, including the maturity of one of the workgroups and the reduced need to meet as often. Other reasons for low attendance include the short-staffed nature of some key partners, the lack of a critical role for some agencies to play, and a perception that a workgroup's composition and focus may be dominated by one group.
- **Inconsistent record keeping on attendance created noticeable gaps in the data.** As mentioned earlier, we could not obtain minutes and attendance data for all workgroups for a 12 month period, because of the haphazard and decentralized way that this information was recorded and stored. Also, in calculating attendance and participation figures, we found that the roster of agencies and individual participants were not always kept up to date, therefore, the attendance figure might be higher or lower if members have dropped off or new members have signed on. Finally, it was not always possible to connect individual names recorded in the minutes with their agencies. There is a great need for a centralized roster that links the names of individual representatives to their organizations.

Recommendations

- **Improve mechanisms for collecting attendance data and meeting minutes.** Based on the challenge of accessing attendance and meeting summary data, at a minimum, we recommend that systematic attendance data (via a sign in sheet) be collected at every meeting whether in person or by phone. In addition, a log of dates and key topics of workgroup teleconference meetings should be kept.
- **Identify appropriate participants at different stages of the workgroups to measure attendance.** To more accurately calculate the base for attendance, we recommend identifying the *stage* of each workgroup is in (start-up, implementation, maturity stage, etc.). Additionally, SPR will work with the Coalition Executive Director to identify

the *types* of participants who are appropriate at various stages (1) initiative planners (the biggest group), 2) initiative implementators (the smaller group that monitors and advances the imitative), and 3) resource members (called on when necessary).[9] Once we have identified those participants who are appropriate to a workgroup's current stage, we will calculate the base for that group's attendance based on those participants.

- **Capture and document health access related efforts that are not MTSAB-funded.** It was suggested in the interviews that this evaluation finds ways to better capture and report the continuum of Coalition work occurring. It is beyond the scope of this evaluation to track the development and outcomes of all the related SCBH projects in detail, however, SPR has begun to review and summarize the number and extent of other efforts SCBH is involved with related to improving health access over a 12-month period. This will help us assess the true gaps of unaddressed areas in the strategic goals, and better understand the outcomes of the MTSAB-funded strategies within the larger context of other ongoing work and SCBH's contribution to a myriad of outcomes.

[9] It is assumed that all members would be kept on the email work group distribution list to assure that they received updates and be kept informed and could raise an issue is necessary.

HEALTH ACCESS STRATEGY #2 *Enroll and retain all eligible children and adults in available public or other subsidized plans or Health program(s).*
HEALTH ACCESS STRATEGY #4 *Develop programs to pay premiums or share of cost for eligible families where appropriate.*

Strategies 2 and 4 are under Goal 1 of the Solano County Health Access Strategic Plan. These two strategies, enrolling and retaining individuals in health insurance programs and covering the costs of these programs, are at the core of ensuring access to health care.

Ongoing Interventions Related to Strategies 2 and 4[1]

The primary interventions related to these strategies and supported with MTSAB funds are the Solano Kids Insurance Program (SKIP), operated by SCBH, and the Solano County Children's Health Initiative plan for low income children ineligible for either Medi-Cal or Healthy Families, called Healthy Kids Solano (HK).

Exhibit 2-1. MTSAB Budget and Expenditures for 2006-07 for Strategies 2 & 4[2]

	Recipient	Approved Budget	Expenditures as of May 31, 2007	Percentage Expended
Strategy 2: Enroll and Retain	SCBH	$299,960	$210,233	70%
Strategy 4: Premiums	SCBH	400,000	400,000	100%
Total		***$699,960***	***$610,233***	***87%***

As shown in Exhibit 2-1, in 2006-07, nearly $700,000 in MTSAB funds were allocated to SCBH to support implementation of Strategies 2 and 4. This included $299,960 to support SKIP and $400,000 to cover the cost of premiums for children enrolled in HK and the family share for HK, Healthy Families, and Kaiser's Child Health Plan. With one month remaining in the fiscal year, 87 percent of the funding allocated for both strategies had been expended. One hundred percent of the allocated funding for Strategies 2 and 4 is expected to be expended by the end of the fiscal year, according to several respondents.

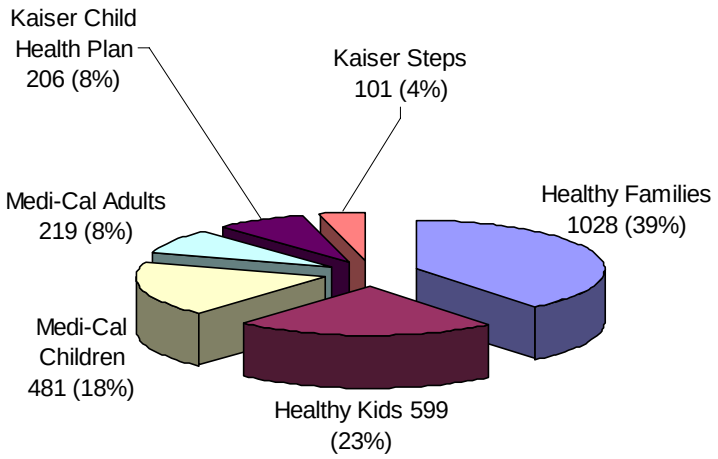
[1] The information presented in this section is based on interviews with the workgroup's chairs, key staff involved with the intervention, a review of relevant documents, and data provided by the SKIP project.

[2] This chart captures expenditures paid out by the County as of 5/31/07 and does not reflect claims submitted for services during May. Workgroups have until June 30, 2007 to expend allocated funds and do not submit claims to the County for June until July. Therefore, complete expenditure data will not be available from the County until after the end of the 2006-07 fiscal year (August 2007).

Solano Kids Insurance Program (SKIP)

The primary ongoing intervention related to achieving Strategy 2 in Solano County is SKIP. Founded in 1998, SKIP assists children and their families with enrollment and retention in publicly-funded health care programs. In 2006, SKIP assisted 2,645 individuals to enroll in health insurance, achieving 95 percent of its goal of assisting 2,700. Between January and April of 2007, SKIP enrolled another 735 individuals and assisted another 178 with re-enrollment. The majority of these new enrollments were in Healthy Families, Medi-Cal and Healthy Kids Solano. (See Exhibit 2-2)

Exhibit 2-2: Individuals Assisted with New Enrollment by SKIP in 2006*



**Individuals assisted with enrollment in CMSP (5 individuals) and AIM (6 individuals) not included in chart.*

A centerpiece of SKIP's enrollment and retention efforts is the program's 100% School Campaign. This campaign works in partnership with all seven school districts in the county to identify uninsured children in each school and enroll them in health care programs. SKIP staff work with targeted schools until the percentage of insured children reaches as close as possible to 100 percent, and then moves on to other schools. Thirty-five (35) schools have met the 100% School Campaign 100% insured threshold. These schools are rechecked yearly by SKIP staff to ensure retention and keep the rate of insured children as close to 100 percent as possible.

In addition to its 100% School Campaign, SKIP also:

- Conducts outreach to all public schools in the county. For example, SKIP partners with school districts to send out information on publicly funded health care programs with application forms for free and reduced lunch.
- Places SKIP and sub-contracted staff at community & county clinic sites.
- Contacts families receiving county Child Health and Disability Prevention (CHDP) services to facilitate enrollment in health care.

- Conducts outreach to groups such as Women Infants and Children (WIC), child care providers, Baby First Solano Collaborative**,** and Family Resource Centers that serve potentially eligible children and families.

In combination with these enrollment and retention efforts, SKIP also provides assistance to families with utilizing health care. For example, in both 2005-06 and 2006-07, using funding from First 5 Solano County, SKIP contacted the families of approximately 100 zero to five-year-olds from First 5 School Readiness Sites. During these follow-up calls, SKIP staff checked whether these children were still insured and, if not, provided assistance with re-enrollment. SKIP staff also asked about care utilization and offered assistance in setting up needed visits to doctors, dentists and vision care providers. First 5 recently renewed its funding to allow SKIP to continue conducting this follow-up.

Due to the receipt in spring 2006 of a state Outreach Enrollment Referral and Utilization (OERU) grant for $200,000 per year for three years (subject to state budget approval), SKIP is further expanding its enrollment, retention and utilization efforts by:

- Hiring two new staff to allow the program to expand outreach from 33 to all 63 public elementary schools in Solano County. This expansion will occur over a three-year period.
- Purchasing a new database to allow staff to enter and manage data more efficiently.
- Contracting with a company to carry out follow-up calls three times a year to at least 1,000 children assisted with enrollment in Medi-Cal and Healthy Families. If, during these follow-up calls, the company finds that children are no longer enrolled or need assistance with utilization, SKIP staff will follow-up and provide appropriate assistance.

Healthy Kids Solano

The other primary intervention related to Strategies 2 and 4 is Healthy Kids Solano (HK). Initiated in December 2005, HK is Solano County's Children's Health Initiative program providing health care to 1,200 low-income county children who are ineligible for Medi-Cal or Healthy Families, primarily due to immigration status. Children are enrolled in HK by SKIP staff and receive benefits through Partnership Health Plan of California and its provider network. While families contribute from $7 to $15 per child per month for HK, the bulk of the premiums for the program (around $1,160 per child per year) are covered by SCBH with funding from a variety of sources, including MTSAB funds. The specific amounts contributed by SCBH for HK are as follows:

- In 2006, SCBH paid $1.1 million in premiums to cover costs for 1,200 children.
- From January through April 30, 2007, SCBH paid $300,000 in premiums for the 1,200 children.

Kaiser Permanente also offers a low-cost program for Solano County children who are ineligible for Healthy Families and Medi-Cal, called the Child Health Plan.

Approximately 1,475 Solano County children have been enrolled in the Child Health Plan.

Enroll and Retain Workgroup Activities 2006-2007

The Enroll and Retain Workgroup, which provides oversight to both HK and SKIP, was somewhat less active in 2006-2007 than in previous years. This was primarily because both SKIP and Healthy Kids Solano were operational during this period and consequently less guidance was required of the workgroup.

However, workgroup members representing the County Health and Social Services Department (HSS), SCBH, Partnership Health Plan of California (PHC), and First Five Solano County did meet whenever there were significant agenda items for the group, but minutes were not formally recorded for these meetings. Topics discussed by the workgroup included:

- **Fundraising to cover premiums for HK**. Because SCBH needs to raise approximately $1.4 million annually to cover the costs of premiums, including $120,000 from local businesses and private donors, the workgroup devoted a significant portion of its time to discussions about fundraising activities.
- **Developing policies for HK waiting list**. Although HK became fully operational early in 2006 and most policy and operational issues were resolved by the middle of the year, in 2006-2007, the workgroup discussed and helped develop waiting list policies for the program.
- **Mobilizing support within the county for state legislation to provide health care for all children**. Because of the great difficulty of funding Healthy Kids at the county level, the workgroup spent time discussing how to prompt the state to take over responsibility for funding HK or another similar program.

Outcomes

Prioritized Outcomes for Strategies 2 and 4 for 2006-2007

(1) Targeted children visit their primary care provider (PCP).

(2) Over 95% of children 0-17 in Solano County are insured.

Outcome (1): <u>Targeted children visit their primary care provider.</u>

Results

- One hundred percent of targeted families (98 children, aged 0-5) that SKIP staff were able to contact for follow-up all three times reported that their child had

visited a doctor[3] at least once during the 10 months since the child became insured. In fact, among *all* children—including those SKIP staff were unable to contact each time—the vast majority were reported to have visited a doctor at least once in the 10 months since becoming insured. (See Exhibits 2-3 & 2-4.)

Enrollment in a particular health program for low-income children did not seem to make a difference in terms of visiting a doctor, as the percentages for all programs were approximately the same.

Exhibit 2-3: Doctor Visits by Children Aged 0-5 Targeted for Follow-up by SKIP

	Total Assisted with Enrollment	Total who Visited a Doctor at least once in 10 Months	Pct who Visited a Doctor at least once in 10 Months *	Pct of all assisted who Visited a Doctor at least once in 10 Months
Healthy Families	38	37	100%	97%
Healthy Kids Solano	17	17	100%	100%
Kaiser Child Health Plan	12	12	100%	100%
Medi-Cal	31	31	100%	100%
Total	98	97	100%	99%

** Children whose families SKIP staff were unable to contact all three times, and who when contacted once or twice indicated that they had not visited a doctor, are excluded from this calculation.*

Data Limitations

- Because of the small number of children included in the data (less than 8 percent of the total number of individuals assisted by SKIP with enrollment in 2006), and the fact that results are self-reported and unverified, these results need to be viewed cautiously and cannot be easily generalized beyond this small target group. Also, in the absence of a much more rigorous evaluation design, we cannot be sure that the follow-up calls by SKIP staff were the primary reason children visited a doctor; however, it is certainly likely that the calls contributed at least somewhat to this positive outcome.

[3] Although the outcome is focused on visits to the child's primary care provider (PCP), because of the managed care structure of each of the four programs, where a child needs to visit his or her PCP before receiving most other kids of care, we are assuming that at least one of each child's visits to a doctor (if he or she went more than once), was to his or her PCP.

