SOCIAL POLICY RESEARCH
ASSOCIATES

Effect of MSA-Funded Strategies on Solano County's 2005-2008 Health Access Strategic Plan: 2007-2008 Report

Final Report
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Executive Summary

Social Policy Research Associates (SPR) is pleased to present the 2007-2008 report of our Evaluation of the Effect of the MSA-Funded Strategies on the 2005-2008 Solano County Health Access Strategic Plan. Our first two years of effort have 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. It is designed to answer three primary evaluation questions:

1. To what extent are the five 2005-2008 Health Access Strategic Plan goals met through the seven MSA-funded strategies?
2. What are the outcomes from MSA-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 MSA-funded strategy thus far, and then provide recommendations for moving forward. We also discuss the extent to which these strategies as a whole are contributing to the realization of the five 2005-2008 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 the health access strategic plan.*

One major activity of HAC this year was to develop and approve a new Health Access Strategic Plan for 2008-2011. HAC has also played a significant monitoring function for MSA-funded workgroups, reviewing modifications to and adoption of MSA spending plans, receiving updates from workgroups, providing guidance on MSA-funded strategies, and connecting the work of the MSA-funded strategies to health reform initiatives and SCBH- and Health Access-related activities.

Prioritized Outcomes for Strategy #1 for 2006-2009:

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

- **Finding #1: Attendance at Hac and workgroup meetings continued to be relatively high**. For the eight HAC meetings that occurred in 2007-08 for which we have minutes, an average of 52% or 15 members attended each meeting.

Overall, the attendance rate was lower than the previous year's average of 64%. For the workgroups, attendance ranged from 78 to 38 percent.

- **Finding #2: The funding raised and leveraged in support of the many SCBH health access initiatives continues to be substantial.** SCBH and its members were very effective securing funds for a variety of health access-related projects in 2007, raising a total of $2,777,086. In addition, SCBH was successful in 2007 in locating funding to support other efforts, such as the $353,276 raised for the Eliminating Disparities in Health Project.
- **Finding #3: The number and extent of partnerships and other efforts SCBH is involved in related to improving health access continued to be substantial.** In 2007-08, SCBH supported 127 committee/work group members representing approximately 37 organizations. In addition to staffing HAC and its affiliated workgroups, SCBH has also been involved in a number of other efforts related to health access. Principal among these efforts was the Eliminating Disparities among African Americans Project.

➢ **<u>Recommendation #1:</u> Improve processes for setting up workgroup-initiated contracts and hiring of staff.** During the past two fiscal years, four Health Access workgroups/strategies (Community Health, Behavioral Health/Primary Care Integration, Frequent Users, and Oral Health) have had difficulty finalizing county contracts or hiring county staff to expend allocated MSA funding. These difficulties have led to major delays in the ability of these strategies to provide important services to Solano County residents. Consequently, HAC and SCBH leaders should continue their recently opened a dialogue with county leaders to try and develop solutions to these problems.

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 interventions related to these strategies and supported with MSA funds are the Solano Kids Insurance Program (SKIP), operated by SCBH, and the Solano County Children's Health Initiative plan, called Healthy Kids Solano (HKS). From July 2007 to March 2008, SKIP assisted 1,858 individuals in enrolling in health insurance, while SCBH paid $800,000 in premiums to cover HKS premium costs.

<u>Prioritized Outcomes for Strategies #2 and #4 for 2007-2008:</u>

(1) Targeted children visit their Primary Care Physician (PCP); (2) Over 95% of children 0-17 in Solano County are insured; (3) Increase in children and families assisted with enrollment who are insured 14 months after initial enrollment; and (4) Increase in percentage of public elementary schools with 100% health insurance coverage.

- **Finding #1: Nearly all children targeted by SKIP saw a doctor within 10 months after enrolling in health insurance**. One hundred percent of zero to five year-olds from School Readiness sites targeted for follow-up by SKIP (99 children) reported that their child had visited a doctor at least once during the 10 months since the child became insured. Similarly, only eight of the 134 (6%) children who were followed up with after six months as part of the follow-up calls funded by the state OERU grant reported that their child had not been to the doctor for routine/preventative check-up.
- **Finding #2: 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.
- **Finding #3: The percentage of children enrolled in Medi-Cal 14-16 months after being assisted by SKIP with initial enrollment stayed about the same over a two year period.** The percentage of children who were enrolled in Medi-Cal 14-16 months after being assisted by SKIP with initial enrollment in the program did not increase from 2007 to 2008, but stayed approximately the same (49% in 2007 compared to 46% in 2008).
- **Finding #4: SKIP succeeded in increasing the number of schools with 100 percent insurance coverage**. During both 2006-2007 and 2007-2008, SKIP succeeded in increasing the number of public elementary schools in Solano County with 100 percent insurance coverage from 36 to 47. As a result, 72 percent of all public elementary schools in the county currently have approximately100% of their students covered by some form of insurance.

➢ **Recommendation #1: Seek additional resources for retention and utilization assistance**. Due to the proven success of SKIP's limited retention and utilization follow-up services to children and their families and the importance of these services to improved health status, SKIP should continue to seek additional resources to provide these services to a larger percentage of the children it assists with enrollment.

➢ **Recommendation #2: Continue to regularly review funding for HKS.** HKS plays a critical role providing insurance coverage for children who are ineligible for other types of coverage. In this period of limited state and local government resources, the Enroll and Retain Workgroup should continue to regularly evaluate the funding situation for HKS to ensure that the program remains viable.

➢ **Recommendation #3: Maintain SKIP's strong focus on enrolling and retaining Latino children in health insurance programs**. Although a majority of individuals already assisted with enrollment by SKIP are 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.

Health Access Strategy #3: *Expand integrated 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 interventions related to Strategy 3 are: training and supporting primary care physicians 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. During 2007-2008, consultation and academic detailing were ongoing services, and on-site BHC service provision continued successfully at three clinic sites.

Prioritized Outcome for Strategy #3 for 2006-2008:

(1) Increased client use of behavioral health consultant (BHC) services on-site; and (2) Increased linkages between behaviorists and primary care physicians.

- **Finding #1: Patient visits to on-site Behavioral Health Consultants (BHCs) increased significantly between 2006-2007 and 2007-2008.** Between these two years, the number of visits to on-site BHCs increased by 177.2% (1,434 visits) and the number of unduplicated clients (at the two county-run clinic sites) increased by 65.1% (440 clients).
- **Finding #2: Behaviorists have successfully established linkages with all or a majority of the PCPs at their respective sites.** All three on-site behaviorists have established strong linkages with either all or a large majority of the adult and pediatric PCPs at their respective sites. The types of linkages ranged from relatively straightforward information-sharing to joint consultation opportunities. The existence of these linkages is evidenced by the fact that, at minimum, all or a large majority of PCPs at these sites have called upon the behaviorists—two of which are half-time—to consult with and/or address their patients' intertwined behavioral and physical health needs.
- **Finding #3: The number of sites with on-site behaviorists increased from two to three in 2007-2008.** These sites included the two county-run clinic sites and La Clinica. CMC also had approved funding for an MSA-funded behaviorist, but was not able to hire one during 2007-2008.

➢ **Recommendation #1: Create and distribute a map of the workgroup's future priorities, activities and associated data collection activities.** Some of the behavioral health objectives of the 2008-2011 Health Access Strategic Plan are relatively new. Currently, there are no obvious workgroup activities designed to meet these objectives, so we recommend that the Behavioral Health Workgroup compare objectives from the two Strategic Plans, determine which should be priorities, and map out specific tasks/activities, timelines, and point people. In

the broader interest of accurately capturing the progress of the Behavioral Health Workgroup on all fronts (even those not being tracked by the evaluation), we also recommend mapping all workgroup activities against all information the workgroup wishes to track (e.g., number and attendance of trainings, number of unduplicated clients served by on-site BHCs).

- **<u>Recommendation #2:</u> Revisit quarterly reporting template for BHC services and apply to all sites.** In light of numerous reporting challenges, we recommend that the quarterly BHC reporting template be revised. Specifically, we recommend adding identifier fields for both clients as well as the BHCs providing services. We also recommend revising the template after a careful consideration of the prioritized outcomes for this evaluation as well as of what the workgroup really wishes to know. Finally, we also recommend that all sites be required to use the quarterly reporting requirements so that data is consistent and comparable and there should be one, clearly identified county staff person who is the source for this data across sites.

Health Access Strategy #5: *Reduce frequent users' inappropriate use of healthcare system.*

The primary intervention related to Strategy 5 and supported with MSA funds is a small pilot project serving Frequent Users of health care in Solano County. Frequent User clients are referred by participating hospitals (NorthBay Medical Center, VacaValley Hospital and Sutter Solano Medical Center) to pilot project staff. These staff attempt to link Frequent User clients to a critical services such as a primary care physician (PCP), mental health and/or substance abuse treatment, housing and disability benefits with the aim of decreasing those clients' inappropriate use of emergency and hospital services. Between April 19, 2006 and July 13, 2007, the Frequent User Project received 53 referrals of frequent users; 19 from North Bay and 28 from Sutter Solano. Since October 2007 when the project's original clinician resigned, the project has been on hold because of delays in the hiring of new project staff.

Prioritized Outcome for Strategy #5 for 2007-2008:

(1) Increased Frequent User (FU) client visits to his/her primary care provider; and (2) Fewer and shorter Frequent User client "administrative" or "avoidable" hospital stays.

- **Finding #1: Fifty-two percent of Frequent User clients visited their PCP more times during the six months following their referral to the program as compared to the 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.
- **Finding #2: Overall inpatient visits, days and ER visits among Frequent User clients decreased significantly during the six months following referral to the project.** Hospital visits declined by 18.4 percent (80 vs. 98 visits),

inpatient days declined by 27.2% (538 vs. 739 days), and (based on data only from Sutter Solano), ER visits declined by nearly 40 percent (226 vs. 138). However, these benefits were spread over only about half of all Frequent User clients. Other clients had either no change or increases in visits or days.

- **Recommendation #1: Streamline future project hiring processes.** To avoid future problems related to lengthy hiring processes and paperwork, the Frequent User Workgroup and the Health Access Committee should work with the county to explore ways of streamlining county hiring processes for future project staff.
- **Recommendation #2: Improve project data collection and storage.** The Frequent User Workgroup should coordinate with project staff and their supervisors to develop clear data collection and storage procedures and point people to ensure that sufficient and up-to-date data is available for workgroup members to effectively evaluate the project's success.
- **Recommendation #3: Compare ER visits before and after referral to the project in addition to changes in inpatient visits and days.** If the workgroup chooses to analyze changes in inpatient hospital visits and days in future evaluations, ER visits should also be included in that analysis. This will allow the evaluation to provide a full picture of how the project has changed the way Frequent Users interact with hospitals in Solano County

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.

Prioritized Outcome for Strategy #6 for 2006-2009:

(1) Gap Fund is operational and a Care Coordinator is providing care coordination; (2) Increased number of uninsured/underinsured children receiving needed urgent oral health treatment; and (3) Increased number of uninsured children served by care coordinator linked to comprehensive health insurance, including dental insurance.

- **Finding #1: The oral health Gap Fund is operational and the care coordinator is providing services to children.** The Gap Fund is operational, with Purchase Orders (POs) established with five individual oral health providers, one county-run clinic (Fairfield), and La Clinica. The current health assistant/care coordinator was hired in winter 2008 and is providing care coordination.
- **Finding #2: In 2007-2008, 32 children had oral health treatment covered by the Gap Fund.** Of these 32 children, nine had no insurance at the time of referral, and an additional five were listed with pending insurance from Kaiser or Medi-Cal. Oral health treatment was provided by all five individual oral health

providers with established POs, although just over half of the total amount spent on services was paid to the only anesthesiologist with whom the county has a PO established, and a quarter was paid to the only individual provider in the county to accept Denti-Cal.

- **<u>Recommendation #1:</u> Revise and align databases.** We recommend that the Oral Health/Gap Fund Database be better aligned with the Oral Health Authorized Gap Funding Spreadsheet. To do this, we recommend that CHDP staff, the Care Coordinator/Health Assistant, and MSA Fiscal Analyst Staff meet in order to—to the extent possible—coordinate the data fields of the database and spreadsheet so that it is easier to cross-reference the children served as well as all of their associated information.

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

The primary interventions related to Strategy 7 are to develop community health leaders and provide health education services to the African American community of Solano County, particularly focusing on diabetes education and awareness.

<u>Prioritized Outcome for Strategy #7 for 2006-2008:</u>

(1) Grantee is funded and beginning program implementation; (2) Increased knowledge by education program participants about diabetes, the role of the physician, the role of the healthcare system, and the role of the individual related to diabetes; and (3) Behavior changes that result in positive health outcomes related to diabetes for African American involved in health education effort.