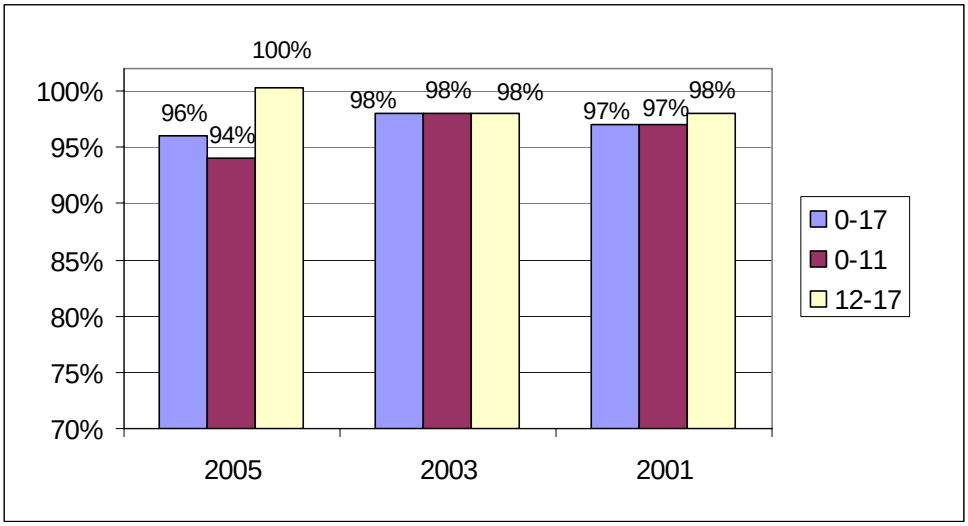
Outcome (2): Over 95% of children 0-17 in Solano County are insured.

Indicator: Percentage of children (0-11) and teens (0-17) that are reported by a parent to be covered by some type of health insurance.

Results

- Based on the most recent data from the California Health Interview Survey, it appears that Solano County has achieved the 95% target of this outcome. Results from CHIS for 2005 show that 96% (95 percent confidence interval: 93 - 99 percent) of the children 0-17 included in the survey were reported to have some type of health insurance. (See Exhibit 2-5.)
- Generally over the period from 2001 and 2005, the percentage of insured children 0-17 in Solano County has remained very high. Although it appears that the percentage of children with insurance has declined slightly over time from 2001 to 2005, these differences are very small and may not be large enough to be significant. (See discussion of data limitations below.)

Exhibit 2-5: Percent of Children with Health Insurance by Age Group, 2001-2005



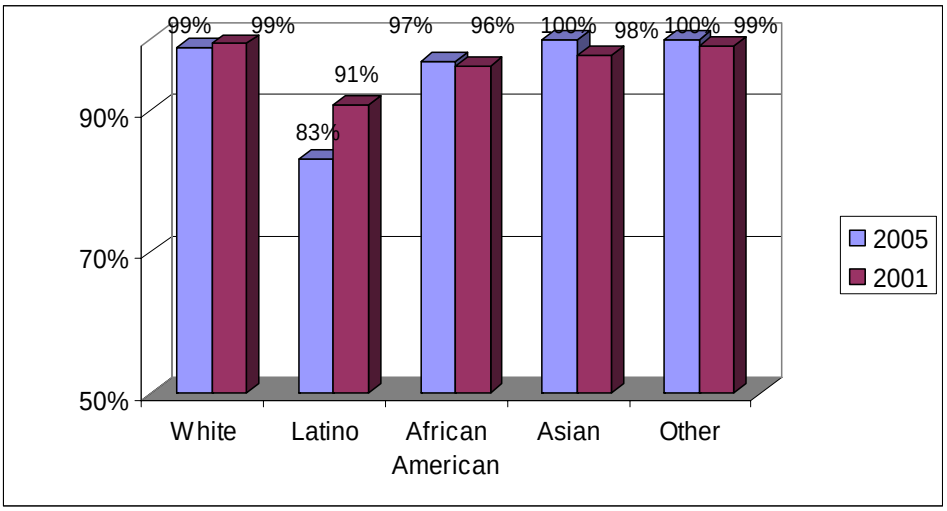
**Source: California Health Interview Survey (CHIS).*

CHIS Data on insurance status for children can be further broken down by the race/ethnicity and poverty status of the children. This is useful because it allows us to see whether there continue to be pockets of children with much lower rates of insurance coverage than others, particularly among groups targeted by the Health Access Strategic Plan such as children under 300 percent of poverty and those who are members of racial and ethnic minority groups.

Health Insurance Coverage and Race/Ethnicity

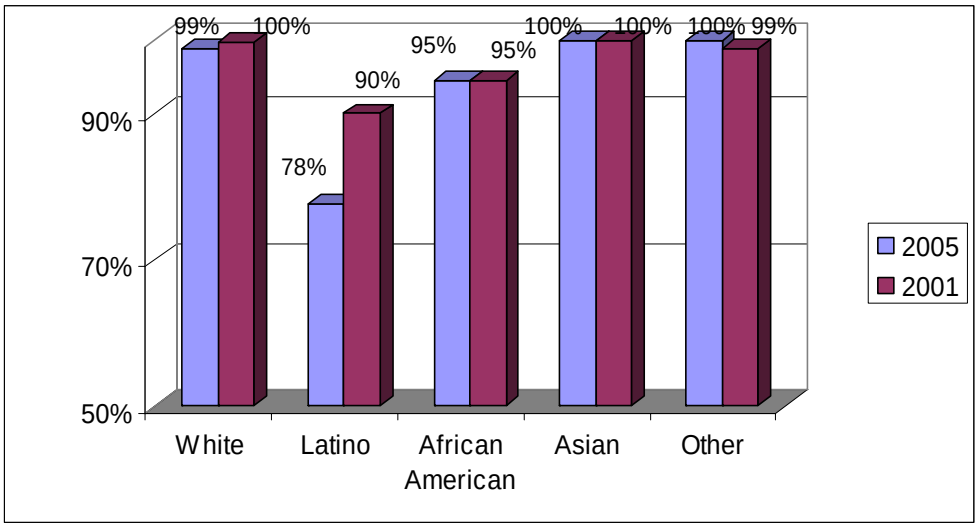
- Although results for children 0-17 of particular racial and ethnic groups in the county were fairly similar to the overall results presented above, the one group for whom results were significantly lower were Latinos. (See Exhibit 2-6.)
  - In 2005, only 83% (95% confidence interval: 69-98) of Latino children in Solano County were estimated to be covered, leaving an estimated 3,000 children uninsured. This percentage is about 13 percentage points lower than for African Americans, the group with the next lowest rate of coverage. It is also a drop of over seven percentage points from 2001.

Exhibit 2-6: Percent of Children 0-17 with Health Insurance by Race/Ethnicity, 2001-2005



  - The difference in rates of coverage among Latinos was even more pronounced for children, 0-11 years old, in 2005, for whom CHIS results estimated that only 78% were insured (95 percent confidence interval: 60 - 96 percent). This is nearly 17 percentage points lower than for African American children and slightly more than a 12 percentage point drop since 2001. (See Exhibit 2-7.)

Exhibit 2-7: Percent of Children 0-11 with Health Insurance by Race/Ethnicity, 2001-2005

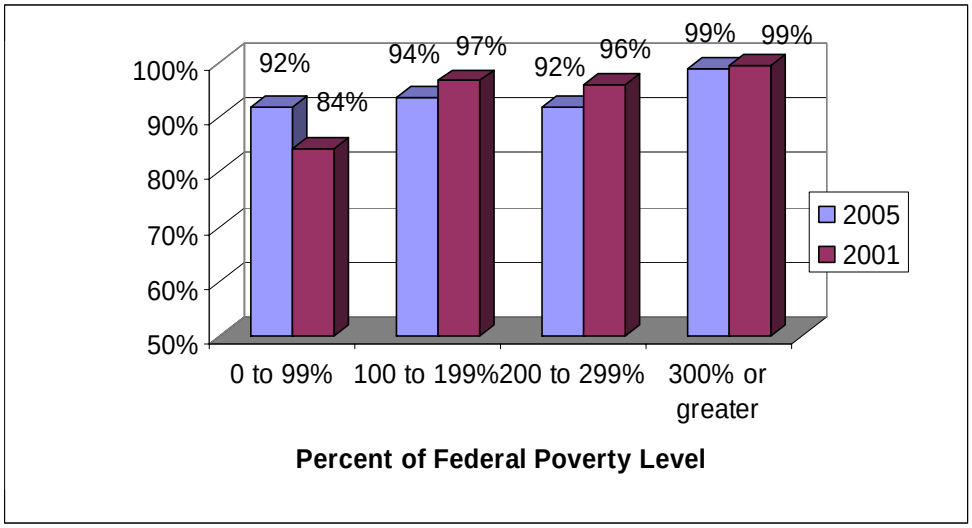


- Although the percentage of insured Latino children seems much lower than for other groups, there is some uncertainty related to these results. Based on the 95 percent confidence interval, the actual percentage of insured Latino children 0-17 in Solano County could be as low as 69 percent and as high as 98; the true percentage for Latino children 0-11, similarly may vary from 60 to 96 percent.

Health Insurance Coverage and Poverty Status

- Results for health insurance coverage among children in Solano County by poverty status also differed somewhat from the overall results for the county. Not surprisingly, the group with the highest percentage of insured children in 2005 (99 percent) were those whose families were at 300 percent of the federal poverty level (FPL) or higher. Much more surprising was the fact that children whose families were at 200-299 percent of FPL and children whose families were at 0-99 percent of FPL were equally likely to be uninsured. This somewhat unlikely result was because the percentage of insured children at 0-99 percent of FPL jumped up eight percentage points, while the percentage insured at 200-299 FPL dropped four percentage points. Although the decline in coverage for children at 200-299 percent of FPL is somewhat disappointing, the size of the decline was still fairly small. (See Exhibit 2-8.)

Exhibit 2-8: Percent of Children 0-17 with Health Insurance by Poverty Status, 2001-2005



Data Limitations

When reviewing the results presented above, it is important to keep in mind the limitations of the data source we are using to calculate these results. These limitations for CHIS data are described below.

- Because CHIS data is based on a survey of a sample of county residents, based on these data alone, it is hard to be absolutely certain that the actual percentage of insured children in Solano County is 96 percent or higher. Because of the possibility of random error in a survey of a sample of the population, in addition to an estimated percentage, CHIS also provides a range of results, within which, it is 95 percent certain (called a 95 percent confidence interval) that the true result for the population lies. In the case of the percentage of insured children in Solano County, this interval is 93 to 99 percent, meaning that there is a chance that the real percentage of insured children (not the percentage of the sample but of the population) could be as low as 93 percent or as high as 99 percent. Generally, these ranges decline as the size of the sample increases.
- Because we did not have access to individual level results for CHIS data until too late in the fiscal year, we were unable to conduct certain statistical tests to determine whether the differences in outcomes in 2001 and 2005 and among the groups were large enough to be statistically significant and not merely due to random errors in conducting the survey. Thus, differences in results between 2005 and 2001 or between groups, especially when small, should be viewed cautiously as they may not reflect real differences in the underlying population.[4]

[4] Due to the strict confidentiality requirements for gaining access to individual-level CHIS data, neither SPR nor Solano County H&SS staff have been able to gain access to this level of data. Instead, county staff obtained these and the other Solano-county aggregate CHIS results included in this report from a special CHIS website available to county health department staff.

- Finally, the CHIS data reported here (the most current) was collected nearly two years ago during the second half of 2005. Because of this lag, we cannot see the effect of any programmatic or policy changes made during 2006 or 2007 (the time period this report is focusing on). Consequently, the current situation in Solano County may have changed substantially since 2005, but CHIS results won't reflect these changes until the next series of data is released in the spring of 2009.

Data Sources

Two primary sources of data were used to calculate results for the outcomes for Strategies 2 and 4: SKIP targeted follow-up data and data from the California Health Interview Survey. Each of these data sources is described in detail below.

SKIP Targeted Children Follow-up Data

The primary data source for the first outcome, "Targeted children visit their PCP" was data collected by SKIP staff as they conducted follow-up calls with the families of 98 children, ages 0-5. These children were from First 5 Solano School Readiness sites and were assisted with enrollment by SKIP staff between January and December 2006. This follow-up was funded by First 5 Solano.

These follow-up calls were conducted by SKIP staff at intervals of two, six and 10 months following the initial assistance and data was recorded on an Excel spreadsheet. During these follow-up calls, parents were asked whether the child had visited a doctor, dentist or vision care provider since the last call and positive and negative responses were recorded by SKIP staff.

These data were then provided to SPR to conduct the analysis required for this report. Because of the timing of the report, these data only included information on follow-up conducted from March 2006 through April 30, 2007. Consequently, for children enrolled after the middle of 2006, one to two planned follow-up calls had not occurred by the time SPR was provided with data (follow-up calls for these children will not be completed until October, 2007). However, because most children were reported to have visited a doctor by the time of the two month follow-up calls, the fact that some of the later follow-up calls had not taken place by the time we conducted our analysis did not have a large impact on results we have included in this report.

California Health Interview Survey

The primary data source for the second outcome is from the California Health Interview Survey (CHIS), a biennial phone survey of randomly selected households in California. CHIS is a collaborative project of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. CHIS has been carried out three times: 2001, 2003 and 2005, and will be implemented again beginning in mid-2007. Data from CHIS takes at least a year after the survey is completed to be released. For example, the results of the 2005 survey were just released in the winter/spring of 2007.

The main purpose of CHIS is to provide data to the state for health planning purposes. Counties can also utilize county-level CHIS data, but in small counties such as Solano, unless CHIS surveys more households than needed for statewide results, not enough data on the county level will be collected to report meaningful results, particularly for smaller subgroups. Because of the expense of contacting additional households, counties that want CHIS to survey additional households have to cover the cost of this oversampling.

Because of the expense involved in oversampling, Solano County has opted to have CHIS do so only in 2001 and 2005. Consequently, as can be seen in Exhibit 2-9, the number of adults and children surveyed in 2003, was a little less than half of the number sampled in 2005. The total number of adults sampled in 2001 was also much higher than in 2003. Because of the much smaller number of people, particularly children, surveyed in 2003, we have often been unable to present CHIS results from 2003. In addition, even some results from the 2005 and 2001 surveys for children 0-11 and 12-17 are based on fairly small sample sizes. In addition, it is likely that some population sub-groups, such as Latinos and low-income people, were undercounted due to their transience and general fear of or unwillingness to participate in surveys.

Exhibit 2-9:
CHIS Sample Sizes in Solano County 2001-2005

Age Groups	2005	2003	2001
0-17	403	174	Not Available
Over 17	1189	502	1553

Another limitation related to CHIS is that the survey is based on self-reported data from households. This means that there is no way to verify whether what a household members reports is true. And indeed, despite the promise of confidentiality made by survey takers, some respondents may feel ashamed in answering certain survey questions honestly, and so may change their answers or simply refuse to answer those questions.

Outcomes for 2007-2008 and 2008-2009

Listed below are the prioritized outcomes we are planning to track for 2007-2008 and 2008-2009 (in addition to the outcomes for 2006-2007).

2007-2008 Prioritized Outcomes

(1) Increase in children and families assisted with enrollment who are insured 14 months after initial enrollment
(2) Increase in percentage of public elementary schools with 100% health insurance coverage

2008-2009 Prioritized Outcome[5]:

(1) Healthy Kids Solano (HK) (or any similar/replacement program(s)) is fully funded with sustainable funding sources

Conclusion

During 2006 and the first few months of 2007, Solano County has achieved considerable success in attaining the prioritized outcomes for Strategies 2 and 4. This success, discussed in detail below, is likely due primarily to the well-established effectiveness of the Solano Kids Insurance Program and the county's recently implemented Children's Health Initiative program, Healthy Kids Solano (HK). In fact some of the remaining challenges identified in the data may be due to the fact that these data were collected prior to full implementation of HK.

Successes

- **Nearly 100 percent of children targeted by SKIP saw a doctor within 10 months after enrolling in health insurance**. Although based on only a small sample of 98 0-5 year olds, these results show that the children targeted by SKIP are actually utilizing one of the most basic primary care services—making it much more likely that they will actually experience improvements in health status. With its new OERU funding, SKIP will begin following up with additional families in mid-2007 and hopefully this new group will be just as successful in accessing basic health care services.
- **Solano County successfully attained the targeted outcome of having more than 95 percent of children (0-17), insured**. Based on 2005 CHIS data, Solano County continued to maintain a very high percentage of insured children (96%), more than three percentage points higher than the rate for the state as a whole (94% of children 0-17 in California were insured in 2005 according to CHIS). CHIS results also demonstrated that these very high rates of coverage were shared by all but one of the county's major racial and ethnic groups. One factor in the county's continued success in this area is undoubtedly SKIP's ability to enroll over 2,000 children per year in health insurance.
- **The percentage of the poorest children in Solano County who were covered by health insurance also increased between 2001 and 2005**. The percentage of children at 0-99 percent of FPL with health insurance jumped from 84 to 92 percent between 2001 and 2005.

Challenges

- **The percentage of Latino children 0-17 with insurance coverage was significantly lower than for other major county racial or ethic groups and**

[5] The other outcome for 2008-2009: "Children assisted by SKIP increased their school attendance rates" was eliminated due to budgetary and feasibility issues.

lower than it was in 2001. CHIS results for 2005 showed that the percentage of Latino children with insurance (83%) was about 13 percentage points lower than for African Americans, the group with the next lowest percentage of covered children. In addition, between 2001 and 2005, the percentage of covered Latino children dropped from 90 to 78 percent. Although this percentage of covered Latino children in Solano County was also lower than the rate for the state as a whole (89%), it was significantly higher than that found by analyses of other national surveys. For example, a report by the Centers for Disease Control and Prevention based on data from its National Health Interview Survey, reported only 74% of Latino children had health insurance coverage.[6]

The reasons for relatively low level of coverage among Latino children are unclear and somewhat unexpected given SKIP's growing success in enrolling Latino children and families.[7] However, one reason is likely due to continued movement in and out of Solano County by Latino families, particularly those who are undocumented. Studies have shown that these families are extremely transient and thus the least likely of all Latinos to have insurance coverage. Thus, even if SKIP enrolls large numbers of undocumented children in health insurance, within a year or so, their families may have moved out of the county and been replaced by other families with children who lack coverage. Because of fears related to their immigration status, undocumented families are also very hard to track and consequently it is difficult to develop reliable estimates of their movement and numbers.

Another likely reason is that it is simply very difficult, even for as well-established a program as SKIP, to identify, enroll and retain Latino children and families in health insurance. Numerous studies have documented the many challenges in enrolling and retaining Latino children, especially those who are undocumented.[8] Effectively reaching Latino families requires intensive efforts by culturally competent staff over time to develop visibility and trust within the Latino community. The increasing percentage of Latinos among SKIP enrollees over the past few years means that the program is becoming more successful with this group, but lagged data from sources such as CHIS may not immediately show evidence of this success.

A third possible explanation for these results is that they are low because the CHIS survey was carried out just prior to implementation of Healthy Kids Solano

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6 "Access to Health Care among Hispanic/Latino Children: United States, 1998-2001." **Advance Data from Vital and Health Statistics.** Number 344. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. June 24, 2004.

7 Although only 49 percent of SKIP enrollees were Latinos in 2001, by FY 05-06, this had increased to 73 percent, and, during the first months of 2007, to 80%.

8 See Scott G, Ni H. "Access to health care among Hispanic/Latino children: United States 1998-2001. Advance data from vital and health statistics; no. 344, Hyattsvile, Maryland: National Center for Health Statistics, 2004.

(HK), a major source of health insurance for undocumented children. Although after 2004, Solano County was able to enroll undocumented children in CaliforniaKids (CalKids), income eligibility for CalKids was limited to families under 250 percent of poverty. Consequently, now that Healthy Kids has been implemented, which is open to undocumented children of families with incomes up to 300 percent of FPL, we would expect the percentage of insured Latino children to increase in the next CHIS survey. Indeed, implementation of HK is one likely reason behind the increasing percentage of Latino SKIP enrollees.

One final possible explanation for the low rate of coverage among Latino children is that, due to the difficulties of successfully surveying undocumented Latino households, the CHIS results are simply inaccurate for this population (and indeed there is a wide confidence interval of nearly 30 percentage points for these results).

- **Relying heavily on CHIS data makes it difficult to be completely certain about the true level of insurance coverage in the county**. Because CHIS data is collected via a phone survey, there is always some level of uncertainty about the accuracy of the results due to possible sampling and data collection errors. Another challenge related to using CHIS data is that due to very strict confidentiality requirements, neither SPR nor Solano County HSS staff had access to individual-level CHIS data until very late in the 2006-2007 fiscal year. Without this individual- level data, we were unable to conduct certain statistical tests to effectively compare differences across groups and time periods. Finally, the fact that CHIS is only administered every other year and the year lag between when the data is collected and when it is released, makes CHIS data much less useful developing timely analyses for county policy makers.

  With these types of challenges related to using a particular data source, there is value in using other sources of data as additional indicators for a particular outcome. Often, however, this is difficult because of the cost of collecting data for multiple indicators. Happily, for next year's report, we will include data for another outcome that can also be used as another indicator of the level of insurance coverage for children in the county. Thus, data collected for this other outcome, "Increase in percentage of public elementary schools with 100% health insurance coverage" will allow us to strengthen our analysis of the incidence of health insurance coverage among children.

Recommendations

To attempt to deal with the challenges outlined above and to improve data collection and analysis for the following year, we have developed a short list of recommendations related to Strategies 2 and 4. These recommendations are detailed below.

- **Continue SKIP's strong focus on enrolling and retaining Latino children in health insurance programs**. Although a majority of individuals assisted with enrollment by SKIP are already Latino, the data presented here suggest that Latinos continue to be less likely than other groups to be insured and thus should continue to be a primary focus for enrollment and retention efforts.

- **Broaden the data and analysis of utilization in the 2008 report.** In conducting the analysis for the outcome "Targeted children visit their primary care provider" in 2008, include data on all children followed-up by SKIP, including follow-up funded by the program's new OERU grant. This larger sample will allow for a much more powerful analysis of utilization, including an understanding of utilization among children over five years old. In addition, to better understand patterns of utilization across groups, it would be useful to also include data on the race/ethnicity of children targeted for follow-up.

HEALTH ACCESS STRATEGY #3 *Expand behavioral health services at primary care sites and increase linkages to specialty mental health and substance abuse and drug treatment services not provided at these sites.*

Health Access Strategy 3 falls under Goal 2 of the Solano County Health Access Strategic Plan, which is to create a primary care-based, comprehensive and integrated system of health care. In a climate of reduced public mental health resources, particularly for those who are not seriously and persistently mentally ill, there remains a serious gap in services. Strategy 3 facilitates access to behavioral health services for some of Solano County's more vulnerable populations by integrating behavioral health into primary care settings and providing direct assistance to physicians via behavioral health consultation services.

Ongoing Interventions Related to Strategy 3

The primary interventions related to Strategy 3 are training and supporting primary care physicians (PCPs) to identify, assess and treat behavioral health disorders; expanding behavioral health services at county and community clinics, as well as via other providers; and expanding access to immediate psychiatric consultation for primary care providers.

Exhibit 3-1:
MTSAB Budget and Expenditures for 2006-07 for Strategy 3[1]

	Recipient	Expense	Approved Budget	Expenditures as of May 31, 2007	Percentage Expended
Strategy 3: Behavioral Health/Primary Care Integration	Solano County	Clinician staff (.85 FTE sup MH clinician; 1 FTE MH clinician; .5 FTE MH clinician; extra help MH clinician)	$217,049	$187,354	86%
	Solano County	Services and supplies	7,000	2,000	28%
Total			***$224,049***	***$189,354***	***85%***

As shown in Exhibit 3-1, in 2006-07, $224,049 in MTSAB funds were allocated to the county to support implementation of Strategy 3. The lion's share of this amount was the $217,049 to support the cost of behavioral health clinician staff. With one month remaining in the fiscal year, 85 percent of the total allocated funding had been

[1] This chart captures expenditures paid out by the County as of 5/31/07 and does not reflect claims submitted for services during May. Workgroups have until June 30, 2007 to expend allocated funds and do not submit claims to the County for June until July. Therefore, complete expenditure data will not be available from the County until after the end of the 2006-07 fiscal year (August 2007).

expended. One hundred percent of the allocated funding for Strategy 3 is expected to be expended by the end of the fiscal year, according to several respondents.

On-Site Behavioral Health Services

The primary ongoing activity related to achieving Strategy 3 has been providing an on-site Behavioral Health Consultant (BHC) at primary care clinic sites that serve a high proportion of Medi-Cal clients. The BHC acts as partner to the primary care physician for patients who have co-existing medical and behavioral health issues. This allows for a more comprehensive approach to patient care and improves the chances of patients accessing behavioral health services.

On-site BHCs may provide a range of services, including immediate patient assessment and intervention, referrals and placement for patients who cannot be treated in the clinic setting, and education of physicians on such issues as depression, anxiety, substance abuse, and medication compliance. BHCs may also work directly with primary care physicians (PCPs) in providing care for patients. For example, a PCP may call an onsite BHC into the exam room to provide a dual consult and provide recommendations to both the physician and the patient on mental health and/or substance abuse issues. BHCs also sometime act as a liaison between PCPs and the county mental health department to facilitate access to necessary care by PCP patients.

By June 2008, the goal for this strategy is to provide on-site behavioral health services at five primary care clinic sites that serve a high proportion of Medi-Cal clients (Solano County Family Health Centers in Fairfield and Vallejo, La Clinica in Vallejo, and Community Medical Centers (CMC) in Dixon and Vacaville). As of June 2007, MTSAB funds have been used to directly support on-site behaviorists only at the two county clinic sites in Fairfield and Vallejo.[2] Currently there are two on-site BHC staff servicing these two county clinic sites, though there were an additional two BHCs who worked at these same sites for only a portion of the 2005-06 and 2006-07 fiscal years. In addition to the turnover of these two staff, the county has faced difficulty in hiring an additional BHC because few candidates are accustomed to working within a primary care setting. A recent list of potential candidates was unsuccessful because candidates either withdrew, or references did not check out.

Consultation Services & Academic Detailing

In addition to the on-site BHCs, the other main activity designed to address the gap in behavioral health services for underserved populations is consultation services for primary care physicians. The Supervising Mental Health Clinician provides on-demand assistance to PCPs needing advice on how to address their patients' behavioral health issues. As part of this support, the Supervising Mental Health Clinician works to ensure

[2] However, the Supervising Mental Health Clinician (whose position is MTSAB-supported) did provide training/consultation services to the current psychologist on staff at La Clinica and to a former BHC staff person at CMC Dixon.

that PCPs can get qualified clients into appropriate county-funded mental health services and that they also receive information on how to address the needs of clients who do not qualify for those services through community-based clinics or private practitioners.

Another ongoing Workgroup activity is academic detailing. Academic detailing consists of visits made by the Supervising Mental Health Clinician, Dr. Cammisa, and others to major practice sites in Solano County in order to educate providers about behavioral health issues, and to inform them about the availability of behavioral health services and how to access those services.

While both consultation and academic detailing are ongoing services, there has been limited ongoing data available to document their exact activities and progress (e.g., number and nature of academic detailing visits, outcomes of consultation services). Data collection has been a main focus of the Workgroup during 2005-06 (see discussion below). A number of H&SS research and planning staff and Workgroup stakeholders have been working to finalize a system whereby data on ongoing BH/PCI activities will be complete, readily available, and in one place.

Behavioral Health/Primary Care Integration Workgroup Activities 2006-2007

The Behavioral Health/Primary Care Integration Workgroup's activities in 2006-07 centered primarily on: (1) collecting data on primary care physicians' requests for behavioral health services through the Supervising Mental Health Clinician or Access system (e.g., doctor requesting service, disposition of patient, tracking activity after referral to county or private provider); (2) working to get additional BHCs on-site at clinics, and, relatedly, (3) working on the Workgroup budget for the 2007-08 fiscal year. As a result of this work, $40,000 in MTSAB funding was approved for each of the following clinic sites: Solano County Family Health Center—Fairfield, Solano County Family Health Center—Vallejo, La Clinica in Vallejo and CMC in Dixon. The funding is to support Behavioral Health Integration Project objectives at each of the four sites (e.g., a half-time BHC onsite, or other staff positions/components of behavioral health integration).