- **Finding #1: A grantee was selected and implemented three community education events on diabetes largely as planned.** The three events were held in May and June 2008 in Fairfield, Vacaville and Vallejo. The events were attended by a total of 101 community participants, far lower than the 240-300 expected by the grantee. In preparation for these events, focus groups and several facilitator trainings were also held.
- **Finding #2: Most community participants at the first event indicated increased knowledge about preventing and managing diabetes.** Thirty-two (97%) community participants at the May 3rd event indicated that they had learned more about appropriate diabetes care management and prevention behaviors that they could practice. In addition, twenty-five (76%) discovered at least one belief or behavior that had prevented them from accessing appropriate medical care for preventing/managing diabetes.
- **Finding #3: Twenty-seven percent (9 of 33) of community attendees at the first event indicated they would like to commit to further healthy living**

activities. Of the thirty-three respondents, three expressed interest in participating in the Solano Wellness Million Pound Challenge, three expressed interest in becoming Critical Mass Health Conductors, and three indicated interest in participating in future African American Advocacy projects. In addition, of the fifteen participants at the first facilitator training who completed a survey, fourteen (93%) committed to at least one healthy activity in the future.

- **Finding #4: Numerous community partners were identified and community leaders trained as a result of efforts by the grantee, Community Education Workgroup, and SCBH.** Fischer Communications, SCBH, and Community Education Workgroup members have established relationships with thirty to fifty community partners who expressed interest in supporting education on diabetes in the African American community. In addition, thirty-one community members were trained as event facilitators/table hosts for the community education events held in May and June.

➢ **Recommendation #1: Streamline or improve the county's RFP process.** The cancellation of the original RFP in March 2007, and subsequent delays that prevented a contract being signed until December 2007, significantly slowed the process of providing diabetes education to the Solano County African American community. A more streamlined and improved RFP process, including stronger communication between the Community Education Workgroup, SCBH and Solano County's H&SS Department, might have allowed the project to begin much earlier.

➢ **Recommendation #2: Include communication protocols in the initial contract.** According to all parties involved, communications between SCBH, the Community Education Workgroup, and Fischer Communications were initially challenging and insufficient, resulting in project implementation delays, which at least partially contributed to low attendance at the community events. Communication challenges were partly due to lack of clarity around proper lines of communication, roles and responsibilities designations, and lack of regularly scheduled check-ins. While some of these items may have been outlined verbally, written documentation of these roles and responsibilities might improve future communications between contractors and SCBH or County staff.

Conclusion

We conclude by assessing the contributions of the seven strategies on the five goals of the 2005-2008 Health Access Strategic Plan (our first primary evaluation question), providing feedback on the relationship between the strategies and the new 2008-2011 Strategic Plan, and providing some overarching successes, challenges and recommendations.

Assessment of the Effect of the MSA-funded Strategies on the Goals of the 2005-2008 Strategic Plan

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%.
- Due to major funding cuts, SKIP has been unable to focus on retention for more than a handful of children.
- No funded strategies are 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 are likely to be having an affect on Objective a: *increase 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) have likely had some effect on Objective b: *expand integrated behavioral health services at primary care sites and increase linkages of specialty mental health and substance abuse and drug treatment services not provided at these sites.*
- SCBH efforts related to Strategy 1 are beginning to have an affect on Objective c: *increase the availability of medical specialty care services*.
- Strategy 6 began to have a major effect on Objective d: *increase 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: *assure that services throughout the healthcare system in Solano County are made available to all patients in a language they can understand*.
- Through SCBH's African American Disparities Elimination Project, Strategy 1 indirectly contributed to achievement of Objective b: *increase the cultural sensitivity and competency of key personnel throughout health system*.
- Strategies 2 and 6 both carried out activities in 2007-2008 related to Objective c: *provide informational and educational materials that are easy to understand in all appropriate languages.*
- Strategies 1, 6 and 7 all conducted activities in 2007-2008 related to Objective d: *address 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 3, and to some extent Strategy 6, involved activities that contributed to Objective a: *assure that there are adequate primary care services located throughout Solano County.*
- Strategy 5, in a small but critical way, helped achieve Objective b: *decrease transportation barriers which prevent residents from timely healthcare*.

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 affected Goal 5 in FY 2007-2008.
- Strategies 2 and 4 both involved activities related to Goal 5.

Current MSA-Funded Strategies and the 2008-2011 Strategic Plan

While this evaluation focused primarily on the effect of the MSA-funded strategies on the 2005-2008 Strategic Plan, we also examined how well the current MSA strategies fit with the new Strategic Plan for 2008-2011. Basically the new Strategic Plan maintains a great deal of continuity with the previous version. However, there are three somewhat major additions to the new Strategic Plan that are not fully addressed by the current MSA-funded strategies. These include an increased focus on improving access to specialty care and pre-natal care, and decreasing inappropriate emergency room (ER) usage.

Overall Successes and Challenges

Successes

- **Most strategies were implemented as planned**. By the end of the year, most strategies had implemented at least some of the interventions and activities as planned. In addition, a majority were planning to expend all of their MSA funding. Given the significant challenges related to implementing new and innovative projects such as the MSA-funded strategies, this is an important achievement.
- **SCBH, HAC and four 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 1, 2 4, and 5, the data highlight the

effectiveness of health access-related programs in the county such as the Solano Kids Insurance Program or SCBH as a whole.

Challenges

- **Hiring staff and finalizing contracts was sometimes extremely challenging.** During fiscal year 2007-2008, several strategies faced significant delays in hiring staff or finalizing contracts to expend MSA funding. For example, both Strategies 5 and 6 faced delays in hiring county replacement staff, resulting in unspent MSA funds. For Strategies 3, 6 and 7, delays and problems with finalizing contracts between providers and the county also led to late implementation and unspent MSA funds. These delays and challenges have meant that Solano County residents did not have access to important health access services for much of the 2007-2008 fiscal year.
- **Turnover in staff has been challenging for implementation and data collection.** Staff in charge of implementation or data collection for several of the strategies left during the 2007-2008 fiscal year. This staff turnover, in some cases, caused both interruption of service delivery and data collection efforts, sometimes for extremely lengthy periods. Consequently, as in the case of Strategies 3 and 5, important data were not available for the evaluation.
- **Data collection practices continue to be problematic for strategies with relatively new interventions.** For Strategies 3, 5 and 6, data collection instruments and processes continued to be somewhat problematic in 2007-2008. For example, data reporting spreadsheets or templates for Strategies 3 and 6 lacked important information. In addition, data collection activities for on-site behaviorists for Strategy 3 were inconsistent. In other cases, data was simply not recorded or retained, as in the case of data on Frequent Users after March 2007 or academic detailing and consultation services under Strategy 3.

Overall Recommendations

- **Consider increasing focus on health care retention and utilization and consider focusing more on adults.** Due to the county's continuing success in achieving nearly 100 percent insurance coverage for children, HAC and the Enroll and Retain Workgroup should consider focusing more on retention and utilization in the future. Further, it might be appropriate for the county to increase its focus on increasing the percentage of adults with health insurance at some point.
- **Determine how to address the additions to the new Strategic Plan.** Because the current MSA-funded strategies do not fully address increasing access to specialty care, pre-natal care or reducing inappropriate ER use, the Health Access Committee should appoint appropriate groups and allocated required resources to focus on these new efforts.
- **Consider whether there are more expedient means of hiring staff or distributing funds to appropriate service providers or grantees.** Due to the issues related to finalizing contracts or hiring county staff for new projects, HAC,

SCBH and the county might want to consider whether or not there are more expedient means of hiring staff or distributing funds to appropriate service providers so that valuable MSA resources are spent and unnecessary time does not pass. A major question for the county to consider is, are there alternative mechanisms for bringing staff on board and distributing the funds while still maintaining close county oversight and involvement for public accountability purposes?

- **Ensure data collection processes and instruments are complete and well-defined.** To ensure that both HAC and its workgroups have access to all data needed for program planning and management purposes, workgroups should ensure that data collection instruments and processes are clearly defined. Point people in charge of data collection should also be appointed and times for regular reporting of data at HAC or workgroup meetings should be scheduled.

INTRODUCTION

Social Policy Research Associates (SPR) is pleased to present the 2007-2008 report of our Evaluation of the Effect of the MSA-Funded Strategies on the 2005-2008 Solano County Health Access Strategic Plan. Our first two years of effort have 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 2005-2008 Health Access Strategic Plan—is the primary focus of our evaluation and this report.

Development of the Health Access Strategic Plan was led by the Health Access Committee (HAC)—one of the primary committees under SCBH since 1998. The first Strategic Plan was approved in 2002; the second, three-year Strategic Plan was adopted in 2005, and a third Strategic Plan to cover mid-2008 to 2011 was just approved earlier this year but will not take affect until July 1, 2008. While SCBH and the county are committed to promoting the health and wellness of all residents, the 2005-2008 Strategic Plan specifically targeted low-income, uninsured and other vulnerable populations residing in Solano County. All residents with incomes at or below 300% of the Federal Poverty Level were considered low-income.

The 2005-2008 Plan was guided by three core principles: (1) people need a way to pay for healthcare 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 2005-2008 Plan was 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 2005-2008 Strategic Plan outlined the following specific goals:

Exhibit 1: 2005-2008 Health Access Strategic Plan Goals

1. Increase the percentage of Solano County residents who 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 were the 2005-2008 Strategic Plan's seven MSA-funded strategies, as well as SCBH, and 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 first contracted by Solano County to conduct a formative and summative evaluation of the success of the MSA-funded strategies being carried out by HAC and its five workgroups in achieving the 2005-2008 Strategic Plan's goals listed above. Consequently, under the direction of the Master Tobacco Settlement Agreement (MSA) Evaluation Subcommittee, SPR developed a three-year evaluation plan for 2006-2007 through 2008-2009, conducted data collection and analysis activities related to the first year of that plan, and presented findings for the first year in a final evaluation report covering 2006-2007. During the spring of 2007, SPR was again contracted by Solano County to carry out the second year of data collection and evaluation outlined in the three-year evaluation plan and present our findings for the second year in this second evaluation Report covering 2007-2008.

In both years of the evaluation, our overarching objective has been to assess the success of the MSA-funded strategies being carried out by HAC and its five workgroups in achieving the 2005-2008 Plan's goals listed above. Consequently, our primary evaluation questions have been as follows:

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

The 2007-2008 year represents the second year of a formal, external evaluation of the MSA-funded strategies. Below, we briefly describe activities from our first year and then outline in more detail our evaluation work during 2007-2008.

First Year: Developing the Evaluation Plan, and Conducting Data Collection and Analysis

One of the primary activities of the first year of the evaluation was to develop a formal, three-year evaluation plan to guide the evaluation's data collection and analysis activities. SPR began development of the plan by carrying out a participatory process to identify the prioritized outcomes (see Exhibit 1-2 below) to track within our evaluation. This process included interviews with key stakeholders, a review of documents, development of logic models, and meetings with each of the workgroups and HAC.

Exhibit 1-2:
Table of MSA-Funded Strategies and Prioritized Outcomes Developed in 2006-2007

MSA-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.	• Active participation on each of the workgroups of organizations whose work is aligned with the workgroup goals/ purpose (2006-2009) • Solano Coalition for Better Health leverages MSA funds, develops partnerships and participates in other efforts related to improving health access (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)[2]
Strategy 3: Expand integrated 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 care 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-

[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.

[2] This outcome was eventually eliminated due to resource limitations and feasibility issues.

MSA-Funded Strategies	Prioritized Outcomes 2006-2009
	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)

Based on these prioritized outcomes, we prepared the evaluation plan, outlining our evaluation questions, design, and data collection and analysis plan.[3] Once we had developed this evaluation plan, we immediately moved forward on completing the first year of data collection and analysis activities outlined in the plan. Finally, after completing our data collection and analysis activities for the year, we presented our results in our Evaluation Report for 2006-2007.

Second Year: Data Collection & Analysis

During the second year of the evaluation, we focused entirely on carrying out data collection and analysis activities related to the second year of the evaluation plan. This included evaluation of both the 2006-2007 and 2007-2008 outcomes. Although specific data collection plans differed across strategies (and these are detailed in the remainder of the report), 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 a dozen workgroup chairs, county staff and other key stakeholders.
- Review of evaluation data from 2006-2007.
- Database queries.
- Quantitative data extraction from external sources such as CHIS.

As in 2006-2007, we encountered some challenges in obtaining the necessary data for our analysis. While specific challenges will be discussed in their respective sections, overarching challenges included incomplete or unclear data sources, and late receipt of data.

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

Overview of this Report

The remainder of this report is concerned with describing the activities, expenditures, successes and challenges of implementing and evaluating each MSA-funded strategy thus far. We do this primarily with an eye toward the strategy's prioritized outcome(s) for 2006-2007 and 2007-2008. 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 MSA-funded strategies, since it is concerned with the very health of the group dedicated to fostering the implementation of the 2005-2008 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/Primary Care Integration), 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 in 2007-2008 related to our larger research question—the extent to which strategies are contributing to the realization of the five 2005-2008 Health Access Strategic Plan goals. As part of this discussion, we highlight key successes, as well as perceived gaps and emerging challenges. We also briefly compare the work of the current MSA-funded strategies to the 2008-2011 Strategic Plan to determine whether there are areas that are not currently addressed by the MSA strategies. 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 the 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, SCBH 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. SCBH's work is shaped by the multiple committees that it supports.