The Workgroup met monthly over the 2006-07 year (excluding October and November 2006). In addition to the major topics above, work group members were concerned with the following issues:

- Dividing the Workgroup into two subgroups: the Clinical Practice Group, and the Future Growth Group. The Clinical Practice Group's goal is to advance the clinical practices and business operations related to BHCs on-site at primary care settings. The goal of the Future Growth Group is to support physicians who do not have an on-site BHC by building those physicians' capacity to manage behavioral health issues in their practices and understand the referral process for county-funded mental health and substance abuse services. These two subgroups were announced in late summer/early fall 2006.

- Discussing next steps to enhance behavioral health integration (e.g., expanding sites where on-site BHCs will be available, improving communication between physicians and BHCs). One specific item discussed was how to simultaneously expand the number of sites with on-site BHCs, while also increasing the capacity of physicians who do *not* have access to an on-site BHC to utilize the services of a BHC located elsewhere.
- Revisiting the nature of the target population being served. Specifically, the Workgroup discussed whether Medi-Cal clients should be targeted or not, given that MTSAB funds are targeted to low-income, uninsured populations (without being specific to Medi-Cal or CMSP).
- Revisiting the matrix/behavioral health strategic plan in order to confirm and edit Workgroup goals.
- Establishing an improved data system in order to facilitate communication about Workgroup activities (e.g., number of curbside consults, tracking BH/PC referrals) and generate reports.
- Establishing a new co-chair of the Workgroup. In winter/spring 2007, Nadine Harris from PHC replaced Glenda Lingenfelter as co-chair. There is now one county and one non-county representative serving as co-chairs.
- Working on billing and reimbursement for behavioral services. The Workgroup discussed challenges related to the ability of Solano County to successfully bill for behavioral health services.

Workgroup meeting attendance by some stakeholders was characterized as sporadic, particularly by physicians and substance abuse partners. On the one hand, this may pose a considerable challenge, since physicians and substance abuse partners are key players in efforts to integrate behavioral health (i.e., substance abuse as well as mental health issues) into primary care settings throughout the county. On the other hand, we should consider contextual factors in evaluating attendance by particular partners—e.g., whether physicians and substance abuse representatives are critical attendees given the Workgroup's current focus and stage of work. As discussed in the section on Strategy 1, one of our recommendations moving forward will be to work with the Coalition Executive Director to identify appropriate participants at different stages of workgroup progress, in order to more meaningfully assess attendance in the future.

Outcomes

Prioritized Outcome for Strategy 3 for 2006-2007

Increased client use of behavioral health services on-site

Indicator: Number of visits for on-site behavioral health services.

Results

- The number of visits and unduplicated clients for onsite Behavioral Health Consultants at the two county clinic sites that received MTSAB funding declined between FY 2005-2006 and FY 2006-2007.[3] The number of visits over the two years declined by 17.5% (235 visits), while the number of unduplicated clients declined by 16.4% (133 clients). (See Exhibit 3-2 below.)
  - We can explain at least some of this decline as due to the decline in visits and unduplicated clients seen by clinician #3. Exhibit 3-2 shows that Clinician #3's number of client visits dropped dramatically between the first and second fiscal years—from 479 to 191—while the other clinicians' number of visits remained comparable. This drop was due to Clinician #3's increasing supervisory responsibilities and less time spent onsite given the hiring of an additional on-site BHC, as well as his increasing responsibilities for providing consult services to primary care providers in the community.

Exhibit 3-2:
No. of Visits and Unduplicated Clients Seen by Onsite BHCs at 2 County Clinic Sites

Clinician	2005-06 Visits	2005-06 Unduplicated Clients[4]	2006-07 Visits	2006-07 Unduplicated Clients
#1	356	224	314	176
#2	505	332	600	387
#3	479	345	191	151
#4	N/A	N/A	unavailable	unavailable
Total	**1340**	**809**	**1105**	**676**

[3] It is unclear whether the data presented here contains all of the visits or unduplicated clients seen by Clinician #4, who was employed for six months of the 2006-07 fiscal year (10/22/06—4/21/07). Without complete data on the services provided by this clinician, the decrease in visits and unduplicated clients from 2005-06 and 2006-07 may not be accurate.

[4] The total number of unduplicated clients is not the sum of unduplicated clients by BHC, because there are presumably a number of duplicated clients *between* clinicians.

Data Sources and Limitations

- The source for the data presented above is the PCMS database. Staff analysts at the county's Health & Social Services Department extracted these data from PCMS on June 17, 2007. These data reflect the number of visits, as well as the number of unduplicated clients seen by the onsite BHC staff at the two county clinic sites in Fairfield and Vallejo funded by MTSAB during fiscal years 2005-06 and 2006-07.
- These data have serious limitations. The data do not reflect all on-site BHC services provided during 2006-07 because data on Clinician #4 is unavailable. If complete data were available, it might reveal an increase in both the number of total visits and/or the number of unduplicated clients seen by on-site BHCs.[5]

Outcomes for 2007-2008 & 2008-2009

Listed below are the prioritized outcomes we are planning to track for 2007-2008 and 2008-2009 (in addition to continuing to track the outcome for 2006-2007).

2007-2008 Prioritized Outcome:[6]

(1) Increased linkages between on-site behaviorists and primary care physicians.

2008-2009 Prioritized Outcome: [7]

(1) Increased number of sites with on-site behaviorists.

Conclusion

With regard to the prioritized 2006-2007 outcome for Strategy 3—increased client use of behavioral health services on-site—the number of visits and unduplicated clients seen by on-site BHCs for 2006-07 actually decreased as compared to 2005-06. Other challenges and successes of note over the past year are detailed below.

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5 An additional, but less serious, contributor to our incomplete 06-07 data is the fact that it only covers up to June 7, 2007 (compared to June 30 of the previous fiscal year). In order to balance our desire for the most recent data with the need to ensure adequate time for our analysis and report-writing, we had the data on client visits and unduplicated clients extracted on June 13, 2007, but the last service date recorded at that time was June 7.

6 The original prioritized outcome for 2007-2008 was: increased satisfaction among PCPs (who treat high percentage of Medi-Cal clients) with behavioral health process and information flow due to the consult process. However, this outcome was dropped when the Workgroup/PHC decided the planned data source (added questions to PHC physician survey) was no longer possible.

7 The original prioritized outcome for 2008-2009 was: improved knowledge and utilization of Dr. Cammisa's principles of practice. However, this outcome was dropped when the Workgroup/PHC decided the planned data source (added questions to PHC physician survey) was no longer possible.

Successes

- **MTSAB funding was approved to support the Behavioral Health Integration Project at four practice sites for the 2007-08 fiscal year.** This funding will support behavioral health integration at two community clinic sites as well as at the two currently supported county clinic sites. Utilization of the approved funding may vary by site (e.g., for a half-time on-site BHC or for other staff positions/components of behavioral health integration). Depending on how the funding is actually used, it may lead to an increase in client use of on-site behavioral health services (prioritized outcome for 2006-07) and/or an increase in the prioritized outcomes for 2007-08 and 2008-09 (increased linkages between on-site behaviorists and primary care physicians; and increased number of sites with on-site behaviorists).
- **On-site BHC service provision continued at the two county clinic sites.** Over the 2006-07 fiscal year, on-site BHC services were successfully maintained at the two county clinic sites with two core BHC staff (Clinicians #1 and #3) and two BHC staff who are no longer employed (Clinicians #2 and #4).
- **Provision of consultation and academic detailing services is ongoing.** During 2006-07, the Supervising Mental Health Clinician continued to provide on-demand assistance to PCPs needing advice on how to address their patients' behavioral health issues, and also continued to work with others on increasing awareness of behavioral health issues and the availability of behavioral health services among providers at major practice sites in Solano County.

Challenges

- **Ongoing BH/PCI data collection procedures are unclear.** Securing data to track progress on client use of on-site behavioral health services was a difficult and inefficient process. It was initially unclear as to whether these data were being collected, for how long, or in what manner, and there was no one readily identifiable person to approach about securing these data. SPR ultimately involved several people in order to secure the data presented in this report. This difficulty slowed down the data collection process considerably.

  Although academic detailing and consultation services are not outcome areas being tracked by this evaluation, we noted that the nature of and responsibility for ongoing data collection in these areas was also unclear.
- **Lack of consensus exists around evaluation outcomes.** As previously described in the introduction of this report, SPR engaged in an extensive, group-based process in order to identify and revise potential outcomes to track for this evaluation and the BH/PCI Workgroup. Two of the three finalized outcomes for BH/PCI required replacements after the Workgroup/PHC decided that the agreed-upon data source (added questions to the annual PHC physician survey) was no longer possible. Concern has also been expressed by the Workgroup that evaluation activities are not aligned with the Workgroup's current focus and activities.
- **Hiring suitable BHCs has been difficult**. It has been difficult to find behavioral health staff able to operate successfully within a primary care setting who also fit

additional criteria required by particular sites—for example, being a Spanish-speaker. Because of this difficulty, even though funding has been approved for 007-08, it is anticipated that it will take a considerable amount of time to successfully establish behavioral health staff at the additional clinic sites.[8]

- **Workgroup meeting attendance by some key players was characterized as sporadic.** In particular, attendance by physicians and substance abuse partners was noted as sporadic or poor. This poses a considerable challenge, given that these are both key players in the effort to integrate behavioral health into primary care settings county-wide.

Recommendations

We have developed a short list of recommendations related to Strategy 3. These recommendations, which are largely concerned with data and planning issues, are detailed below.

- **Assign clear data collection roles and responsibilities.** Moving forward on increasing client use of on-site behavioral health services, it will be critical to identify key staff responsible for both data collection and reporting. This will not only facilitate accurate and timely communication about the Workgroup's activities and progress, but also provide greater transparency on use of funds.
- **Ensure all data needed for evaluation and planning purposes are being effectively collected.** At a minimum for the purposes of this evaluation, the number of client visits and the number of unduplicated clients seen by on-site BHCs at all practice sites supported by MTSAB funding should be tracked on an ongoing basis. Ideally, the number of visits and clients should be able to be broken out by BHC staff, as well as by practice site, to allow analysis of the extent to which any increase in client use of services is accounted for by particular staff, or by particular practice sites. Disaggregating the data in these ways might, in turn, lead to an analysis of how to replicate successful strategies with regard to providing on-site BHC services. Also for the purposes of this evaluation, SPR and county/Workgroup representatives should discuss what information should be tracked by the county/Workgroup (as opposed to by SPR) for the 2007-08 prioritized outcome (increased linkages between on-site behaviorists and PCPs).

  In the broader interest of accurately capturing the progress of the BH/PCI Workgroup on all fronts (even those not being tracked by the evaluation), and being able to easily sort and summarize data related to BH/PCI Workgroup activities, we recommend developing a data map that will identify *all* information the Workgroup wishes to track (e.g., number and nature of academic detailing activities, curbside consults, referrals); established or planned mechanisms for collecting that data (e.g., staff responsible, current systems, planned databases);

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[8] Again, how each site chooses to use its approved funding may vary. For those sites that use the funding to hire a staff position other than an on-site BHC, this challenge may not relevant.

time points for data collection, the specific data fields where that information is or will be captured; and reports to be generated.

- **Distribute updated BH/PCI matrix/strategic plan.** Over the 2006-07 fiscal year, the BH/PCI Workgroup made a number of important changes. These changes included revisiting the Workgroup's original goals, its target population and establishing two sub-groups. To make these changes clear to everyone, and also perhaps to rejuvenate Workgroup attendance among some key players, the Workgroup should consider revising its matrix/strategic plan to reflect these and any other changes and distributing it to all stakeholders. This revised matrix/strategic plan would also serve as an opportunity to integrate the outcomes being tracked by this evaluation with other outcomes desired by the Workgroup with regard to behavioral health and primary care integration.

HEALTH ACCESS STRATEGY #5 *Reduce frequent users' inappropriate use of the health care system*

Strategy 5 is included in the Health Access Strategic Plan under Goal 2, Objective b, which calls for the increased integration of Behavioral health services and primary care. Many research studies have documented the existence of a small group of adults who have very high numbers of lengthy hospital stays and frequent emergency room admissions. These 'frequent users' are low-income people who typically have at least one chronic health condition, face mental health or substance abuse issues and lack access to stable housing. Despite their regular use of hospital services, most of these frequent users are not receiving effective treatment and continue to suffer from very poor health outcomes. Because of their disproportionate use of acute care services, these individuals are extremely costly to the health care system. Consequently, Solano County's commitment to ensuring access for this population to treatment is critical to the achievement of a health care system that is both more effective and financially stable.

Exhibit 5-1:
MTSAB Budget and Expenditures for 2006-07 for Strategy 5[1]

	Recipient	Expense	Approved Budget	Expenditures as of May 31, 2007	Percentage Expended
Strategy 5: Frequent Users	Solano County	Staff (1 FTE - MH Clinician)	$109,453	$86,506	79%
	Solano County	Staff (.15 FTE - Sup MH Clinician)	24,602	16,635	68%
	Solano County	Services and Supplies	15,945	1,752	11%
Total			***$150,000***	***$104,893***	***70%***

As shown in Exhibit 5-1, $150,000 in MTSAB funds were allocated to Solano County for implementation of Strategy 5, with all of this funding allocated to cover the costs of the Frequent User project, which is described below. $109,453 was allocated to employ

[1] This chart captures expenditures paid out by the County as of 5/31/07 and does not reflect claims submitted for services during May. Workgroups have until June 30, 2007 to expend allocated funds and do not submit claims to the County for June until July. Therefore, complete expenditure data will not be available from the County until after the end of the 2006-07 fiscal year (August 2007).

one FTE mental health clinician, $24,602 was allocated for .15 FTE staff time to supervise this clinician and a total of $15,945 was allocated for services and supplies. With one month remaining in the fiscal year, 70% of funding allocated for Strategy 5 had been expended. According to several respondents, 100 percent of the allocated funding for Strategy 3 is expected to be expended by the end of the fiscal year.