The Health Access Committee of SCBH is the body that is tasked with developing and monitoring recommendations to modify the Health Access Strategic Plan, adopted by both SCBH and the Solano 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

One major activity of HAC this year was to develop and approve a new Health Access Strategic Plan for 2008-2011. In addition to developing the new strategic plan, HAC has also played a significant monitoring function for MSA-funded workgroups. Consequently, HAC has reviewed modifications to and adoption of recommended MSA spending plans, received updates from workgroups, provided guidance on MSA-funded strategies, and connected the work of the MSA-funded strategies to health reform initiatives and SCBH- and health access-related activities (e.g. the Healthcare for Homeless initiative, SKIP, etc.).

Exhibit 1-1. MSA Budget and Expenditures for 2007-08 for Strategy 1[1]

	Recipient	Approved Budget	Expenditures as of May 31, 2008	Percentage Expended
Strategy 1: Health Access Coalition	SCBH	$150,000	$74,023	49%

For fiscal year 2007-08, $150,000 was budgeted to SCBH for activities related to Strategy 1 in support of other strategies. As of May 31, 2008, the 2007-2008 Financial

[1] This chart captures expenditures paid out by the County as of 5/31/08 and does not reflect claims submitted for services during May. Workgroups have until 6/30/08 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 2007-2008 fiscal year (August 2008).

Status Report shows that only 49 percent of this funding had been expended: a decrease of 5 percent from the previous year. However, the Executive Director of SCBH reported that she expects to expend 100 percent of funding allocated to Strategy 1 by June 30, 2008. During this fiscal year, SCBH provided professional and staff support to HAC and all five workgroups.

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 MSA funds, develops partnerships and participates in other efforts related to improving health access

Results for 2007-2008

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

Indicators:

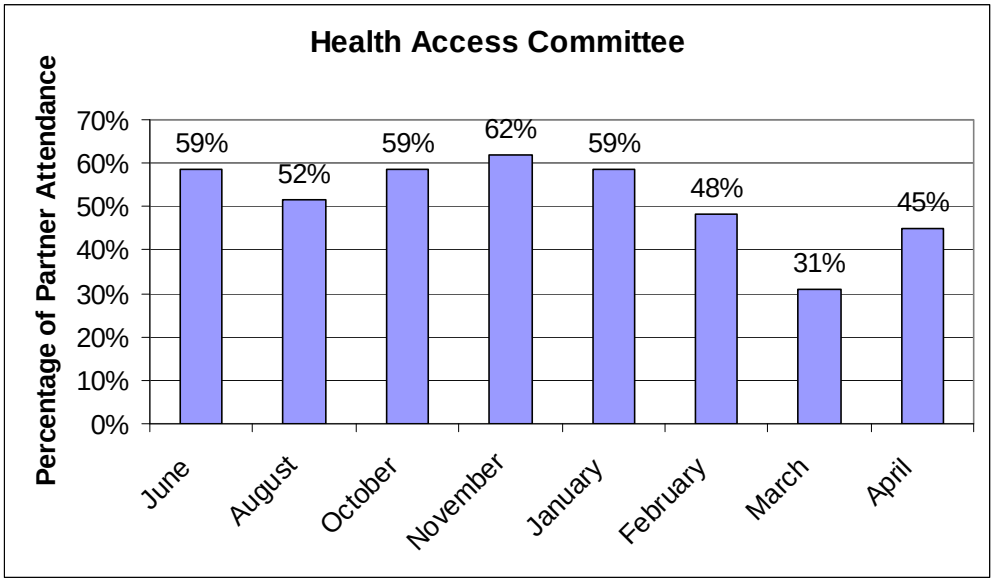
1. ***Workgroup Attendance over a 12-month period by partner organizations for each workgroup***
2. ***Partner organization participation in workgroups over a 12-month period***

Results

- **Workgroup Attendance and Participation**
  - **Health Access Committee**. For the eight HAC meetings that occurred in 2007-08 for which we have minutes, an average of 52% or 15 members attended each meeting. Overall, the attendance rate was lower than the previous year's average of 64%. The Health Access Committee included representatives from the following organizations: Clinic Consortium, Community Medical Centers, Faith in Action, First 5, La Clinica de La Raza, Partnership Health Plan of California, Planned Parenthood, SCBH, and Solano County, including the Department of Health and Social Services (H&SS) and Youth and Family Services.

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

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



- **Enroll and Retain.** Meeting attendance for this group was strong with an average attendance rate of 78% (five of seven members regularly attended) in 2007-2008. No meeting minutes were available for the previous year for comparative purposes.
- **Behavioral Health/Primary Care Integration**. Workgroup meeting attendance was average for 2007-2008. Meeting minutes for the five meetings held show an average of 46% or seven members in attendance. This is an improvement over the previous year's 33% average.
- **Frequent Users.** Minutes and attendance information were only available for three of the six meetings scheduled for this year. Attendance at these meetings improved this year with 11 of the 19 members, or 58%, attending. Last year's average was 45%.
- **Oral Health**. In 2007-2008, workgroup participation was relatively low with an average of only 38% of members in attendance (9 of 24 members). However, the workgroup chair felt that workgroup attendees were particularly motivated and energetic. No meeting minutes were available for the previous year for comparative purposes.
- **Community Education**. No attendance data were available for this year.[3]

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

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

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 workgroup minutes (which usually include attendance figures), SCBH's annual financial report/audit and the Executive Director's monthly reports. To gain additional insight into the operations of individual workgroups, we also interviewed the chairs of workgroups, as well as other key staff.
- 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, SCBH did an excellent job of keeping the roster updated and provided two updates of the roster for the evaluation—once in August 2007 and again in April 2008.
- As noted, we were not able to obtain any attendance and meeting summary data for the Community Education Workgroup.

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

As in past years, SCBH has undertaken many efforts outside of its work with HAC and the MSA-funded workgroups. The supporting information presented for the following two indicators describes the extent of fund leveraging and activities beyond MSA-funded work that also contribute to promoting health access for Solano residents.

Indicators:

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

Results

- Excluding MSA funds, SCBH generated more than $2.78 million in funding between January 1, 2007 and December 31, 2007. The major sources of this funding were as follows:[4]
  - **$1,079,453** from The California Endowment ($200,000), First 5 Solano ($184,000), Solano Magazine ($52,140), Solano County ($193,000) and Syers ($50,000) for **Healthy Kids Solano**.
  - **$889,500** from First 5 ($86,000), Kaiser ($42,000), Medi-Cal ($407,000), the Solano Community Foundation ($5,000), and United Way ($60,000) for the **Solano Kids Insurance Program (SKIP)**.
  - **$353,276** from The California Endowment ($177,683), Kaiser ($98,993), United Way ($67,500), the Champions Fundraising Event ($8,500), and

[4] This data is based on the 2008 Solano Coalition for Better Health Budget based on funds raised in 2007. See also Strategy 2 for more information on leveraged dollars used to support Health Kids Solano.

individual donations ($500), for the **Elimination of Health Disparities in Solano** project.

- **$8,000** from Solano County ($3,000) and the Solano County Clinic ($5,000) for the **Pharmacy Assistance Program**.
- **$117,702** 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 MSA dollars into perspective. Within Solano County, MSA funds represent a small percentage of the total funding used for 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.[5] This is in comparison to the $1.5 million available for MSA-funded strategies in 2007-2008.

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

In 2007-2008, SCBH supported 127 committee/work group members representing approximately 37 organizations. This is in contrast to last year's 180 members from 39 organizations.[6] The SCBH Board includes 20 representatives from 19 different organizations, of which almost all have representatives on the MSA workgroups. Appendix A includes a full list of the 37 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 HAC and its affiliated workgroups, SCBH has also been involved in a number of other efforts related to the goals of the 2005-2008 Health Access Strategic Plan. These activities are organized by relevant strategic plan goals below:

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[5] Source: The Solano County Health Access Strategic Plan 2005-2008.

[6] We were not able to obtain data for non-MSA workgroups and committees this year. Therefore, the drop in numbers committee/workgroup members may reflect this absence of data rather than an actual decline.

Efforts related to Strategic Plan Goal 2

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

- **Pharmacy Assistance Program:** Although SCBH received the Pharmacy Assistance Program contract from the County for fiscal year 2007-2008, the future of the program is uncertain.
  - Due to lack of funding, Solano County clinics will no longer be involved with the Pharmacy Assistance Program.
  - SCBH does not have the ability to cover the cost of the program so the SCBH Executive Committee voted to develop a transition plan with a June 30th termination date. However, the SCBH Executive Director commented that a small amount of funding might become available so the program may continue on a much smaller scale.
- Other Goal 2 related efforts undertaken by SCBH in 2007, included:
  - Received a grant from Kaiser to review the specialty care needs of the county and to develop a plan to resolve some of the specialty care access issues in Solano County. Kaiser will provide $147,00 for the first year and approximately $300,000 for a possible second year. SCBH will work with the Clinic Consortium and other community partners to develop a plan.

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**: Patrick Hughes led the SCBH board in reviewing the recommendations outlined and approved by the SCBH Executive Committee. Three major issues identified through the study and recommended for action steps were prenatal care, emergency room utilization, and the over-all capacity of the safety net to provide care throughout the county. These issues were incorporated into the new 2008-2011 Health Access Strategic Plan.
- **Influence on the statewide Children's Health Initiative (CHI), State Children's Health Insurance Program (SCHIP) reauthorization, and the Governor's health plans**: SCBH has worked to rally key stakeholders around a number of important state and national proposals and legislation. Sample activities included:
  - Airing 85 public service announcements and running more than 150 health columns, articles, and paid and free ads about key health issues.
  - Presenting information to and contacting U.S. Congressional and Senate representatives to request support for policies related to children's health.
- Other Goal 5 related efforts undertaken by SCBH in 2007, included:
  - **Meeting with policy makers**. Co-sponsoring the Lunch Conversation on Healthcare Reform arranged by the Clinic Consortium and attended by Assemblywoman Lois Wolk and other legislators and/or their staff.

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 the African American residents of Solano County. The goals of the project, along with activities implemented to achieve them, include:

  — *Increase individual behaviors, which positively contribute to personal health and wellness, and increase the role of the extended family and community in supporting positive behaviors*

  ✓ A grant for $67,000 from United Way was secured to support the development and implementation the Critical Mass Health Conductors (CMHC) in Solano County project. So far, 35 community residents have been trained in healthy behaviors and received their CMHC number.

  ✓ In February, the third annual *Champions for Healthy African Americans* celebrated existing efforts to improve the health and wellness of African Americans in Solano County. Over 300 community members attended the celebration.

  ✓ SCBH secured a community benefit grant from Kaiser Permanente to design a community health promotion campaign. This campaign will include the *Million Pound Challenge* that will begin in June 2008.

  — *Improve the quality of care received by African American residents*

  ✓ A countywide conference on inequality was hosted in May 2007 in partnership with First 5 Solano, the Public Defenders Office, Black Infant Health, and Partnership Health Plan of California.

  ✓ The first ever Continuing Medical Education credit (CME) workshop for physicians and practitioners targeted at providing more effective services to the African American community was planned and hosted by members of the Physicians Advisory Committee, the Solano County Medical Society and SCBH's Board.

  ✓ SCBH continued to partner and work with U.C. Berkeley and Touro University to develop programs for African American residents of Solano County interested in the healthcare field.

  — *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*

  ✓ The SCBH Disparities Elimination Strategic Plan was presented, approved and endorsed by the Solano County Board of Supervisors in February 2007.

  ✓ SCBH received a grant from The California Endowment to create a Solano County African American Advocacy program to empower and train residents in advocacy and leadership skills.

Data Sources and Limitations

- The data sources for this outcome included interviews with SCBH's outgoing and current Executive Directors, the SCBH 2007 budget, the SCBH Annual Report,

and the 2007-2012 Strategic Plan of the Solano County African American Disparities Elimination Project.

- Due to limited resources, it was not possible for us to track in great detail all of SCBH's other activities although they relate to the 2005-2008 Health Access Strategic Plan. Comprehensively tracking activities outside of the Strategic Plan would entail resources beyond the scope of this evaluation. In addition, we were reliant on SCBH staff to share with us all relevant and necessary information, but despite repeated requests for information, received less information on other SCBH activities this year than last year.

Conclusion

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

Successes

- **Successful transition of a new executive director**. The first Executive Director of SCBH retired in early 2008 after twelve years of service. During his tenure, SCBH grew to have18 staff members and a budget of approximately $3 million. Since the first Director's retirement, the new Executive Director, Rosalía Velázquez has smoothly transitioned into her role of overseeing completion of the strategic planning process; managing program development and implementation; developing collaborative partnerships; and shaping fundraising strategies. She is actively looking for strategies to implement in the future, particularly on how to expand programs while continuing to achieve the goals of SCBH. Ms. Velázquez observed that her leadership is supported by the continuing strong commitment of partners in this work.
- **Development and approval of the Health Access 2008-2011 Strategic Plan**. In 2000, the SCBH Board and the County Board of Supervisors approved the first Health Access Strategic Plan. At that time, it was agreed that the plan should be revised every three years. In the summer and fall of 2007, thirty-five community members met and, with the help of Bobbie Wunsch, developed the new 2008-2011 strategic plan. The plan was presented for final approval to HAC in January 2008 along with funding recommendations. Over the next three years, this plan will provide a defined focus for HAC's efforts, supported by SCBH, to continue to expand health access for Solano County residents.
- **The funding raised and leveraged in support of the many SCBH health access initiatives continues to be substantial.** SCBH and its members have been very effective securing funds for a variety of health access-related projects, raising a total of $2,777,086 in 2007. In addition, SCBH has been successful in locating funding to support other efforts, such as the $353,276 raised in 2007 for the Eliminating Disparities in Health Project.

- **Restructuring of staffing to the workgroups**. In the previous year, the outgoing Executive Director expressed a goal of restructuring SCBH's staffing of the health access workgroups to augment both professional and administrative support. Consequently, for this fiscal year, a senior SCBH staff person was assigned to staff each of the health access workgroups. According to most respondents, this change has enabled the workgroups to function more efficiently.
- **Improved record keeping**. In the past, because of the haphazard and decentralized way that workgroup minutes and attendance information were recorded and stored, we faced many challenges in obtaining the workgroup minutes and attendance data required for preparation of our evaluation. In addition, in calculating attendance and participation figures, we found that the rosters of agencies and individual participants were not always kept up to date. However, there have been *noticeable* improvements related to minutes and attendance data during the 2007-2008 fiscal year. For example, in most workgroups, minutes were taken and attendance noted at every meeting and this information accompanied subsequent meeting notification mailings to the workgroup members. In addition, SCBH worked with SPR to create and maintain a centralized workgroup roster that links the names of individual representatives to their organizations. This enabled SPR to more accurately determine workgroup attendance rates for the purposes of this evaluation.

Challenges

- **Timeliness of setting up contracts and hiring staff through the county**. Despite the persistent efforts of both SCBH and county staff, several health access workgroups have faced major challenges and delays in setting up and finalizing county contracts and/or hiring county staff for health access work. This was a major issue that surfaced in the 2006-2007 Evaluation Report and it was again noted by numerous respondents this year. As a result of these challenges and delays, MSA funds have been going unspent and community members have not received important services on a timely basis. To attempt to open dialogue and find solutions to these challenges, a group of HAC members recently met with the SCBH Executive Director and members of the Solano County Board of Supervisors to discuss issues related to the county's contracting process.

Recommendations

- **Improve processes for setting up workgroup-initiated contracts and hiring of staff.** During the past two fiscal years, four health access workgroups/strategies (Community Health, Behavioral Health/PCI, Frequent Users, and Oral Health) have had difficulty finalizing county contracts or hiring county staff to expend allocated MSA funding. These difficulties have led to major delays in the ability of these strategies to provide important services to Solano County residents. Consequently, HAC and SCBH leaders should continue their recently opened a dialogue with county leaders to try and develop solutions to these problems.

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 MSA 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 (HKS).

Exhibit 2-1. MSA Budget and Expenditures for 2007-08 for Strategies 2 & 4[2]

	Recipient	Approved Budget	Expenditures as of May 31, 2008	Percentage Expended
Strategy 2: Enroll and Retain	SCBH	$300,000	$220,025	73%
Strategy 4: Premiums	SCBH	$400,000	$338,625	85%
Total		**$700,000**	**$558,650**	**80%**

As shown in Exhibit 2-1, in 2007-2008, $700,000 in MSA funds were allocated to SCBH to support implementation of Strategies 2 and 4. This included $300,000 to support SKIP and $400,000 to cover the cost of premiums for HKS and the family share of cost for children enrolled in HKS, Healthy Families, and Kaiser's Child Health Plan for certain families. With one month remaining in the fiscal year, 80 percent of the funding allocated for both strategies had been expended. Key workgroup respondents said that they expect one hundred percent of the allocated funding for Strategies 2 and 4 to be expended by the end of the fiscal year.

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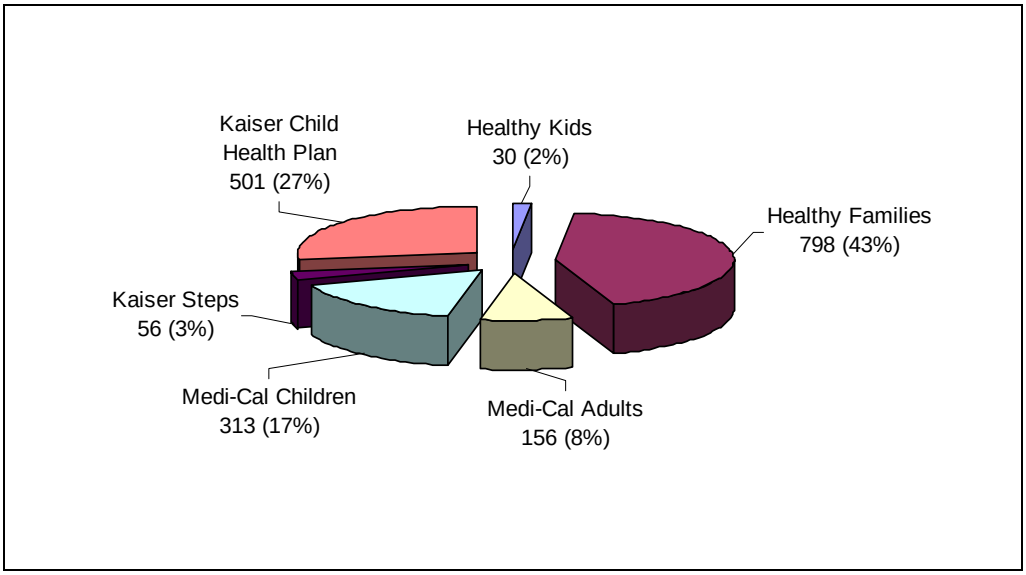
[1] The information presented in this section is based on interviews with the workgroup's chairs, key staff involved with the intervention, a review of relevant documents, and data provided by the SKIP project.

[2] This chart captures expenditures paid out by the County as of 5/31/08 and does not reflect claims submitted for services during May. Workgroups have until 6/30/08 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 2007-2008 fiscal year (August 2008).

Solano Kids Insurance Program (SKIP)

One of the primary ongoing interventions related to achieving Strategies 2 and 4 in Solano County is SKIP. Founded in 1998, SKIP assists children and their families with enrollment and retention in publicly-funded health care programs. From July 2007 to March 2008, SKIP assisted 1,858 individuals to enroll in health insurance. The majority of these new enrollments were in Healthy Families, Medi-Cal and the Kaiser Child Health Plan (See Exhibit 2-2).

Exhibit 2-2: Individuals Assisted with New Enrollment by SKIP in 2007*



**Individuals assisted with enrollment in CMSP (2 individuals) and AIM (2 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. Forty-seven schools met the 100% School Campaign threshold in 2007-2008 (see Outcome 3 below). 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 and 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), Baby First Solano Collaborative**,** Family Resource Centers, and child care providers 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 2005-2006, 2006-2007, and 2007-20808,[3] 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 (see Outcome 1 below) and offered assistance in setting up needed visits to doctors, dentists and vision care providers.

In the spring of 2007, SKIP received a state Outreach Enrollment Referral and Utilization (OERU) grant for $200,000 per year for three years. With this grant, SKIP had planned to significantly expand its efforts to conduct follow-up with children and families. For example, SKIP planned to contract with a firm to carry out follow-up calls three times a year with at least 1,000 children it had assisted with enrollment in Healthy Families and Medi-Cal. However, because the budget signed by the Governor in August of 2007 eliminated OERU funding for fiscal year 2007-2008,[4] SKIP was only able to conduct a small portion of those follow-up calls before the loss of funding caused the follow-up contract to be cancelled.

Healthy Kids Solano

The other primary intervention related to Strategies 2 and 4 is Healthy Kids Solano. Initiated in December 2005, HKS is Solano County's Children's Health Initiative program providing health care in 2007-2008 to 960 low-income county children who were ineligible for Medi-Cal or Healthy Families, primarily due to immigration status. Children are enrolled in HKS 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 HKS, the bulk of the premiums for the program (around $1,160 per child per year) are covered by SCBH. For example, from July 2007 to March 2008, SCBH paid $800,000 in premiums to cover premium costs.

The funds to cover HKS premium costs are raised from a variety of sources, including MSA funds (see above), foundation funding and fundraising from individuals and businesses. Due to fears that foundation funding would be withdrawn by the end of the 2007-2008 fiscal year and that state funding would not be forthcoming, during the summer and fall of 2007 the Enroll and Retain Workgroup developed a number of possible contingency plans for how to continue covering the costs for HKS during the

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[3] SKIP has two more years of funding from First 5, with an option to renew the grant for an additional two years.

[4] OERU funding is also unlikely to be available in the 2008-2009 fiscal year due to the state's sizeable budget deficit.

2008-2009 fiscal year and beyond. However, because the foundations decided to continue funding HKS and because of the better than expected success of the workgroup's individual and business fundraising efforts that raised nearly $400,000, by May 2008, it appeared that it would not be necessary to adopt a contingency plan at the beginning of the 2008-2009 fiscal year.

Kaiser Permanente also offers a low-cost program for Solano County children who are ineligible for Healthy Families and Medi-Cal, called the Kaiser Child Health Plan. This program has thus far enrolled approximately 2,000 Solano County children.

Enroll and Retain Workgroup Activities 2007-2008

The Enroll and Retain Workgroup, which provides oversight to both HKS and SKIP, was quite active in 2007-2008, particularly during the fall of 2007 when the group met monthly. This was primarily due to the group's focus on contingency planning for HKS. Key workgroup members included county staff, including the director of H&SS; SCBH staff, including the Director of SKIP and often the organization's Executive Director; and representatives from First Five Solano County. In addition, a few new members were added during contingency planning, some of whom have continued to attend. These included representatives from the Clinic Consortium and United Way. Major topics discussed by the workgroup during 2007-2008 included:

- **Contingency funding plans for HKS**. As discussed above, during the fall and winter of 2007-2008, Enroll and Retain Workgroup meetings were primarily focused on discussing possible plans for how to support HKS in future years.
- **Fundraising to cover premiums for HKS**. The workgroup devoted a significant portion of its time to discussions about fundraising activities, particularly the Solano Magazine-sponsored golf tournament that together with county matching funds raised approximately $400,000 to support HKS.
- **Pending state and federal legislation and regulations related to children's health insurance**. The workgroup spent a significant amount of time discussing proposed legislation and regulations related to children's health insurance and possible advocacy steps. For example, the group discussed proposals for state-wide health reform, possible changes to Medicaid eligibility rules, and changes to the SCHIP program.
- **Impact of state and county budget cuts**. The workgroup regularly discussed the impact of state and county budget cuts, such as the loss of OERU funding.

Outcomes

Prioritized Outcomes for Strategies 2 and 4 for 2007-2008

1) Targeted children visit their primary care physician (PCP)

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

3) Increase in children and families assisted with enrollment who are insured 14 months after initial enrollment

4) Increase in percentage of public elementary schools with 100% health insurance coverage

Results for 2007-2008

Outcome (1) Targeted children visit their primary care physician

Indicator:

Percentage of children targeted by SKIP for follow-up who have visited a doctor during the last 10 months

Results

- One hundred percent of zero to five year-olds from School Readiness sites targeted for follow-up by SKIP (99 children) reported that their child had visited a doctor[5] at least once during the 10 months since the child became insured (see Exhibit 2-3). 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 the same.

  Similarly, only eight of the 134 (6%) children who were followed up with after six months as part of the follow-up calls funded by the state OERU grant reported that their child had not been to the doctor for routine/preventative check-up.[6]

[5] Although the outcome is focused on visits to the child's primary care provider (PCP), 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 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 kinds of care.

[6] Parents for thirty-nine of the children reported that their child had visited the doctor for a routine/preventative check-up, while parents for the remaining 88 children did not respond, either because the phone number on record was incorrect, the parent declined to speak with the interviewer or did not answer the question.

Exhibit 2-3: Dr. Visits by Children Aged 0-5 Targeted for Follow-up by SKIP in 2007-2008

	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*
Healthy Families	50	48	100%
Healthy Kids Solano	5	5	100%
Kaiser Child Health Plan	23	23	100%
Medi-Cal	21	21	100%
Total	99	97	100%

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

The results for 2007-2008 were basically the same as those for 2006-2007, in which 100% of targeted children were reported by their parents as having visited a doctor in the 10 months since they were enrolled in health insurance (see Exhibit 2-4).

Exhibit 2-4: Dr. Visits by Children Aged 0-5 Targeted for Follow-up by SKIP in 2006-2007

	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 *
Healthy Families	38	37	100%
Healthy Kids Solano	17	17	100%
Kaiser Child Health Plan	12	12	100%
Medi-Cal	31	31	100%
Total	98	97	100%

** 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 Sources

The primary data source for this outcome was data collected by SKIP staff as they conducted follow-up calls with the families of approximately 100 children, ages zero to five in 2006 and 2007.[7] These children were from First 5 Solano School Readiness sites and were assisted with enrollment by SKIP staff between January and December 2006 and 2007. 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

[7] Ninety-eight children were followed up with in 2006 and 99 in 2007.

conducted from March 2006 through April, 2007 and March 2007 through April 2008. Consequently, for children enrolled after the middle of 2006 or 2007, one to two planned follow-up calls were not included in the data. However, because most children were reported to have visited a doctor by the time of the six month follow-up calls, the fact that some of the later follow-up calls had not taken place by the time we were provided with data did not have a large impact on results we have included in this report.