Ongoing Interventions Related to Strategy 5

The primary intervention related to Strategy 5 and supported with MTSAB funds is a small pilot project involving a full-time mental health clinician who is assigned to work with frequent users. The project's two partnering hospitals, North Bay and Sutter Solano, most typically identify and refer these frequent users to the clinician and Frequent Users Project.

This Frequent User Project began in March 2006, when the mental health clinician for the project was hired. She works with these referred "frequent users" to link them to a primary care physician (PCP) and obtain preventative and ongoing care for them with the aim of decreasing their inappropriate use of emergency and hospital services. Early in the project, it became clear that to be successful, the Frequent Users Workgroup and the project's mental health clinician would need to work closely with a number of other organizations and agencies that provide services that are critical to decreasing the need for inpatient services by frequent user clients. These services include housing, substance abuse and mental health treatment, and disability benefits.

According to a document developed by members of the Frequent User Workgroup in February 2006, the Frequent User Project serves:

> *"Low income adult residents of Solano County who are seeking care at a participating hospital, either inpatient or outpatient, and who suffer a combination of mental illness, substance abuse behaviors, and chronic medical problems, as well as homelessness or near homelessness."*

Between April 19, 2006 – March 12, 2007, the project received 48 referrals of clients who met this definition; 19 from North Bay and 28 from Sutter Solano.[2] However, only some of these referrals are served by the project as a few refuse to participate while others are referred to more appropriate services. In April 2007, the project's clinician reported that she had a case load of 15 clients, 10 of whom she was actively managing. According to the project's database, as of April 1, 2007, the average length of time in the project was 3.6 months.

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[2] The difference in number of referrals received from the two hospitals has raised concern among Frequent Users Workgroup members that the referral process may be inconsistent and that hospital discharge staff may need greater education about the availability of Frequent Users Program and its eligibility criteria.

Characteristics of Frequent User Project Clients

Of the 48 Frequent Users referred to the project, the average age was 48, with four clients under 30 and five over 61. Eighty-one percent (35) of referred clients were enrolled in Medi-Cal, 21% (9) were enrolled in CMSP, and 9% (4) were uninsured or their enrollment status was unknown. The most common chronic conditions suffered by clients were congestive heart failure (CHF) or some other heart condition, followed by diabetes, pancreatitis, and cellulitis. Sixty-seven percent (33) of the 48 clients were identified as having substance abuse issues, most commonly related to alcohol, methamphetamines, cocaine, speed, marijuana and opiates.

Frequent User Workgroup Activities 2006-2007

Because of the recent implementation of the Frequent Users project, the Frequent Users Workgroup was very active in 2006-07. The workgroup met monthly and formally recorded its minutes. Regular participants included the Frequent User Project's clinician, as well as representatives from H&SS, Sutter Solano Medical Center, North Bay Hospital, and more recently, representatives from local emergency and transitional housing organizations.

Major topics discussed by the workgroup in 2006-07 have included:

- Identification of potential partnerships with housing organizations to provide interim care, long term, short term, and transitional housing for frequent user clients. Housing member representation on the Frequent Users Workgroup currently includes Mission Solano Bridge to Life Center, Fairfield/Suisun Community Action Council, and Christian Help Center.
- Provision of in-service training for hospital staff on how to access county services.
- Feedback from the project's clinician on best practices and challenges in her work with hospitals regarding frequent user clients.
- Development of next year's budget for the Frequent User Project using MTSAB funding.

Outcomes

Prioritized Outcome for Strategy 5 for 2006-2007

Increased Frequent User (FU) client visits to his/her primary care provider

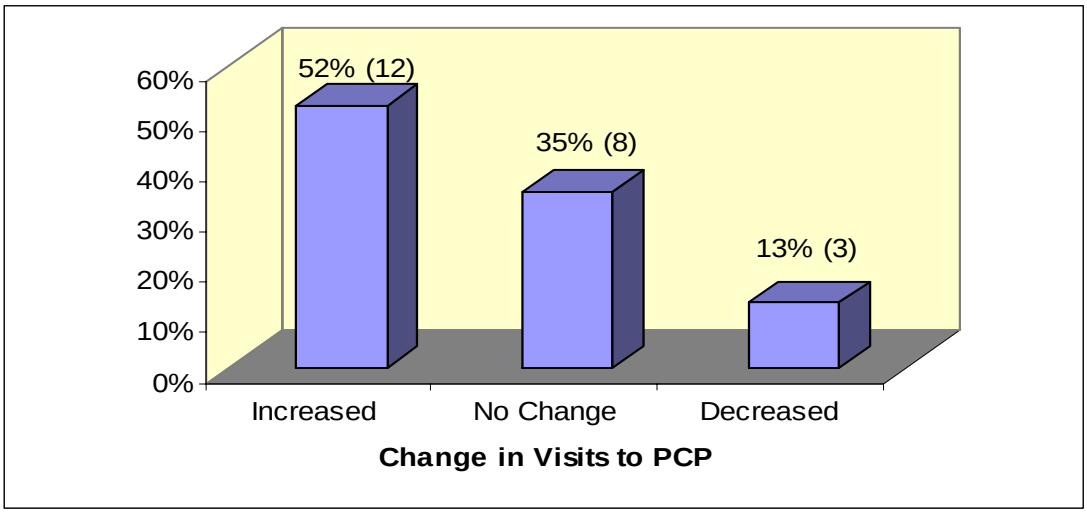
Indicator: Number of times each client visits his/her primary care provider six

months prior and six months after being referred to the Frequent User Project[3].

Results

- For the 23 frequent user clients on Medi-Cal who were enrolled in the Frequent Users Program for at least one month between the program's inception and February 2007:
  - **12 (52 %)** *increased* their number of visits to their PCP during the period six months after their referral to the Frequent User program as compared to the period six months prior to referral. Of these, 10 (43% of clients) went from having had zero PCP visits prior to referral to having one or more visits after receipt of project services. This is a critical finding, because it means that these clients who, despite their chronic conditions, had not visited a PCP in months before referral to the project, became at least somewhat connected to the primary care system via their PCP following receipt of project services.
  - **3 (13%)** *decreased* their number of visits to their PCP during the period six months after their referral to the Frequent User program as compared to the period six months prior to referral.
  - **8 (35%)** clients' number of visits to their PCP remained *unchanged* at zero during the period six months after their referral to the Frequent User program as compared to the period six months prior to referral.

Exhibit 5-2:
Changes in the Number of PCP Visits by Frequent User Medi-Cal Clients Post Referral as Compared to Pre-Referral



[3] For those clients who had participated in the project for less than six months, the post-enrollment period was truncated to the amount of time between the referral date and March 2007.

- Although we explored the data looking for correlations between increased visits to PCPs and time spent in the project or frequency of contact with the project clinician, due to the very small numbers involved, we did not see any strong correlations.

Data Sources and Limitations

H&SS provided SPR with a spreadsheet of all clients referred to the Frequent Users Program as of March 2007. Based on this spreadsheet, SPR requested data on PCP visits six months prior to the client's referral and six months after from PHC.

SPR decided upon a 6 month pre- and post- referral date time period because this period provided an adequate amount of time for clients post-referral date to have been enrolled in the program and to have made a visit to their PCP. Given the transience of this population, we felt it best not to extend this time period any longer, given the high chance that clients might move out of PHC's service area and no longer be trackable.

This pre- and post- referral date design in which clients are compared against themselves is preferable to a quasi- experimental and control group design. That is, given the unique characteristics of each of the frequent users, it would have been infeasible to appropriately match one-on-one those clients enrolled in the frequent users program against those not enrolled in the program, control for all confounding variables, and accurately measure outcomes (i.e., # of PCP visits 6 months post frequent users referral date).

However, this evaluation comes with several data limitations:

- One of the most important limitations to our analysis is the small size of our sample. Therefore, we cannot safely generalize these findings to clients other than those included in this analysis.

  Although 48 clients had been referred to the project between May 2006 and March 2007 when we accessed the data, for the following reasons, our sample of clients for the analysis declined by more than 50 percent as follows:

  - Only 34 were enrolled in the program for at least one month, which was the minimum length of time we felt necessary for a client to be impacted by the program and therefore included in our outcomes analysis.
  - We could not collect data on PCP visits by CMSP or uninsured clients, and therefore excluded them from our analysis. This further reduced the total number of frequent user clients we could track from 34 to 28.
  - Five of the 28 clients on Medi-Cal who we submitted to PHC for data could not be found in PHP's MIS, reducing the number of clients in our analysis to 23.
- Due to strict HIPPA and agency confidentiality issues, Partnership Health Plan of California could only provide us de-identified client data on the 23 frequent users client on Medi-Cal. Given this constraint, we cannot make any conclusions

regarding the possible varying effectiveness of the Frequent Users Program for clients of different age groups, races, genders, chronic medical conditions, etc.

Outcomes for 2007-2008 & 2008-2009

Listed below are the prioritized outcomes that we plan to track for 2007-2008 and 2008-2009, in addition to the 2006-2007 outcome.

2007-2008 Prioritized Outcome:

1) Fewer and shorter Frequent User client "administrative" or "avoidable" hospital stays.

- *Anecdotal evidence of frequent users' reduced usage of hospital services.* Although data will not be collected on the number of hospital visits until 2008, anecdotal evidence from hospital staff indicates that frequent users in this pilot have used emergency services less as they have connected with a primary care physician. We hope the data we collect over the next year will help us to examine this issue more systematically.

2008-2009 Prioritized Outcome:

1) Frequent User client receiving on-going substance abuse and/or mental health services.

Conclusion

Based on a very small sample, a slight majority of Frequent User clients on Medi-Cal experienced increased visits to their PCP following referral to the project. For 10 of these clients, the number of visits went from zero to one or more signaling at least a basic attachment to the non-acute primary care system. Other successes and challenges related to Strategy 5 are discussed in further detail below.

Successes

- **Successful launch of Frequent Users Project.** In 2006-07, the Frequent Users Workgroup successfully defined the objectives of its project and hired a full-time mental health clinician to work directly with frequent users. This clinician quickly began working with referred clients. The Project also established relatively smooth coordination and communication between H&SS, the two participating hospitals, and the project's clinician.
- **Consistent participation of Frequent Users Workgroup members.** The Frequent Users workgroup has met regularly each month, with consistent participation by core necessary members, namely, the mental health clinician and representatives from North Bay and Sutter hospitals.
- **Timely identification of intervention challenges.** The Frequent User workgroup has been quick to recognize the problem areas in working with frequent users and has then sought additional resources in these areas. For

example, early in the project, the need for emergency, transitional, and long term housing for the frequent users population was quickly identified by the Workgroup. To address this shortage, the Workgroup actively recruited representatives from local housing organizations.

Challenges

- **More services are needed for the frequent user population.** From the onset of this project, it became clear to the mental health clinician and Workgroup that Frequent User clients need an array of services to reduce their dependence on hospital-based care. The highest priorities for support services include:
  - *Short-term housing* is the most urgent housing-related need, although the group recognizes that *long-term and transitional housing* are also needed. The workgroup is currently working on identifying appropriate housing facilities for homeless frequent users once they are discharged from the hospital.
  - *Substance abuse treatment* is also a need, and is a future topic the workgroup plans to discuss.
  - *Faster enrollment in disability benefits* is also proving to be critical. The workgroup plans to research how other counties have "fast-tracked" the disability benefits enrollment process for frequent users.
  - *Incentives for frequent user client participation.* According to one respondent, more funds need to be set aside to purchase "reward cards" such as gift certificates to Walmart and Target to incentivize clients to cooperate with the Frequent User Program and mental health clinician.
- **The characteristics of this population and small size of the project present important challenges to measuring impact.** As discussed earlier, we felt that the pre-, post- program referral date evaluation design would be most accurate in measuring the number of PCP visits outcome. However, selection of this evaluation design resulted in a small client sample size.[4] Client transience also presents a challenge; we anticipate that it will be difficult to track the impact of the Frequent Users Project on clients over time, given that this client population has a tendency to move frequently from one hospital service area to another, and no PCP data will be available once a client moves out of the PHP service area. The resulting small sample size of clients served underscores the need to be cautious when making generalizations about the effectiveness of the project.
- **The need for more disaggregated and more accurate data on frequent users being served.** According to respondents, data currently being captured on frequent user clients is not disaggregated or accurate enough. For example, "unknown" and "none" are currently categorical "chronic conditions" options.

[4] It is important to note that a different evaluation design would have presented a different set of constraints that likely also would have resulted in a small sample size.

However, workgroup members have argued that such categorization is inaccurate; by definition, all frequent users must have some type of chronic condition to be served by the project. Elimination of the use of these categories will make it more likely that data will be recorded correctly. For similar reasons, some workgroup members have argued for redefining and identifying additional categories related to substance abuse. Finally, because access to health care is often correlated with demographic factors such as race/ethnicity and gender, it would be useful to also collect and record this information.

- **Confidentiality issues prohibit client data identifiers.** Due to strict HIPPA and agency confidentiality issues, Partnership Health Plan of California could only provide de-identified data on its Frequent User participants. Given this constraint, we cannot disaggregate data along different participant characteristics, and therefore cannot draw conclusions regarding the possible varying effectiveness of the Frequent Users Program for clients of different age groups, races, genders, chronic medical conditions, etc.

Recommendations

Below are several recommendations related to Strategy 5. These recommendations are focused both on this evaluation and the project itself.

- **Continued timely identification of intervention challenges and targeting of key partners.** The Workgroup has proactively identified areas of need for its frequent users clients and has begun to identify partnerships with organizations and agencies that can provide these services, such as transitional housing. However, Workgroup respondents stated that because 2006-07 was the inaugural year of the Frequent Users Program, the majority of their time was spend on "getting the program up and running." As the project enters its second year of operation, the workgroup should continue to shift greater attention to identifying potential partnerships with agencies and organizations that can address the multiple support service needs of its Frequent Users clients.
- **Better information regarding the referral process.** The majority of referrals to the project are from Sutter Solano Medical Center. The Workgroup has not fully explored why this is, but surmise that the difference in number of referrals may be due to 1) different screening techniques, 2) different client bases by region, 3) the number of staff at the hospitals, and 4) different criteria being used by staff of the different hospitals for referral to program. The Workgroup needs to collect additional information regarding the referral process to understand whether hospital discharge staff are aware of the Frequent Users Program and its eligibility criteria. The workgroup is concerned that not all eligible patients are being referred to the Frequent Users Project, and, therefore, patients who could benefit are being missed.
- **More detailed and accurate information on frequent users.** The Workgroup has already suggested that ethnicity, gender, length of time in the County, and current location be added to the Frequent Users caseload log. Such information would allow the Workgroup to track the Program's effectiveness with different

types of clients. Information logged on the Frequent Users client spreadsheet should also be more consistent and accurate to best measure Frequent Users Program impact among clients of different backgrounds. This requires greater clarity around the different categories currently being captured and greater consistency in the types of data being captured itself. For example, as noted earlier, the "none" category should be eliminated as an option for the "chronic medical condition" field, given that, by definition, clients referred to the program must suffer from a chronic medical condition.

It is our understanding that the project's clinician is primarily in charge of recording frequent user data. Adequate and accurate recording of frequent user data may require more time than the clinician has available, and therefore, the Frequent User Workgroup might consider ways to decrease this burden, such as by allocating support staff resources to go toward frequent user data collection.

- **Better access to confidential client data for evaluation purposes.** As discussed earlier, it was not possible to evaluate the data for this year's prioritized outcome along different demographic and medical characteristics such as gender, age group, and chronic medical condition because the PHC client data had to be stripped of these identifiers for confidentiality reasons. To facilitate improved analyses for the purposes of evaluation, the County, PHC, and partnering hospitals should work out an agreement to provide the evaluators and other appropriate parties with access to individual client data with identifiers.

HEALTH ACCESS STRATEGY #6 *Increase the availability of dental services.*

Strategy 6 falls under Goal 2 of the Solano County Health Access Strategic Plan, which is to create a primary care-based, comprehensive and integrated system of health care. One of the most critical, yet often overlooked, aspects of primary health is oral health care. Dental cavities is the most common childhood disease in the United States. In Solano County, the widespread incidence of oral health problems among children is further complicated by the additional challenges of few dentists accepting DentiCal, an insufficient supply of pediatric dentists, and large areas of the county that lack adequate oral health services for un-insured residents. MTSAB-supported work on oral health issues began as a natural outgrowth of other work being done to facilitate children's overall access to health care and insurance coverage.

Ongoing Interventions Related to Strategy 6

The primary interventions related to Strategy 6 are: (1) increasing oral health prevention efforts in Solano County through a public health campaign designed to raise awareness of the importance of oral health care; and (2) increasing access to oral health treatment services through a Gap Fund that provides oral health services to un- and under-insured children, care coordination, and linkages to comprehensive health insurance.

Exhibit 6-1:
MTSAB Budget and Expenditures for 2006-07 for Strategy 6[1]

	Recipient	Expense	Approved Budget	Expenditures as of May 31, 2007	Percentage Expended
Strategy 6: Oral Health	Solano County	Staff (extra help—health assistant)	$5,000	$3,208	64%
	Solano County	Gap Funding	50,000	0	0%
	California Dental Association	Strategic plan	19,500	19,500	100%
Total			***$74,500***	***$22,708***	***30%***

As shown in Exhibit 6-1, in FY 06, $74,500 in MTSAB funds were allocated to activities related to Strategy 6. The majority of this amount was the $50,000 allocated for the

[1] This chart captures expenditures paid out by the County as of 5/31/07 and does not reflect claims submitted for services during May. Workgroups have until June 30, 2007 to expend allocated funds and do not submit claims to the County for June until July. Therefore, complete expenditure data will not be available from the County until after the end of the 2006-07 fiscal year (August 2007).

Gap Fund. With one month remaining in the fiscal year, only 30 percent of the allocated funding had been expended due largely to the relatively slow implementation of the Gap Fund. The great majority of expended funds as of May 31 went to the California Dental Association for the preparation of the Oral Health Care Strategic Plan.

Oral Health Workgroup Activities 2006-2007

The Oral Health workgroup's activities in 2006-07 centered on the following:

- **Completing the Oral Health Care Strategic Plan.** The strategic plan, prepared by the California Dental Association Foundation in November 2006, summarizes project activities and major findings, and outlines the oral health prevention and oral health treatment goals moving forward. The plan was informed by parent and dental provider interviews and focus groups—designed to surface attitudes about children's oral health and perceived barriers to receiving services.
- **Releasing the public health campaign RFP.** The RFP was released in spring 2007. Interviews with finalists were to be conducted in late June, with an award likely being made by the end of the 2006-07 fiscal year.
- **Working to implement the Gap Fund, hiring a care coordinator, and identifying oral health providers.**
  - Considerable work went into navigating the county's fiscal policy and confirming whether purchase orders or contracts would be the mechanism used to distribute gap funding to pay for needed care. By late spring 2007, purchase orders were confirmed as the fiscal protocol and, according to the chair of the Oral Health Workgroup, at least two children may receive Gap Fund services by the end of the 2006-07.
  - The temporary care coordinator—housed in the CHDP program under the Solano County Health & Social Services Department—began case management services in spring 2007. The permanent care coordinator position, pending final approval, will also be housed in CHDP.
  - Finally, the workgroup identified oral health providers likely to provide care through the Gap Fund and worked to negotiate appropriate fee schedules for various services.
- **Conducting the pilot program at Mare Island Elementary School.** A pilot program was also administered by Solano County's Smile in Style in 2006 at Mare Island Elementary School in Vallejo to provide preventative oral health care for children as well as a fund for emergency dental care. A total of 292 students were screened for oral health services, 13 were categorized as needing urgent oral health services, 32 were referred to La Clinica for treatment, and 22 children received care.

- **Working on proposed MTSAB funding for FY 2007.** The approved Oral Health spending plan for 2007-08 includes $35,000 for the care coordinator, $65,000 for the Gap Fund, and $60,000 for the public health campaign.

The workgroup met in person and by phone over the 2006-07 year, although meeting minutes were available only for July 2006, February 2007 and March 2007.

Outcomes

Prioritized Outcome for Strategy 6 for 2006-2007[2]

Gap Fund is operational and a Care Coordinator is providing care coordination.

Indicators:

1. The Gap Fund is operational and all necessary provider contracts and MOUs are in place.
2. A Care Coordinator has been hired/appointed.

Results

- Fiscal protocols for the Gap Fund were approved in spring 2007. A limited number of children may receive oral health services from the Gap Fund by the end of FY 2006. A temporary care coordinator was hired in late spring 2007 and was undergoing training. The permanent care coordinator position, pending final approval, has yet to be filled.

Data Sources and Limitations

- The primary sources for the data presented above were interviews with the chair of the Oral Health workgroup and the MTSAB project manager staff in Solano County's Health and Social Services Department, Research & Planning.
- Minutes were not available for all Oral Health workgroup meetings. As a result, we do not have a complete record of all topics covered during workgroup meetings, or of details pertaining to discussion and decisions on the Gap Fund and Gap Fund Coordinator (prioritized outcome area).

Outcomes for 2007-2008 & 2008-2009

Listed below are the prioritized outcomes we are planning to track for 2007-08 and 2008-09 (in addition to continuing to track the outcome for 2006-2007).

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[2] The original prioritized outcome for 2006-09 was: increased number of Solano County dental providers who participate in the California Dental Association Foundation's Pediatric Oral Health Access Program (POHAP). However, this outcome was replaced with the current one in order to better align with MTSAB funding priorities (e.g., Gap Fund and care coordinator).

2007-2009 Prioritized Outcome:[3]

(1) Increased number of uninsured/underinsured children receiving needed urgent oral health treatment.

2007-2009 Prioritized Outcome:[4]

(1) Increased number of uninsured children served by care coordinator linked to comprehensive health insurance, including dental insurance.

Conclusion

With regard to the prioritized 2006-07 outcome for Strategy 6—Gap Fund is operational and a Gap Fund Coordinator is providing care coordination—Solano County is on track, with both likely to occur by the end of the 06-07 fiscal year. Other major successes are listed below.

Successes

- **An extensive strategic planning process was completed.** The end product of this process reflected considerable effort to gather and reflect the perceptions of key stakeholders (e.g., parents, providers), as well as best practice models. The strategic plan also laid the foundation for moving forward with the workgroup's two overarching goals.
- **Over 200 children were provided with direct oral health services.**[5] Even before the Oral Health Care Strategic Plan was completed, Smile in Style administered the pilot project at Mare Island Elementary School that allowed nearly 300 children to be screened for oral health services, 32 to be referred to La Clinica's dental clinic for treatment, and 22 to receive care.

Challenges

- **Confirming the fiscal protocols for releasing gap funding was time-consuming.** There were long-standing questions to be resolved as to whether the gap funds would be distributed through purchase orders or contract mechanisms and this process delayed the county's ability to use the funding tp pay for much-needed care. However, eventually these questions were resolved in favor of purchase orders, finally allowing funds to be used via a mechanism that is much more efficient, particularly for urgent service needs.

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[3] The original prioritized outcome for 2007-09 was: increased number of children 0-17 with a dental visit in past 12 months. However, this outcome was replaced with the current one in order to better align with MTSAB funding priorities (e.g., Gap Fund and care coordinator).

[4] The original prioritized outcome for 2008-09 was: decreased number of caries among children 0-5. However, this outcome was replaced with the current one in order to better align with MTSAB funding priorities (e.g., Gap Fund and care coordinator).

[5] This pilot project's timeframe spanned two fiscal years: FY 2005 and FY 2006.

Recommendations

We have only one recommendation at this time, as follows:

- **Clarify age group of oral health treatment target group.** Based on our review of the evolution of key workgroup documents, there is some question as to the specific age group of uninsured and underinsured children being targeted for oral health treatment and coordination services via the Gap Fund and coordinator position (as described in the recommended spending plan versus the strategic plan). While the targeted age group may be clear to workgroup members, it would be helpful to have it formally documented for a wider audience in an updated plan that reflects approved MTSAB spending for the Oral Health workgroup for FY 07. Clarifying the age group will also help ensure that our evaluation tracks and analyzes all data of interest for 2007-09 (e.g., the workgroup may be interested in having SPR break down the number of uninsured children receiving urgent oral health treatment by various age groups).

HEALTH ACCESS STRATEGY #7: *Address beliefs, attitudes, knowledge, and experiences that negatively impact appropriate utilization of health services.*

Strategy #7[1] is under Goal 3 of the Solano County Health Access Strategic plan, which calls for the county to "Increase appropriate utilization of health services by Solano's racially and ethnically diverse population." Strategy 7 is critical to ensuring access to health care by the county's racially and ethnically diverse population because it attempts to go beyond simply ensuring that individuals have health insurance. Specifically, the strategy focuses on promoting utilization of services by addressing individuals' beliefs, attitudes, knowledge, and experiences with health services.

Interventions Related to Strategy 7

The Community Education Workgroup provides oversight for all activities undertaken as part of Strategy 7. Throughout 2006 and during the first few months of 2007, the workgroup focused on developing plans for an intervention to provide health education services to the African American community in Solano County.

To carry out this intervention, in late 2006 and early 2007, staff from Solano County and SCBH, with early assistance from the workgroup, began a Request for Proposals (RFP) process to select a grantee who would carry out this intervention. This RFP called for a grantee to:

- Create, organize, and facilitate a minimum of four diabetes-focused faith-based support groups, which will build capacity and result in behavioral change among participants. These support groups will focus on diabetes education, care, and management that are appropriate for the African American community and will be held in predominantly African American faith, fraternal, or sorority based institutions within Solano County.
- Identify community faith, fraternal, or sorority-based organizational leaders that are likely to become and remain involved with the community health education and promotion activities beyond the County funding period.

[1] The information presented here on Strategy 7 is based on interviews with the workgroup chair, information from key SCBH and H&SS staff, and a review of workgroup minutes and relevant documents.

Outcomes

Prioritized Outcome for Strategy 7 for 2006-2007

Grantee is funded and beginning program implementation.

Indicators:

1. A grantee has been selected and a contract signed to implement the services outlined in the Community Education Workgroup RFP.
2. The selected grantee is moving forward on implementing the services specified in the contract.

Results

- **Because of problems with the RFP process, the RFP that was issued in February 2007 was cancelled and no grantee was selected**. The Community Education Workgroup issued an RFP on February 14, 2007 for its Health Promotion and Education Campaign, with the intent to award contractors and vendors by March 23, 2007 to implement the services outlined in the RFP. Potential contractors and vendors submitted proposals, but were notified by the Health and Social Services Department in late March that the County had cancelled the entire RFP. Applicants were encouraged to reapply when the RFP is reissued.

2006-07 Expenditures for Strategy 7

Given the cancellation of the RFP, it is not surprising that Community Education Workgroup has not expended most of the MTSAB funding allocated to it for the 2006-07 fiscal year. However, it has expended 100% of funds allocated to SCBH, primarily to cover the cost of providing professional staffing for the workgroup.