Data Limitations

Because of the small number of children included in the data (less than eight 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 findings 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.

Outcome (2) Over 95% of all 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[8]

- Based on the most recent data from the California Health Interview Survey, it appears that Solano County has achieved the 95% target for 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. In fact, we found that the difference in results for 2003 as compared to 2005,[9] was too small to be statistically significant.[10] This means that the difference in results has a very high probability of being due to sampling error rather than actual differences in the underlying population.

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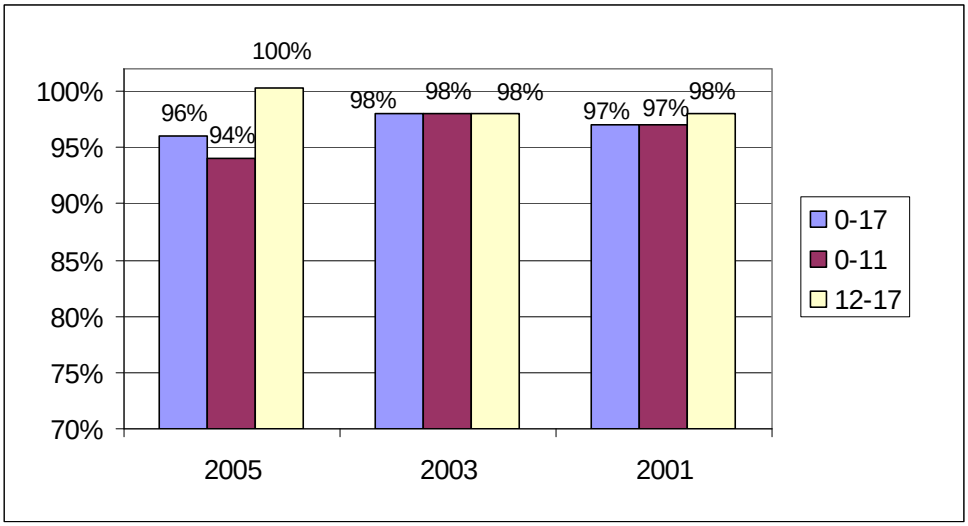
[8] Because CHIS data is only collected every other year, these are basically the same results reported in last year's report. The only change is that we conducted statistical tests on some of the results.

[9] Individual-level data for 2001 were not available, so we were not able to statistically compare results for either 2003 or 2005 with results for 2001.

[10] In this report, we use the traditional .05 level to determine statistical significance.

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



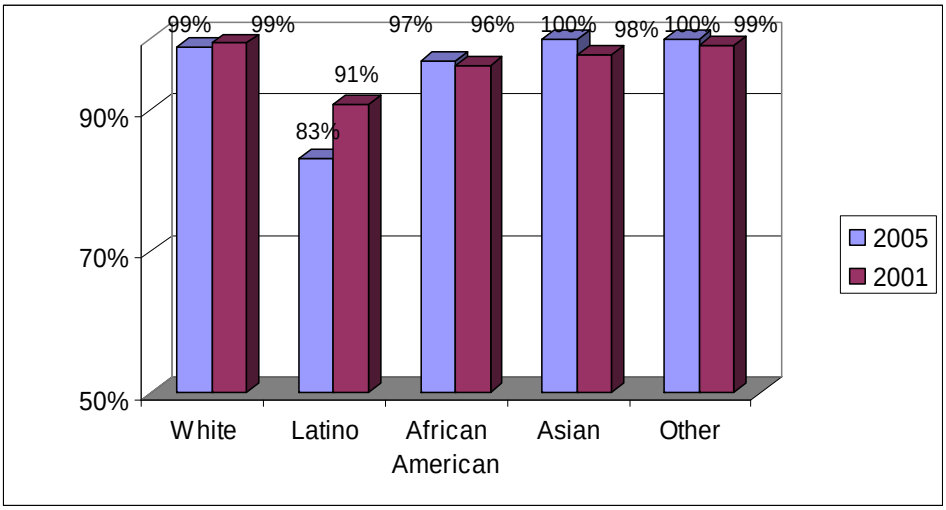
**Source: California Health Interview Survey (CHIS).*

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 2005-2008 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

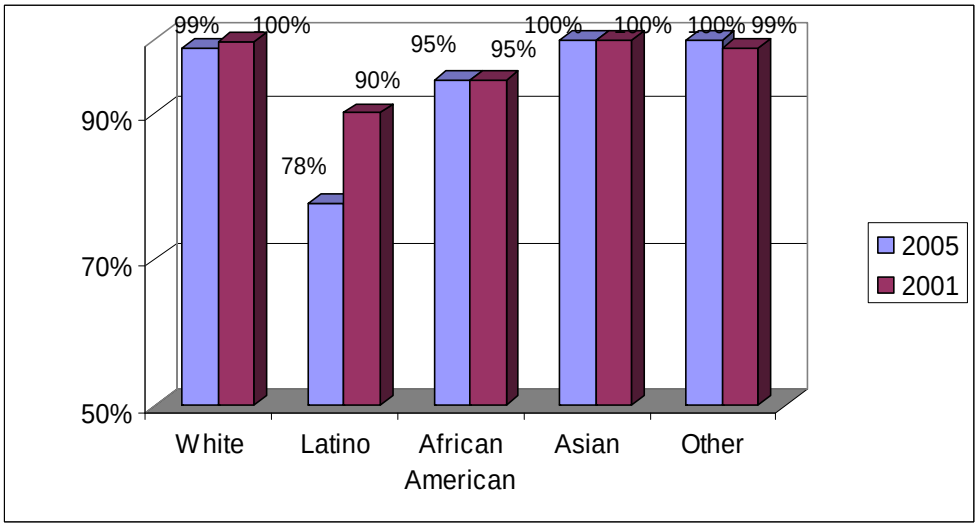
- Although results for children 0-17 of particular racial and ethnic groups in the county were fairly similar to the overall results presented above, the one group for whom results were significantly lower were Latinos. (Please see Exhibit 2-6.)
  - In 2005, only 83% (95% confidence interval: 69-98) 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, CHIS results estimated that only 78 percent of 0-11 year-olds 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



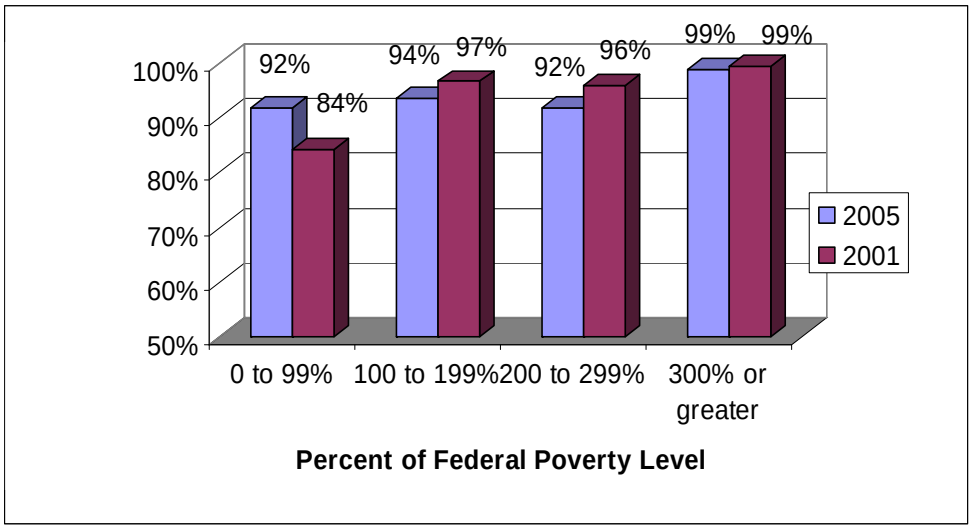
– Although the percentage of insured Latino children seems much lower than for other groups, there is some uncertainty related to these results. Based on the 95 percent confidence interval, the actual percentage of insured Latino

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. However, we did find that the difference in insurance status between Latinos and other ethnic groups in 2005 was statistically significant.[11]

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. 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.[12] 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 Source

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, 2005, 2007 and will be conducted again

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[11] Because we did not have access to individual level data for 2001, we could not conduct these tests for the 2001 results or differences in results between 2001 and 2005.

[12] However, the differences in insurance status by poverty level in 2005 were too small to be statistically significant. Because we did not have access to individual-level 2001 data, we could not conduct similar statistical tests on results from that year or the difference in results for 2001 compared to 2005.

beginning in mid-2009. 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 and results for 2007 will not be available until 2009.

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.

Data Limitations

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. Even some results from the 2005 and 2001 surveys for children 0-11 and 12-17 are based on fairly small sample sizes.

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 unverified, self-reported data from households. 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.

One other major limitation related to CHIS is that because it is based on a sample of county residents, it is subject to random sampling errors. To deal with the possibility of random error in the survey, CHIS provides a range of results, within which, they project that we can be 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 of these problems related to random sampling error, based on CHIS data alone, it is hard to be absolutely certain that the actual percentage of insured children in Solano County is 96 percent or higher.

As noted above, differences among groups for a number of the results from 2005 and 2003 presented above were too small to be statistically significant, meaning that they had a high probability of being due to sampling error rather than actual differences between groups in the underlying population. Because we did not have access to individual level results for 2001 CHIS data we could not conduct these tests for results from 2001 or differences between results in 2001 and 2005. However, anytime those differences were small, they should be treated cautiously as they were unlikely to be statistically significant.

A final limitation is that the CHIS data reported here (the most current available) was collected nearly three 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 2007 or 2008 (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.

Outcome (3) Increase in children assisted with enrollment in Medi-Cal who are insured 14 months after initial enrollment

Indicator:

Percentage of children assisted with enrollment in Medi-Cal by SKIP who were enrolled in Medi-Cal 14 to 16 months later

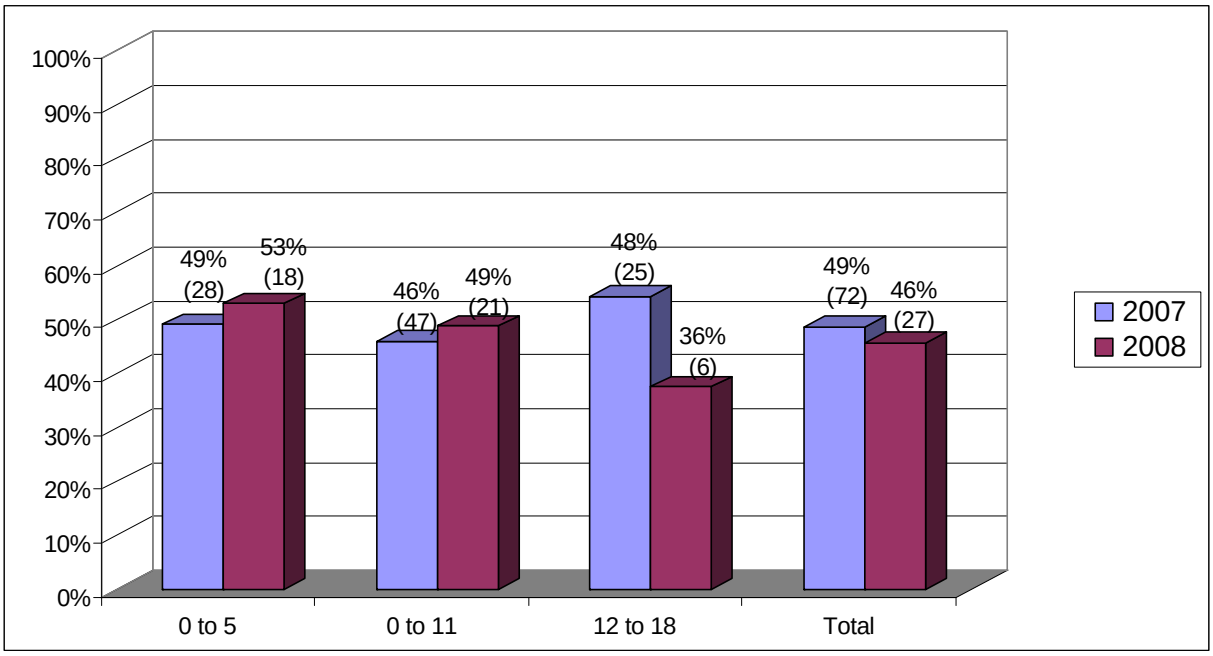
Results

- The percentage of children who were enrolled in Medi-Cal 14-16 months after being assisted by SKIP with initial enrollment in the program did not increase from 2007 to 2008, but stayed approximately the same (49% in 2007 compared to 46%[13] in 2008).
- Generally, the percentage of youth by age group who were enrolled in Medi-Cal 14-16 months after initial enrollment also stayed about the same, with about half of the sample still enrolled in each year[14] (see Exhibit 2-10).