Exhibit 7-1:
MTSAB Budget and Expenditures for 2006-07 for Strategy 7[2]

	Recipient	Approved Budget	Expenditures as of May 31, 2007	Percentage Expended
Strategy 7: Community Education	SCBH	$14,245	$14,245	100%
	Contract TBD	10,000	0	0%
	Uncommitted	$75,755	$0	0%
Total		***$100,000***	***$14,245***	***14%***

[2] This chart captures expenditures paid out by the County as of 5/31/07 and does not reflect claims submitted for services during May. Workgroups have until June 30, 2007 to expend allocated funds and do not submit claims to the County for June until July. Therefore, complete expenditure data will not be available from the County until after the end of the 2006-07 fiscal year (August 2007).

Other Prioritized Outcomes for Strategy 7

Due to the cancellation of the original RFP and the development of a different scope of work for the new RFP, we do not expect to be able to use the outcomes that were originally prioritized for this strategy. Instead, if the activities funded under the new RFP continue to fall under the scope of this evaluation, we will need to develop new outcomes and indicators that are appropriate to the new scope of work.

Conclusion

Even though the Community Education Workgroup met for much of 2006-07, due to the cancelled RFP, no community education activities were carried out. However, County and SCBH staff have indicated that the RFP will be re-issued later in 2007 and once a grantee is selected and awarded funding, community education activities with the African American community will begin.

Conclusion: The Contributions of the Strategies to the Strategic Plan

In the previous sections, we reviewed and analyzed of each of the seven strategies to assess progress, successes, and challenges faced within the implementation of the seven MTSAB-funded strategies. In this final section, we will step back to focus on the extent to which the five major goals of the Health Access Strategic Plan are met by the seven strategies. We will conclude this final section by presenting overarching successes and challenges related to the contribution of these strategies to achievement of the Strategic Plan goals, as well provide recommendations to supplement the recommendations already made in the sections focused on individual strategies.

Goal by Goal Assessment

Overall, the MTSAB-funded strategies have both directly and indirectly contributed to all five strategic plan goals. However, there are a couple of content areas and one broad group within the Plan's target population—low-income adults—that have received little direct focus by the strategies. In terms of low-income adults, although three strategies focus primarily on adults, two of those three (Strategies 5 and 7) are aimed at only portions of the low-income adult population (frequent users and African Americans), rather than at the entire population. Related to this limited focus on adults, two of the three content areas that appeared to be less emphasized also relate to the adult population: (1) enrolling adults in health insurance and other health programs (under Goal 1); and (2) advocating for expanded healthcare options for adults (under Goal 5). A third content area which seemed to receive only limited focus was decreasing logistical barriers, particularly transportation (under Goal 4). Below we present each of the strategic goals and discuss how the funded strategies contributed to their implementation.[1]

Goal 1. ***Increase the % of Solano County residents consistently enrolled in health insurance or other health programs.***

Objectives

a. Enroll/retain all eligible children and adults in available public or other subsidized plans or health programs.
b. Link low-income and working adults to affordable healthcare services.

In terms of at least a significant portion of its target group, children 0-17, the MTSAB-funded strategies, particularly 2 and 4, have had a major effect on the county's ability to successfully achieve Goal 1. However, the funded strategies have been much less successful in terms of increasing the number of adults enrolled in health insurance or other health programs.

[1] Appendix C maps each of the seven strategies to the five strategic goals.

- **Strategies 2, 4 and 1 have likely[2] had a major role in keeping the percentage of children ages 0-17 with health insurance close to 100%.** The 2005 CHIS results continued to show that the percentage of uninsured children in the county is very low (4%), and in all likelihood, this success is due at least partially to the efforts of SKIP, which is partially supported by Strategy 2 and overseen by the Enroll and Retain Workgroup. In addition, although the CHIS data was collected too early to reflect the effects of Healthy Kids Solano (HK) (partially funded by Strategy 4), it is also likely that HK is also increasing the percentage of insured children in the county, particularly among undocumented children. Strategy 1, through the efforts of SCBH merely staffing the Enroll and Retain Workgroup and HAC, also contributed significantly to the efforts to setting up HK and generating additional funding for SKIP.
- **SKIP (Strategy 2) is also beginning to focus more and more on retention, and thus is likely having an effect on keeping children consistently enrolled**. Although we will not report results on the retention of children assisted with enrollment by SKIP until next year, with its new OERU funding, SKIP will be systematically following up with a much larger group of children than in the past and this will likely improve the percentage of children who stay consistently insured.
- **No funded strategies are focused on assisting large numbers of adults with enrollment or retention in health insurance.** Although both SKIP and the Frequent Users Project (implemented under Strategy 5), did assist small numbers of adults with enrollment in health insurance,[3] neither of these strategies is likely to have had a major impact on increasing the percentage of adults consistently enrolled in health insurance. This lack of focus on adults could be one reason why CHIS results from 2005 estimate that only 90.9 percent of Solano County adults 18 and over were insured (down slightly from 2001, when 91.5% were estimated to be insured).

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[2] It is beyond the scope of this evaluation to connect directly the efforts of SKIP to the overall percentage of uninsured children in the County. Such an effort would have required a complex quasi-experimental design that was infeasible given the evaluation's resource and time constraints.

[3] In 2006, SKIP assisted 219 adults with enrollment in Medi-Cal, five in CMSP, and up to six in AIM (AIM serves both mothers and their infants and could be either adults or children). From its inception to the end of March, 48 adults had been referred to the Frequent User Project; an unknown number of these has been assisted with enrolling in a health insurance programs such as Medi-Cal or CMSP.

Goal 2. ***Create a primary care based comprehensive system of health care that is integrated, financially sustainable, & has a strong infrastructure.***

Objectives

a. Increase the capacity, efficiency & coordination of the primary care system in Solano County.
b. Expand integrated behavioral health services at primary care sites & increase linkages to specialty mental health & substance abuse and drug treatment services not provided at these sites.
c. Increase the availability of medical specialty care services.
d. Increase the availability of dental services.

Goal 2 is extremely broad, focusing on the development of a strong, integrated, and sustainable primary care system in the county. Because of its breadth, all but Strategy 7, included activities that contributed to this goal. While several of these strategies targeted nearly the entire population of low-income adults (Strategy 3) or children (Strategies 2, 4 and 6), Strategy 5 focused on a group of adults (frequent users) who suffer disproportionately poor health outcomes, but are extremely costly to the system.[4] The one objective that was less directly related to MTSAB-funded activities was the objective to increase the availability of medical specialty services. The contributions of the strategies to the specific objectives of Goal 2 are detailed below.

- **Six of the seven funded strategies are likely to be having an affect on *Objective a, increasing the capacity, efficiency and coordination of the primary care system in Solano County.*** Because this objective is as broad as the goal itself, each of the funded strategies is likely to have made a contribution, as follows:
  - Strategy 1: HAC and SCBH annually are involved in multiple efforts related to improving the county's primary care system.
  - Strategies 2 and 4: Getting uninsured residents enrolled in health programs, means that the county's primary care system can draw down funding from external payors to cover the costs of providing services to those residents.
  - Strategy 3: Integrating behavioral health services with primary care services allows the primary care system to meet patient needs more efficiently.
  - Strategy 5: The Frequent User Project helps the county health care system become more efficient and coordinated in treating patients suffering from chronic illnesses, behavioral health problems and housing instability.
  - Strategy 6: One of the key goals of the Oral Health care coordinator is to help children get needed oral health by increasing coordination between providers and payors.

[4] Strategy 1, through its support of SCBH which carried out numerous activities related to both broad and narrow groups of Solano County's low-income population, cuts across all of these areas. Strategy 7 would have focused on African American adults, who also suffer poorer health outcomes in most areas than other racial or ethnic groups, but the strategy's intervention was never implemented.

- **Both Strategy 3 (expand behavioral health services), and Strategy 5 (Frequent Users) have likely had some effect on Objective b, *expanding integrated behavioral health services at primary care sites and increasing linkages of specialty mental health and substance abuse and drug treatment services not provided at these sites*.**
  - Strategy 5's Frequent User Project, which was implemented primarily over the last year, has made a small but important contribution to this objective, as one of the main tasks of the project's clinician has been to connect identified hospital patients with necessary mental health and substance abuse services available in outpatient settings. Sixty-seven percent of the 48 clients referred to the project were identified as having substance abuse issues.
  - All of the on-going efforts related to Strategy 3—increasing the number of on-site behavioral health consultants at primary care sites that serve a high proportion of Medi-Cal clients, consultation services for primary care physicians and academic detailing activities—are likely to have made a contribution to this objective. However, because of the data issues discussed in the section on Strategy 3 above, it is somewhat unclear exactly to what extent this strategy has been effective in providing these services.
- **Strategy 1, via the efforts of SCBH and the CMSP Task Force, is likely to have had an effect on Objective c, *increasing the availability of medical specialty care services***. In the past year, the CMSP Task Force, which was staffed by SCBH, focused on promoting access to specialty care for CMSP clients.
- **Strategy 6 began to have a major effect on Objective d, *increasing the availability of dental services* over the past year.** Although the Smile in Style pilot program at Mare Island Elementary School was the major effort under Strategy 6 which resulted in increased dental services during 2006-2007, the successful completion of an Oral Health Care Strategic Plan, and efforts late in the fiscal year to operationalize a gap fund and care coordinator, make it very likely that dental health services will increase more significantly during the next fiscal year.

Goal 3. ***Increase appropriate utilization of health services by Solano's racially and ethnically diverse population.***

Objectives

a. Assure that services through the healthcare system in Solano County are made available to all patients in a language they understand.
b. Increase cultural sensitivity and competency of key personnel throughout health system.
c. Provide info and educational materials easy to understand in all appropriate languages.
d. Address beliefs, attitudes, knowledge and experiences that negatively impact appropriate utilization of health services.

Three MTSAB-funded strategies, Strategies 1, 2, and 6, are likely to have contributed to Goal 3. In general, the activities implemented under these strategies focused most on providing accessible and appropriate educational materials, increasing cultural competency and least on ensuring that health services are linguistically accessible. In addition, the fact that the intervention under Strategy 7 was not implemented meant that

the objective aimed at beliefs, attitudes, knowledge, and experiences was not addressed as much as planned by MTSAB-funded strategies. The contributions of the strategies to specific objectives are detailed below.

- **Strategy 2, via SKIP services, contributed to Objective a, which aims to assure that services throughout the healthcare system in Solano County are made available to all patients in a language they can understand.** SKIP has bilingual (Spanish-English) staff who educate and assist families with how to utilize the health care system. In addition to these bilingual staff, through partnerships with other agencies, SKIP also provides similar assistance in other languages. However, other than SKIP's efforts, no other strategy appears to have focused on ensuring the accessibility of services to linguistic minorities.
- **Strategy 1, indirectly through the Cultural Competence Conference Series co-sponsored by SCBH contributed to achievement of Objective b, *increasing the cultural sensitivity and competency of key personnel throughout health system***. Although not funded directly by MTSAB, SCBH jointly sponsored a conference in May, 2007 aimed at increasing the cultural competence of providers entitled "Strengthening Partnerships and Skills to Reduce Inequities Among Residents of Solano County." SCBH's Disparities Project also developed a strategic plan in 2006-2007 that aims to carry out additional activities related to cultural sensitivity and competence in working with the African American community.
- **Strategies 2 and 6 both carried out activities in 2006-2007 related to Objective c, *providing informational and educational materials that are easy to understand in all appropriate languages.*** All SKIP (Strategy 2) materials are available in both English and Spanish and many materials distributed by SKIP on health programs such as Medi-Cal and Healthy Families are available in numerous other languages. In addition, Strategy 6, as part of the Oral Health Care Strategic Plan, has begun implementation of an oral health prevention campaign that will develop materials that are ethnically and culturally appropriate for different populations and are translated into various languages.
- **Strategies 6 and 1 began efforts in 2006-2007 related to Objective d, *addressing beliefs, attitudes, knowledge, and experiences that negatively impact appropriate utilization of health services*.** Under Strategy 6, at the end of 2006-2007, the Oral Health Workgroup began implementation of a campaign to increase awareness of the importance of oral health care that will attempt to address the beliefs, attitudes, and perceptions of oral health held by various diverse communities in Solano County. In addition, SCBH's Disparities Project is beginning implementation of plans for activities that will address beliefs, attitudes, knowledge and experiences that negatively impact appropriate utilization of health services. By contrast, due to issues related to the issuance of its RFP, Strategy 7's planned intervention related to addressing beliefs, attitudes, knowledge, and experiences about diabetes within the African American community was not implemented this fiscal year, although it should be implemented next year.

Goal 4. ***Decrease logistical barriers, which prevent appropriate utilization of the healthcare system by Solano County residents.***

Objectives

a. Assure that there are adequate primary care services located throughout Solano County.
b. Decrease transportation barriers which prevent residents from timely healthcare.

Four MTSAB-funded strategies, (Strategies 1, 3, 5, and 6) contributed to attainment of Goal 4. In general, the activities of the funded strategies were aimed more at somewhat specialized primary care services like behavioral health and dental services, rather than core medical services. Also, there was very little focus on decreasing transportation barriers, with only Strategy 5 assisting its small group of clients with overcoming this challenge.