[13] Although there appears to have been a slight decrease from 2006 to 2007, this is difference was not statistically significant and so there was a high probability it was due to sampling error caused by a very small sample in 2006 rather than a real difference in the overall number of children still enrolled in both years.

[14] Although the percentage of 12-18 year olds who were still enrolled dropped by 10 percentage points, because of the very small sample in 2008, this difference was not statistically significant at the .05 level, and thus was likely due to sampling error rather than a true decline in enrollment for this age group during 2007.

Exhibit 2-10: Percent of Children Assisted with Enrollment in Medi-Cal who were Insured 12-14 months after Initial Enrollment by Age



Data Sources

- These findings are based on children who were assisted with initial Medi-Cal enrollment by SKIP during the months of January, February and March in 2006 and 2007. Basic data on these children were captured by SKIP staff during the initial enrollment process. These data were then shared with Solano County H&SS staff approximately 14-16 months after the children were initially assisted with enrollment. Solano County staff then looked up each child on the Medi-Cal enrollment database to determine whether these children were enrolled.

Data Limitations

- Because of differences in the number of children assisted with enrollment in Medi-Cal between January and March in the two years, the size of the sample we examined declined from 148 children in 2006, to only 59 in 2007. The very small sample size in 2007 and the small size of the difference in results for the two years resulted in very low statistical power for the analysis. Consequently, none of the differences between the two years were statistically significant, so there was a high probability that the differences were due to sampling error rather than real differences in the underlying population of all children enrolled during the two years. In addition, the small sample size in 2007 made it impossible to examine changes in enrollment by city of residence or race/ethnicity because these sub-groups became too small for the results to be meaningful.
- The fact that children are not enrolled in Medi-Cal 12-14 months after enrollment does not necessarily mean that those children are no longer insured. Instead,

those children might be covered by other types of public insurance, such as Healthy Families, or by private insurance through a parent or guardian's employer. In addition, some children who have moved out of state may be enrolled in Medicaid in that other state, but their out-of-state enrollment does not show up in California's Medi-Cal system. However, due to limited resources and confidentiality protections, SPR was unable to check for enrollment of children not found in the Medi-Cal system for enrollment in these other insurance programs.

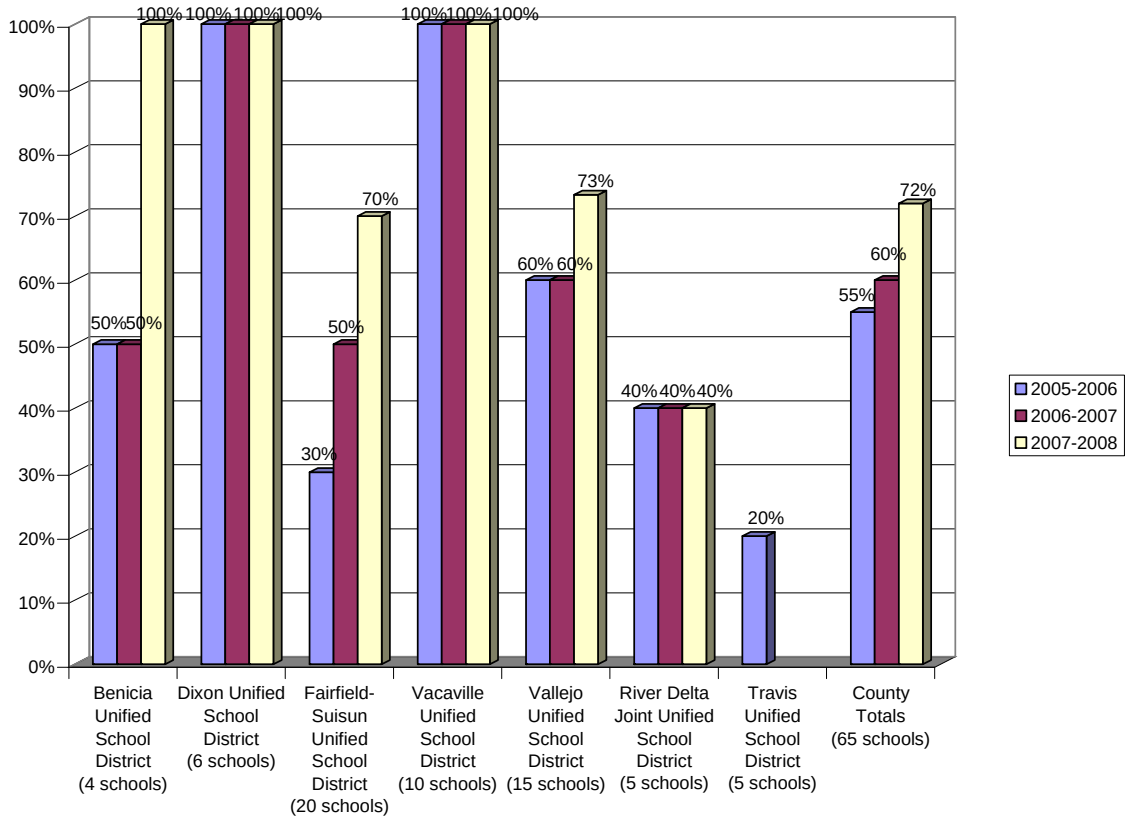
Outcome (4) Increase in percentage of public elementary schools with 100% health insurance coverage

Results

- Solano County achieved this outcome in both the 2007-2008 and 2006-2007 school years. The percentage of public elementary schools in the county with 100% health insurance coverage increased by 21 percent (8 schools) from 2006-2007 to 2007-2008 and eight percent (3 schools) from 2005-2006 to 2006-2007. As of the 2007-2008 school year, 72 percent (47 of 65) of all public elementary schools in Solano County had achieved 100% health insurance coverage (see Exhibit 2-11).
- The largest increase in the number of 100% insured public elementary schools between 2006-2007 and 2007-2008 was in the Fairfield-Suisun Unified School District. In this district, the number of elementary schools with 100% health insurance coverage increased from 10 in the 2006-2007 school year to 14 in the 2007-2008 school year, an increase of 40%. The two other school districts that saw increases in the number of elementary schools with 100% health insurance coverage were Benicia Unified and Vallejo Unified, which each had two additional schools achieve 100% coverage from 2006-2007 to 2007-2008.[15] In only one school district was there a slight decrease between 2005-2006. In this small school district (five schools), Travis Unified, only one school was 100% certified in 2005-2006, and this school was not re-certified in either 2006-2007 or 2007-2008.

[15] In both the Dixon and Vacaville Unified School Districts, because all district elementary schools were at 100% insured in all three years, there was no way the percentage of 100% schools could have increased between 2005-2008.

Exhibit 2-11: Percent of Public Elementary Schools with 100% Health Insurance Coverage



** Charter public elementary schools were excluded from this calculation.*

Data Sources

These data are based on SKIP records and data on schools and school districts from the California Department of Education's DataQuest website.

Outcome for 2008-2009

Listed below is the outcome that was prioritized by HAC and the Enroll and Retain Workgroup to be added to the evaluation in 2008-2009 (in addition to the outcomes for 2006-2008).

2008-2009 Prioritized Outcome[16]:

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

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

Conclusion

During 2007 and the first few months of 2008, Solano County attained three of the four 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. 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 HKS.

Successes

- **Nearly all children targeted by SKIP saw a doctor within 10 months after enrolling in health insurance**. Although based on small samples, these results show that the children targeted by SKIP are actually utilizing one of the most basic primary care services—examination by their primary care physician. Proof that these children are using basic health care services makes it much more likely that these children will actually experience improvements in health status.
- **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.
- **SKIP succeeded in increasing the number of schools with 100 percent insurance coverage**. During both 2006-2007 and 2007-2008, the SKIP program succeeded in increasing the number of public elementary schools in Solano County with 100 percent insurance coverage from 36 to 47. As a result, 72 percent of all public elementary schools in the county have been certified by SKIP to have approximately 100 percent of their students covered by some form of insurance.

Challenges

- **Limited funds are available for retention and utilization work.** Due to the complexity of the health care system, many newly enrolled low income children quickly lose health insurance coverage or are unable to obtain the services they need because their parents can't figure out how to access care. Consequently, follow-up with newly-insured families at regular intervals to help parents keep their children insured and assist them with utilizing services, is critical. In addition, based on the results presented above, SKIP staff have been extremely successful in assisting families with basic utilization. However, funding for follow-up efforts are currently scarce. While the state previously provided funding for these efforts through OERU grants, this funding was eliminated last summer and

is unlikely to be restored anytime soon. Currently, the only funding for follow-up is from First Five Solano, which is funding follow-up for only 100 zero to five year-olds per year, about eight percent of all individuals assisted by SKIP with enrollment.

- **Funding for HKS is extremely challenging.** Healthy Kids Solano provides a critical source of insurance coverage for low-income children in Solano County who are ineligible for other publically-funded programs like Medi-Cal or Healthy Families. However, covering the cost of premiums for HKS requires significant resources. For this reason, Solano and many other counties have counted on the state with its much deeper pockets to eventually step in and fund CHIs such as HKS around the state. However, given the state's own budget shortfall this year, funding for HKS from the state is very unlikely this year or in the near future. In the absence of state funding, many counties (Solano included) have also relied on foundation funding to provide at least partial support for their CHI. Unfortunately, foundations are typically unwilling to support any single activity for long period of time. Consequently, in the absence of on-going state or foundation funding, an even greater share of the burden for HKS is likely to fall on Solano County and the Enroll and Retain Workgroup and raising the funds necessary to keep the program afloat will become an ever greater challenge.
- **The percentage of Latino children 0-17 with insurance coverage was significantly lower than for other major county racial or ethic groups and 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 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.[17]

  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.[18] 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

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[17] "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.

[18] Although only 49 percent of SKIP enrollees were Latinos in 2001, by FY 05-06, this had increased to 73 percent in 2006, and, during the first months of 2007, to 80%.

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 to identify, enroll and retain Latino children and families in health insurance, even for as well-established a program as SKIP. Numerous studies have documented the many challenges in enrolling and retaining Latino children, especially those who are undocumented.[19] 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 demonstrate 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 (HKS), 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 HKS 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).

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.

- **Seek additional resources for retention and utilization assistance**. Due to the proven success of SKIP's limited retention and utilization follow-up services to children and their families and the importance of these services to improved

[19] 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, Hyattsville, Maryland: National Center for Health Statistics, 2004.

health status, SKIP should continue to seek additional resources to provide these services to a larger percentage of the children it assists with enrollment.

- **Continue to regularly review funding for HKS.** Healthy Kids Solano plays a critical role providing insurance coverage for children who are ineligible for other types of coverage. In this period of limited state and local government resources, the Enroll and Retain Workgroup should continue to regularly evaluate the funding situation for HKS to ensure that the program remains viable.
- **Maintain SKIP's strong focus on enrolling and retaining Latino children in health insurance programs**. Although a majority of individuals already assisted with enrollment by SKIP are 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.

HEALTH ACCESS STRATEGY #3 *Expand integrated 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 (2005-2008), 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—primarily by integrating behavioral health services into primary care settings.

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.[1]

Exhibit 3-1:
MSA Budget and Expenditures for 2007-2008 for Strategy 3[2]

	Recipient	Expense	Approved Budget	Expenditures as of May 31, 2008	Percentage Expended
Strategy 3: Behavioral Health/Primary Care Integration	Solano Co.	Staff (.65 FTE Sup. M.H. Clinician)	$60,000	$42,586	71%
	Solano Co. Primary Health Clinic (Fairfield)	Behavioral Health Integration Project	40,000	40,000	100%
	Solano Co. Primary Health Clinic (Vallejo)	Behavioral Health Integration Project	40,000	40,000	100%
	La Clinica	Behavioral Health Integration Project	40,000	9,749	24%

[1] These interventions are listed in the Solano County Health Access Strategic Plan (2005-2008).

[2] This chart captures expenditures paid out by the County as of 5/31/08. Workgroups have until 6/30/08 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 2007-2008 fiscal year (August 2008).

	Recipient	Expense	Approved Budget	Expenditures as of May 31, 2008	Percentage Expended
	Community Medical Centers	Behavioral Health Integration Project	40,000	0	0%
	John Preston	Training for primary care providers and behaviorists	1,800	0	0%
	Solano Co.	Services and supplies	3,525	1,283	38%
Total			***$225,325***	***$133,618***	***59%***

As shown in Exhibit 3-1, $225,325 in MSA funds were allocated to Solano County to support the implementation of Strategy 3 in 2007-2008. The majority of this amount, $220,000, was used to support the cost of implementing behavioral health integration at four clinic sites—the two county-run primary health clinics, La Clinica, and Community Medical Centers (CMC). Behavioral health integration at these sites has consisted of hiring of Behavioral Health Consultants (BHCs, or behaviorists). With one month remaining in the fiscal year, 59 percent of the total allocated funding had been expended. The relatively large unspent amount is partially due to delays in finalizing a contract between the county and La Clinica and CMC for the Behavioral Health Integration Project and a hiring delay for a BHC at the CMC site in particular.

In the previous fiscal year (2006-2007), $206,164 of the total $250,000 budgeted was expended. An uncommitted amount of $25,591 accounted for over half of the balance, along with various unspent amounts under staff, services and supplies.

On-Site Behavioral Health Services

The primary ongoing activity related to achieving Strategy 3 has been providing on-site Behavioral Health Consultant (BHC) services at primary care clinic sites that serve a high proportion of Medi-Cal clients. The BHC acts as partner to the primary care physicians 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 in providing care for patients. For example, a PCP may call an onsite BHC into the exam room to provide a dual consult and offer recommendations to both the physician and the patient on mental health and/or substance abuse issues. BHCs also sometimes act as a liaison between PCPs and the county mental health department to facilitate access to necessary care by PCP patients.

The goal for this strategy was to provide on-site behavioral health services by June 2008 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 CMC in Dixon and Vacaville). As of June 2008, MSA funds have been used to directly support on-site behaviorists at the two county-run clinic sites in Fairfield and Vallejo, as well as at La Clinica in Vallejo.[3] Currently there are three MSA-funded BHC staff serving these three clinic sites, though there were an additional two BHCs—including the Supervising Mental Health Clinician—who worked at the two county clinic sites for a portion of the 2007-2008 fiscal year.[4]

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 was consultation services for primary care physicians. The Supervising Mental Health Clinician, employed by the county, provided 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 worked to ensure that PCPs could get qualified clients into appropriate county-funded mental health services and that they also received information on how to address the needs of clients who did not qualify for those services through community-based clinics or private practitioners.

Another continuing Strategy 3-related activity during the 2007-2008 fiscal year was academic detailing. Academic detailing consisted of visits made by the Supervising Mental Health Clinician, Partnership Health Plan of California's Medical Director, Dr. Chris 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 were ongoing services during all or part of the last two fiscal years, there has been extremely limited ongoing data available to document their exact activities and progress (e.g., number and nature of academic detailing visits, outcomes of consultation services). Thus, while these services were perceived as critical by some workgroup members for reaching PCPs not served by on-site behaviorists, their full value cannot be evaluated here.

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[3] Funding was approved for a BHC to serve the CMC sites, but the position was not filled during the 2007-2008 fiscal year.

[4] The Supervising Mental Health Clinician retired in December 2007, while the second BHC departed her position in April 2008, though she is still with the county.

Behavioral Health/Primary Care Integration Workgroup Activities 2007-2008

The Behavioral Health/Primary Care Integration Workgroup's activities in 2007-2008 centered primarily on: (1) providing integrated BHC services at additional sites and (2) data collection and reporting.

With regard to the first item, the workgroup worked to establish MOUs and contracts with La Clinica and CMC in order to implement the Behavioral Health Integration Project and provide BHC services at these additional sites. La Clinica's contract was finalized and approved in fall 2007 and a new behaviorist began providing services in November 2007. Although the CMC's contract was approved in winter 2008 it has yet to hire any behaviorist. The workgroup also focused on finding new staff to provide behavioral health services at both county clinic sites.

With regard to data collection and reporting, workgroup members focused on how to document on-site BHC service provision. The need for improved data collection came to the forefront of the workgroup's agenda due to recommendations made in last year's evaluation report, coupled with HAC's request for data on the Behavioral Health Integration Project for the HAC funding meeting in December 2007. The workgroup discussed several possible reporting requirements and drafted a quarterly reporting template that all sites with MSA-funded behavioral health services would be required to submit to the county. In winter 2008, the workgroup also decided that each clinic site would also be required to submit at least one "story" or case study about a patient per quarter, to fully illustrate how the BHC operates in a primary care setting and the benefit of doing so. Finally, the workgroup focused on revising the behavioral health/primary care communication form used by community primary care physicians to refer patients to publicly funded mental health managed care. The aim was to simplify the form and make it adaptable for any primary care setting. As of the end of this fiscal year, additional revisions to the form were still being considered.

The workgroup met five times during the course of the 2007-2008 fiscal year (August, October, January, February, May). In winter 2008, the work group formally decided to meet less frequently given the Behavioral Health Integration Project's relatively advanced stage of implementation. In addition to the major topics described above, workgroup members also:

- Considered whether some of the responsibilities of the Supervising Mental Health Clinician—who was supported only until the end of 2007—should continue to be funded. In particular, the workgroup examined the nature and impact of the Supervising Mental Health Clinician's support for private PCPs through outreach/education activities, as well as curbside consults—whereby PCPs were provided with immediate psychiatric consultation on their patients.
- Established new workgroup leadership. Michael McGlathery joined Nadine Harris as co-chair, replacing Rod Kennedy. Nadine Harris became the sole co-chair once Michael McGlathery departed in December 2007. The other co-chair position remains open as of the end of the 2007-2008 fiscal year.

- Determining which of the practice sites would be accessing an additional $40,000 in Mental Health Substance Abuse (MHSA) funding to screen at least 500 clients each year for depression.
- Reviewing the Health Access Strategic Plan Logic Model to determine which of the Behavioral Health Integration goals for 2005-2008 had been met and what changes should be made for the new strategic plan going forward. For example, one of the new goals for the 2008-2011 plan is to specifically train prenatal providers to screen, identify, treat and refer for behavioral health conditions.
- Reviewing the most common issues addressed by on-site behaviorists (e.g., anxiety, depression) as well as the benefits of having behaviorists on site (e.g., doctors feeling more comfortable because they have a behaviorist they can refer patients to).
- Determining whether or not all allocated dollars would be spent by the end of the 2007-2008 fiscal year, and how unspent dollars might be reallocated to clinics and to sponsor a psychopharmacology education/training event for primary care providers and behaviorists.

Overall, workgroup meeting attendance was characterized as very good, though representation from the physician community has diminished this past fiscal year, mainly due to the demanding work schedules of physicians. The workgroup chair noted that there was some initial confusion about the workgroup's goals, and therefore some lack of clarity regarding whom exactly from the community should be attending the meetings. Moving forward, the workgroup chair noted that the workgroup probably needed clearer and perhaps broader objectives in order to boost attendance further. For example, the workgroup might improve attendance if it moved beyond its focus on supporting physicians at sites with onsite BHCs, to conducting outreach and behavioral health education activities for the broader physician community.

Outcomes

Prioritized Outcomes for Strategy 3 for 2006-2008

1) Increased client use of behavioral health consultant (BHC) services on-site

2) Increased linkages between behaviorists and primary care physicians

Results for 2007-2008

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

Indicator:

Number of visits for on-site behavioral health services

Results

- The number of patient visits to onsite Behavioral Health Consultants at the sites that received MSA funding increased significantly between FY 2006-2007 and FY 2007-2008. As can be seen in Exhibits 3-2 and 3-3, the number of visits over the two years increased by 177.2% (1,434 visits) and the number of unduplicated clients (at the two county-run clinic sites) increased by 65.1% (440 clients).[5]
  - We can explain part of the increase in number of visits as due to the addition of a third site with an onsite BHC in 2007-2008 (La Clinica). However, even without the additional visits contributed by the La Clinica site (311), we would have observed a considerable increase in number of visits at the two county-run clinic sites alone (1,123, or a 138.8% increase). As can be seen in Exhibit 3-3, a majority of the increase in the overall number of visits can be attributed to Clinician #6, who had 976 visits in 2007-2008. Clinician #6's visits account for 68.1% of the overall increase in visits between 2006-2007 and 2007-2008. However, it should be noted that only a portion of Clinician #6's full-time position is supported by MSA funds; the remainder is covered by the Healthcare for the Homeless program.[6]

Exhibit 3-2:
No. of Unduplicated Clients at County-run Clinic Sites[7]

2005-2006 Unduplicated Clients	2006-2007 Unduplicated Clients	2007-2008 Unduplicated Clients
809	676	1116

[5] The amount of increase in client visits may, in fact, be different than what is presented here due to last year's challenges surrounding data on Clinician #4's visits, as well as the fact that data for Clinician #7 is only available for six months of the current fiscal year (see data sources and limitations). In last year's evaluation report (for 2006-2007), it was unclear whether the data presented contained all of the visits with Clinician #4, who was employed for six months of the 2006-2007 fiscal year (10/22/06—4/21/07). Without complete data on the services provided by this clinician, there is no way to accurately quantify the change in visits from 2006-2007 to 2007-2008. With regard to the number of unduplicated clients, we can only report on the two county clinics because the La Clinica site does not keep track of the number of *unduplicated* clients seen by its onsite BHC. Incomplete data on Clinician #4 from 2006-2007 also means that the number of unduplicated clients reported for the two county clinic sites may not be completely accurate.

[6] Clinician #6 is working full-time on the Behavioral Health Integration Project; the Healthcare for the Homeless Program funding is considered matching funding to MSA funds.

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

Exhibit 3-3:
No. of Client Visits with Onsite BHCs at County-run Clinic Sites and La Clinica

Clinician	2005-2006 Visits	2006-2007 Visits	2007-2008 Visits
#1 Rosalind Bowler[8]	356	314	351
#2 Kelli Kekki	505	600	N/A
#3 Michael McGlathery[9]	479	191	240
#4 Ena Rios	N/A	unavailable	N/A
#5 Theresa Baides[10]	N/A	N/A	365
#6 Bruce McGhee[11]	N/A	N/A	966
#7 Heather Barnett and May Kim[12]	N/A	N/A	311
Total	**1340**	**809**	**2243**

For the two county-run clinic sites in 2007-2008, we can further disaggregate the number of client visits by site as well as by clinician, as seen in Exhibit 3-4. These data show that the Vallejo county-run clinic site had more than double the number of client visits than the Fairfield county-run clinic site—primarily due to the contributions of Clinician #6, who was full-time in 2007-2008, but only partially supported by MSA funds. Without his contributions, there would have been a much more modest increase in the number of client visits at the two county-run clinic sites (157 rather than 1,123).

Exhibit 3-4:
No. of Client Visits by Onsite BHC and by County-run Clinic Site, 2007-2008

Site	Clinician #5	Clinician #1	Clinician #6	Clinician #3	Total
Vallejo	4	349	927	106	1386
Fairfield	361	2	39	134	536
Total	**365**	**351**	**966**	**240**	**1922**

Data Sources and Limitations

- The sources of the data presented above are the PCMS database (a system used by patient care programs run by Solano County's Health & Social Services Department) and the BHC Quarterly Report Form. Staff analysts at the county's Health & Social Services Department extracted data from PCMS in April and May 2007. These data reflect the number of visits, as well as the number of

[8] Clinician #1 ceased work as MSA-funded BHC in April 2008.

[9] Clinician #3 ceased work as MSA-funded Supervising Mental Health Clinician in December 2007.

[10] Clinician #5 began work as MSA-funded BHC in September 2007.

[11] Clinician #6 began work as a partially MSA-funded BHC during the 2007-2008 fiscal year.

[12] Clinician #7 is a combination of the two different staff members who served the La Clinica site in the 2007-2008 fiscal year. One of these two staff left her position in October 2007 while the other began in November 2007. Their numbers are combined because this site did not document client visit/service information by individual clinician.

unduplicated clients seen by onsite BHC staff at the two county-run clinic sites in Fairfield and Vallejo funded by MSA during 2007-2008. The exact time frame covered by these PCMS data is July 1, 2007—May 16, 2008.[13] Client visit data from the La Clinica site are from the newly developed[14] BHC Quarterly Report Form that is submitted by La Clinica staff to the County. For the purposes of this report, we had access to only two data submissions from La Clinica that covered the period from October 2007—March 2008.

- These data have a number of limitations. The data do not reflect all on-site BHC services provided during 2006-2007 because data on Clinician #4 is unavailable. If these data were available, they might reveal a different number of total visits and/or unduplicated clients seen by on-site BHCs, and therefore a different trend over the last two years. The data also do not reflect all on-site BHC services provided during the 2007-2008 fiscal year because data from the La Clinica site only covered the time frame of October 2007—March 2008 (i.e., half the fiscal year).[15] Finally, because the La Clinica site does not report on the number of *unduplicated* clients seen by its BHC, we cannot calculate the total number of unduplicated clients across all sites, or determine accurate trends for the number of unduplicated clients over the last three fiscal years.

Outcome (2) Increased linkages between on-site behaviorists and primary care physicians

Indicator:

Number, types and strength of linkages between on-site behaviorists and primary care physicians

Results

- Overall, behaviorists have successfully established linkages with all or a majority of the PCPs at their respective sites. The types and strength of these linkages vary across sites and across physicians, and depend largely on the specific function(s) the behaviorist serves. We discuss the definition, number, type and strength of linkages between on-site behaviorists and PCPs below.
- All three on-site behaviorists have established linkages with either all or a large majority of the adult and pediatric PCPs at their respective sites (Clinician #5 at the Fairfield county-run clinic site; Clinician #6 at the Vallejo county-run clinic site; and Clinician #7 at La Clinica). The existence of these linkages is evidenced by the fact that, at minimum, all or a large majority of PCPs at these sites have called upon the behaviorists—two of which are half-time—to consult with and/or

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[13] Due to the June deadline for this report, we could not extract data from the full 2007-2008 fiscal year.