- **Strategies 1, 3, and to some extent Strategy 6 involved activities that contributed to *assuring that there are adequate primary care services located throughout Solano County*.** SCBH (Strategy 1), through its efforts over the past year to assist both CMC, regarding the community clinic in Vacaville, and La Clinica with its dental clinic in Vallejo, helped both of those two communities to have access to services. Through its support of onsite behavioral health consultants at community clinics in Fairfield and Vallejo, Strategy 3 has helped to ensure that basic behavioral health services are available in these communities. Finally, the Mare Island Elementary School pilot project carried out under Strategy 6, ensured that children at this Vallejo School had access to a basic dental screening.
- **Strategy 5, in a small, but critical way, has *decreased transportation barriers, which prevent residents from timely healthcare*.** Due to the efforts of the Frequent User Project clinician, who often takes clients lacking transport to health care appointments, Strategy 5 has decreased the transportation barriers faced by these chronically ill frequent user clients.

Goal 5. ***Advocate for policies and actions that increase access to healthcare for low-income, uninsured, and other vulnerable populations.***

Objectives

a. Increase community awareness and understanding of the value of health insurance for all.
b. Advocate for new resources to expand primary care based and preventative services.
c. Advocate for policies and actions that expand eligibility and increase utilization of publicly funded federal and state health benefit programs.
d. Advocate for expanded healthcare options for adults.
e. Support the growth and effectiveness of a health access coalition committed to the implementation, modification, and evaluation of this health access strategic plan.

Activities related to Strategy 1, and to some extent Strategies 2 and 4, were related to attainment of Goal 5. Most of these advocacy efforts were only indirectly related to MTSAB funding, since they were carried out by SCBH and occurred outside of the HAC

and its workgroups. The one objective that seemed to be less of a focus of advocacy efforts was *advocating for expanded healthcare options for adults.*

- **Strategy 1, through its support of HAC, SCBH and the Health Access Strategic Plan, is the primary strategy that affected Goal 5 in FY 2006-2007.** Numerous activities undertaken by SCBH, both directly funded with MTSAB money, and leveraged from other sources, were related to each of Goal 5's objectives.
  - SCBH supported SKIP's efforts to increase efforts to *increase community awareness and understanding of the value of health insurance for all* (Objective a).
  - SCBH's recent completion of a Safety Net Study in late 2007 will give SCBH and its partners the material to effectively *advocate for new resources to expand primary care based and preventative services* (Objective b).
  - SCBH, in partnership with the Enroll and Retain Workgroup, has also been at the forefront of efforts to encourage state action to support health coverage for all children (Objective c).
  - Through its coordination of the CMSP Task Force, to some extent, SCBH has also *advocated for expanded healthcare options for adults* (Objective d).
  - Finally, a prime focus of Strategy 1 is *support for the growth and effectiveness of a health access coalition (both HAC and SCBH) committed to the implementation, modification, and evaluation of this health access strategic plan* (objective e.)
- **Strategies 2 and 4 both carried out activities related to Goal 5.**
  - Strategy 2, through the efforts of SKIP, was very involved during 2006-2007 in carrying our activities related to Objective a, *increasing community awareness and understanding of the value of health insurance for all.* For example, SKIP staff authored a number of media articles, ran newspaper and radio ads, and participated in community events to spread awareness.
  - Both the Enroll and Retain Workgroup (an activity related to both Strategies 2 and 4) and the director of SKIP, have also been very involved over the past year in state-level efforts to *advocate for policies and actions that expand eligibility and increase utilization of publicly funded federal and state health benefit programs* (Objective c), particularly related to insurance coverage for all children.

Overall Successes and Challenges

Overall, fiscal year 2006-2007 was a largely positive year for the implementation of the seven MTSAB-funded strategies. Although as detailed above, some challenges remain, by and large the Health Access Committee and its five workgroups were able to achieve

important successes. In this final section, we attempt to discuss a few broader successes and challenges.

Successes

- **Most strategies were fully implemented**. By the end of the year, most of strategies had at least begun implementation of planned interventions and activities. In addition, most had or were planning to expend all of their MTSAB funding. Given the significant challenges related to implementing new and innovative projects, this is an important achievement.
- **SCBH, HAC and four of the workgroups continued to effectively coordinate implementation of the strategies.** Although attendance was not as high for some groups as hoped, the fact that all of these groups, staffed by volunteers, continued to meet on a regular basis to oversee the efforts of particular strategies reflects the underlying strength of the coordination among health care partners in Solano County and the dedication of numerous staff.
- **Where data were available and accurate, it often showed impressive results.** Particularly in the case of Strategies 2 and 4, the data highlight the effectiveness of health access-related programs in the county such as the Solano Kids Insurance Program.

Challenges

- **Putting structures in place to expend funding was sometimes extremely challenging due to the County's strict requirements for procurement and hiring of staff or contractors.** During fiscal year 2006-2007, two of the newest funded strategies had some difficulty in implementing structures to expend allocated MTSAB funding. In the case of Strategy 6, the complexity of using public funds to develop protocols for how to operationalize the Gap Fund meant that almost none of the $50,000 allocated for this purpose was spent by the end of the year. For Strategy 7, problems with the RFP process meant that the long-awaited RFP has had to undergo another round of revisions and none of the funding allocated for that purpose was expended by the end of the fiscal year. Because funding that is not expended by June 30 is not automatically carried over into the next fiscal year, these problems may mean fewer resources focused on these strategies and their target populations.
- **Developing and sustaining new projects has been challenging.** Determining how to best manage, fund, and collect appropriate data for new projects has been challenging for several of the newer strategies. For example, in several cases, staff with other multiple duties have been given temporary responsibility for overseeing implementation of these projects, which means that these managers often have had great difficulty devoting the amount of time needed to make the projects successful. In addition, while MTSAB funds can serve as core funding for these projects, at least in the short term, typically successful implementation means identification of supplemental or long-term funding, which can be extremely challenging. Finally, determining what data to collect and

implementing effective and efficient systems to collect those data has been challenging to some of the strategies.

- **Identifying available, accurate, and appropriate outcomes and data sources for a few of the strategies has been challenging in this first year of an external evaluation**. Over the past year, SPR has worked extensively with the workgroups to identify appropriate outcomes and data sources for this evaluation. Despite carrying out a participatory process with each workgroup and HAC to identify the most appropriate outcomes to track, the prioritized outcomes for two of the strategies have had to be changed and a few may need further revisions in the future. For some of the strategies (particularly Strategy 3), we also had difficulty identifying appropriate and accurate data sources. However, these kids of challenges are typical for the first year of an evaluation, particularly when the interventions being evaluated are new.

Overall Recommendations

Based on the overall challenges and successes discussed above, we have developed a few overall recommendations, which are detailed below.

- **Continue to increase the focus on health care utilization and consider focusing more on adults.** Due to the county's continuing success in achieving nearly 100 percent insurance coverage for children, in the future, HAC and the enroll and retain workgroup should continue to increase their focus on utilization, since without the latter, we cannot expect to see improved health status among the county's children. In addition, at some point, it might be appropriate for the county to shift its focus to increasing the percentage of adults with health insurance.
- **Consider whether there are more expedient means of distributing funds to appropriate service providers or grantees.** Due to the issues related to expending money for new projects, MTSAB, HAC, SCBH and the County might want to consider whether there are more expedient means of distributing funds to appropriate service providers or grantees so that valuable MTSAB resources and time do not slip away. A major question for the County to consider is, are there alternative mechanisms for distributing the funds while still maintaining close County oversight and involvement for public accountability purposes?
- **Workgroup and HAC members should continue to work closely with the evaluators.** Because of the challenges of identifying and accessing appropriate and accurate data sources, particularly for new interventions and activities, it will be important over the next year for the SPR team and the workgroup and HAC members to continue to work closely. This is crucial so that the evaluation can proceed smoothly and the reporting can focus on formative and more summative outcomes as we move forward.

APPENDIX A:
List of 2006-2007 Partner Agencies

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Appendix A:
Organizational Participants of the SCBH Health Access Workgroups

(CDA) California Dental Association Foundation
(SKIP) Solano Kids Insurance Program
American Cancer Society
BARHI
Black Infant Health
Caminar Inc.
Child Start Inc.
Community Medical Centers
Daily Republic
Delta Sigma Theta
Dixon Unified School District
Fairfield Unified School District
Faith in Action
First 5
Kaiser Permanente
Kaiser Permanente/ Delta Sigma Theta
La Clinica de La Raza
Law Enforcement
Maternal Child Health Bureau
NorthBay Healthcare
Omega Boys and Girls Club
Pac Health
Partnership HealthPlan of California
Planned Parenthood
Smile N Style
Solano County
Solano County C.W.S
Solano County Department of H&SS
Solano County Office of Education
Solano Medical Society
Sutter Health
Sutter Medical Center
Touro University
Tri-City Branch NAACP

UC Berkeley, the School of Public Health
United Way of the Bay Area
Vallejo Unified School District
VCUSC – Student Health Services
Youth & Family Services

APPENDIX B:
County Funding of Health Access and Services

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Appendix B:
Summary of Relationship of County Health Access Efforts to the MSA Health Access Strategic Plan

Strategic Goal	Description of Related Effort	Resources
Goal 1: Increase the percentage of Solano County residents who are consistently enrolled in a health insurance plan or other health programs	Solano Kids Insurance Program (SKIP)	1,122,000
	Healthy Kids Solano	1,145,000
Goal 2: Create a primary care based comprehensive system of health care that is integrated, financially sustainable, and has a strong infrastructure.	MH: State Hospital Cost	1,081,781
	MH- Adult Services: Psychiatric Emergency Services+B74	1,814,013
	MH- Adult Services: Institutional Services	857,837
	MH- Adult Services CONREP Program	546,629
	Mental Health Adult Services- Crisis and Acute Administration	1,081,358
	MH- Adult Services: Psychiatric Health Facility	138,707
	Emergency Shelter	8,400
	Emergency Shelter Care Direct Costs	21,434
	Homeless Assistance	984,005
	Homeless Demonstration Grant	221,883
	Homeless Case Management	145,311
	Adult Day Treatment Horizon House	551,020
	Solano Transitional Opportunity Program	1,140,370
	PH: Smile in Style	93,316
	PH: Childhood Lead Poisoning	101,821
	PH: Immunization	339,576
	PH: Women, Infants, & Children	1,719,105
	PH: Adolescent Family Life Program	317,525
	PH- Child Health and Disability Prevention	781,092
	SA- Contracted Drug and Alcohol Services	1,248,926
	SA- Substance Abuse Administration	958,996
	Family Health Services- Dental Services Bureau	986,691
Goal 3: Increase appropriate utilization of health services by Solano's racially and ethnically diverse population.	Solano County African American Disparities Elimination Project	317,000
	PH- Black Infant Health	
	PH- AIDS Community Education	257,865
	PH- HIV Community Outreach	
	PH: Perinatal Outreach	
	PH- Health Promotion and Education	370,598
	SA- Latino Substance Abuse Program	264,168
Goal 4: Decrease logistical barriers which prevent appropriate utilization of the healthcare system by Solano County residents.	PH- Neighborhood Services Center	342,665
Goal 5: Advocate for policies and actions that increase access to health, support healthy behaviors and healthy communities.	PH- Assessment and Policy Development	407,909
		19,367,001

*Budgetary data provided in this table is taken from Solano County Health and Social Serivces Department Strategic Plan FY 2005-2008

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APPENDIX C:
Goals and Strategies

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Appendix C. Funded Strategies & their Effect on Plan Goals

Funded Strategies that Could Impact Goals

Goals

#1 Support Health Access Committee (HAC)
#2 Enroll & Retain
#4 Pay premiums/share of cost
#5 Reduce Frequent User Inappropriate Usage

→

1. Health Coverage

Increase the % of Solano County residents consistently enrolled in health insurance of other health programs.

Objectives

a. Enroll/retain all eligible children and adults in available public or other subsidized plans or health programs.
b. Link low-income and working adults to affordable healthcare services.

#1 Support HAC
#2 Enroll & Retain
#3 Increase Behavioral Health Services
#4 Pay premiums/share of cost
#5 Reduce Frequent User Inappropriate Usage
#6 Increase Dental Services

→

2. Primary Care System

Create a primary care based comprehensive system of health care that is integrated, financially sustainable, & has a strong infrastructure.

Objectives

a. Increase the capacity, efficiency & coordination of primary care system in Solano County.
b. Expand integrated behavioral health services at primary care sites & increase linkages to specialty mental health & substance abuse and drug treatment services not provided at these sites.
c. Increase the availability of medical specialty care services.
d. Increase the availability of dental services.

#1 Support HAC
#2 Enroll & Retain
#6 Increase Dental Services

→

3. Appropriate Utilization

Increase appropriate utilization of health services by Solano's racially and ethnically diverse population.

Objectives

a. Assure that services through the healthcare system in Solano County are made available to all patients in a language they understand.
b. Increase cultural sensitivity and competency of key personnel throughout health system.
c. Provide info and educational materials easy to understand in all appropriate languages.
d. Address beliefs, attitudes, knowledge and experiences that negatively impact appropriate utilization of health services.

Solano County Health Access Strategic Plan Logic Model

Funded Strategies that Could Impact Goals

Goals

#1 Support HAC
#3 Increase Behavioral Health Services
#5 Reduce Frequent User Inappropriate Usage
#6 Increase Dental Services

→

4. Logistical Barriers

Decrease logistical barriers which prevent appropriate utilization of the healthcare system by Solano County residents.

Objectives

a. Assure that there are adequate primary care services located throughout Solano County.
b. Decrease transportation barriers which prevent residents from timely healthcare.

#1 Support HAC
#2 Enroll & Retain
#4 Pay premiums/share of cost

→

5. Advocacy

Advocate for policies and actions that increase access to healthcare for low-income, uninsured, and other vulnerable populations.

Objectives

a. Increase community awareness and understanding of the value of health insurance for all.
b. Advocate for new resources to expand primary care based and preventative services.
c. Advocate for policies and actions that expand eligibility and increase utilization of publicly funded federal and state health benefit programs.
d. Advocate for expanded healthcare options for adults.
e. Support the growth and effectiveness of a health access coalition committed to the implementation, modification, and evaluation of this health access strategic plan.