[14] The BHC Quarterly Report Form was developed this fiscal year.

[15] An additional, but less serious, contributor to our incomplete 2007-2008 data is the fact that—due to concerns for meeting this report's deadline—the data from the two county clinic sites only covers up to 5/16/08 (as opposed to 6/30/08, the end of the fiscal year).

address their patients' intertwined behavioral and physical health needs. As all three behaviorists are Licensed Clinical Social Workers (LCSWs), they are restricted to providing patients psychotherapeutic services of a non-medical nature and cannot prescribe medications.

- With specific regard to the number of linkages, Clinician #5 has established linkages with six PCPs, Clinician #6 has established linkages with nine PCPs, and Clinician #7 has established linkages with nine PCPs. All clinicians noted that some providers were more likely than others to call upon their services, and that pediatric providers were much less likely than adult providers to call upon the behaviorists. Reasons given for variance across primary care providers included a lack of opportunity (e.g., the schedules of the PCPs and behaviorists did not overlap); some degree of hesitance about or distrust of behavioral health services; a fundamental resistance to change (i.e., having a behaviorist onsite); a lack of proximity between PCPs and behaviorist office space; insufficient BHC outreach to PCPs; and the reluctance of many parents to have their children referred to or involved with behaviorists. Two of the three behaviorists noted that the number of linkages they had with PCPs increased over time simply as a result of physicians getting to know them, how they work, and the various services that they could provide physicians and patients alike.
- With specific regard to the types of linkages, these ranged from relatively straightforward information-sharing to joint consultation opportunities. In general, there appeared to be some inter-behaviorist and inter-day variation in terms of how much of behaviorists' time was spent in direct interaction with primary care providers versus in appointments with the patients themselves. For example, one behaviorist described how s/he tries, as much as possible, to have a "warm handoff," whereby the PCP brings her/him into the exam room during the patient's appointment to facilitate introductions and then immediate intervention and/or follow-up appointments. This BHC estimated that each day s/he had between one to five such warm handoffs interspersed with her regularly scheduled appointments with clients. On the other end of the spectrum was a BHC who indicated that given the overloaded schedules of physicians, s/he "never tries to stop and talk to a primary care provider unless there is an emergency situation" that the PCP should know about his/her patient. Overall, the types of linkages observed between BHCs and PCPs included the following:
  - **Educational information-sharing**. Behaviorists may leave mental health literature in physicians' boxes, or make presentations on mental health topics at PCP staff meetings.
  - **Liaison to MH/SA.** PCPs can rely on BHCs to serve as liaisons between patients and county mental health and substance abuse services. One clinician indicated that s/he makes approximately two to three urgent referrals per week to county mental health. As a result of this linkage, PCPs are able to reduce the intensity of their patient caseload.
  - **Specialist referral.** Perhaps the most significant linkage is that of the BHC as the specialist referral. PCPs, who can feel overwhelmed and ill-equipped

to deal with patients' mental health needs, particularly during short appointment times, rely on BHCs as specialists to whom they can immediately refer patients. This not only ensures that patients actually get their needs addressed, but also reduces the PCP's burden and allows him/her to concentrate on the physical aspect of a patient's care. As a result of this type of linkage, PCPs may also feel more comfortable with behavioral health issues in general, given their greater familiarity with how behaviorists on their primary care team address such issues. PCPs may refer their patients to behaviorists either as a separate appointment, or during a warm handoff—whereby the physician introduces the BHC to a patient during his/her appointment. The BHC may be introduced as part of the primary care team, a mental health specialist, or simply a specialist in whatever the presenting problem appears to be, such as anxiety or depression.

  - **Joint consults.** Either during a patient appointment or when the patient is not present, BHCs and PCPs may consult about a patient's condition and potential solutions. This may occur very informally—e.g., as PCPs and BHCs pass each other in the hallway—or through formal meetings.

  - **Ongoing data-sharing about patients.** BHCs and PCPs may keep one another appraised of patient developments—primarily through the use of key clinic forms, such as behavioral health screening and referral forms, as well as patient medical charts. For example, at one site the behavioral health referral form has sections for both the PCP and the BHC to fill out about the initial presenting problem/reason for referral (such as insomnia, anger, domestic violence) as well as the assessment and intervention provided. At another site, the BHC's notes are entered directly into the patient's medical chart. Ongoing data-sharing may also occur informally when, for example, a BHC wants to give a PCP advance notice of a particularly troubling behavioral health issue found with a patient.

- With regard to the strength of linkages, we rely on the perception of the behaviorists themselves—specifically, how strong they feel their linkages with PCPs truly are. Overall, the three behaviorists reflected positively on the strength of their linkages with PCPs given that the PCPs are utilizing them as key supports and working members of the primary care team. Behaviorists often discussed the strength of their linkages by discussing the strength of the *outcomes* of these linkages, though key challenges were also noted. Both are discussed below.

  - The primary outcome cited was that by serving as critical supports for PCPs and providing specialist care for patients, behaviorists reduce the workload of PCPs, which allows PCPs to focus more exclusively on the traditional physical aspect of patient care. As one behaviorist observed, "When patients come in here, they drag everything with them…substance abuse, homelessness, domestic violence." By providing mental health and targeted case management services, this behaviorist "minimizes what patients bring

into the exam room." The other major positive outcome cited was simply that patients have access to behavioral health services, particularly those who may be in critical need of services, but who are not seriously and persistently mentally ill. By providing behavioral health services, the BHCs not only address mental health issues per se, but also can positively affect physical health issues, as the two are often inextricably intertwined (e.g., stress and hypertension). Finally, because physicians know they have BHCs to whom they can refer patients, physicians are more comfortable, in the words of one behaviorist, "opening the Pandora's Box of mental health issues" during a patient's appointment time. Behaviorists also perceived a heightened awareness among PCPs about behavioral health issues and interventions, simply by virtue of reading BHCs' notes on key clinic forms.

- Behaviorists largely agreed that the primary challenge to effective linkages was the overwhelming caseload and severe time constraints of the PCPs. Physicians have very little time for basic interaction with BHCs, let alone more intensive joint case consult time, which some of the behaviorists felt would be beneficial. One behaviorist indicated that a 30-40 percent no-show rate among scheduled patient appointments actually helped him/her interact with physicians more. Another behaviorist also felt that more time to provide psychoeducation to PCPs would be beneficial in deepening their understanding of behavioral health issues (e.g., drug seeking behavior), and ultimately enhancing PCPs' relationships with and treatment of patients.

Data Sources and Limitations

- In order to assess the linkages between on-site behaviorists and primary care physicians, we relied on the perceptions of the three current behaviorists as conveyed during telephone interviews conducted in spring 2008. These interviews were qualitative and semi-structured in nature, in order to fully understand the history and nature of behaviorists' relationships with PCPs. As a result, we do not have any objective quantitative measures to assess linkages across sites (e.g., scaled response survey questions). Another limitation is that we did not have sufficient resources to survey the primary care physicians who may have used BHC services. A survey of this sort would have also likely been infeasible at this time because to construct such a survey, we first needed a fundamental understanding and documentation of what BHC-PCP linkages would have looked like at each site.
- Our original intent for measuring this outcome was to assess changes in linkages over fiscal years. However, because all three behaviorists started within this fiscal year, we had no way to assess changes between 2006-2007 and 2007-2008—specifically in terms of increased number of linkages, increased types of linkages, and increased strength of linkages across years. As a result, this year's data collection was focused on exploring what these linkages looked like (in terms of number and nature) and the extent to which the behaviorists felt they were effective or not. The information presented here may be used as a baseline

for subsequent years, and as a resource for crafting quantitative data collection tools that can be applied across sites in the future.

Outcome for 2008-2009

Listed below is the prioritized outcome the evaluation plan called for us to evaluate in 2008-2009. Although this outcome is technically outside the scope of our evaluation timeframe for this report, we can provide a straightforward assessment here.

Prioritized Outcome for Strategy 3 for 2008-2009

1) Increased number of sites with on-site behaviorists

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

Indicator:

Number of sites with on-site behaviorists

Results

- From 2006-2007 to 2007-2008, the number of sites with MSA-funded behaviorists providing services increased from two to three (the two county-run clinic sites and La Clinica). The number of sites with approved funding for MSA-funded behaviorists increased from two to five. These include the two county-run clinic sites, La Clinica and CMC (who would share a behaviorist between 2 sites, Dixon and Vacaville—CMC has not hired a behaviorist yet).

Data Sources and Limitations

- Minutes from the Behavioral Health Workgroup meetings, as well as interviews with county staff, were the sources for tracking this outcome. There are no apparent limitations to these data sources for the purposes of measuring this outcome.

Conclusion

With regard to the prioritized 2006-2007 outcome for Strategy 3—increased client use of behavioral health services on-site—we found that the number of client visits with BHCs increased from 2006-2007 to 2007-2008 by 177.2% and the number of unduplicated clients (at the two county clinic sites) increased by 65.1%. With regard to the prioritized 2007-2008 outcome for Strategy 3—increased linkages between on-site behaviorists and primary care physicians[16]—we found that all three behaviorists have established

[16] As previously discussed, we were limited this year to exploring the number, types and perceived strength of these linkages, rather than focusing on increases or decreases with regard to these linkages over time.

linkages with all or a majority of PCPs at their respective sites; that these linkages centered on the BHC as a critical specialist/referral contact for PCPs needing to address their patients' intertwined behavioral and physical health issues; and that these linkages have ensured patient access to behavioral health services as well as increased PCPs' comfort in raising mental health issues during limited appointment times. Finally, with regard to the prioritized 2008-2009 outcome for Strategy 3—increased number of sites with on-site behaviorists—there has been an increase in number of sites with operational BHCs (from two in 2006-2007 to three in 2007-2008).

Other successes and challenges of note over the past year are detailed below.

Successes

- **Contracts were approved to support the Behavioral Health Integration Project at two additional practice sites.** Contracts were approved for an MSA-funded on-site behaviorist at La Clinica as well as at CMC for the 2007-2008 fiscal year.
- **On-site BHC services continued at the two county-run clinic sites and began successfully at La Clinica.** Over the 2007-2008 fiscal year, on-site BHC services were successfully maintained at the two county-run clinic sites with two current BHC staff (Clinicians #5 and #6, the latter only partially supported by MSA funds) and two BHC staff who are no longer employed (Clinicians #1 and #3). On-site MSA-funded BHC services were successfully provided at La Clinica by one key staff (Clinician #7).
- **Data collection and reporting requirements were strengthened for the Behavioral Health Integration practice sites.** The workgroup prioritized improved data collection and reporting as critical to understanding the impact of the Behavioral Health Integration Project. These improvements included a quarterly reporting template that was drafted for practice sites to use and submit to the county on their BHC-client visits. Another improvement was that the workgroup also required that practice sites submit at least one patient "story" or case study per quarter to complement the quantitative report.

Challenges

- **Ongoing data collection procedures are inconsistent.** Although the workgroup drafted a quarterly reporting template that is ostensibly to be used by all practice sites with MSA-funded behaviorists, only one of the sites is actually using this template (La Clinica). The other two (county-run clinic) sites have not used this template; data on their BHC visits is captured by the PCMS database. The data fields of these two sources differ; thus we are not able to effectively compare data across sites or report on prioritized outcomes across sites. For example, the quarterly report template does not have identifiers for clients or for the BHCs providing services. As a result, we cannot report on the number of unduplicated clients served overall, or break down client visits by individual BHC. The quarterly report template also does not have a field to indicate site, which

may be helpful once CMC has hired a behaviorist so that we can break down services by site (Dixon versus Vacaville).

- **Data is not being collected and reported for some activities**. Apart from data collection related to BHC visits, we also noted that data on academic detailing and consultation services was lacking. Although these were not areas related to outcomes tracked by this evaluation, the unclear nature of and responsibility for data collection in these areas underscored a larger challenge with regard to documenting the activities and outcomes of the Behavioral Health Workgroup.
- **Utility of quarterly reporting template is limited.** As indicated above, the current version of the quarterly reporting template does not have identifier fields for clients or for BHCs, which limits an assessment of progress in terms of number of unduplicated clients served, or number of clients served by any particular BHC. The current version of the template has eight data fields: date of service, age, sex, race, ethnicity (whether they are Hispanic), primary diagnosis, secondary diagnosis and CPT code. It is unclear the extent to which the Behavioral Health Workgroup considered additional or alternate data fields that would provide information pertinent to the overall Health Access Strategic Plan, or to the prioritized outcomes for this evaluation, such as zip code, insurance status, and each client's PCP.
- **There have been hiring and turnover challenges for BHC staff.** All of the primary care sites with on-site behavioral health services have had turnover among behaviorists or have had difficulty in hiring an appropriate clinician. For example, from the 2005-2006 to 2007-2008 fiscal years, there have been eight different MSA-funded behaviorists across all practice sites. Only two of these eight provided services for at least a portion of all three fiscal years, and only one other behaviorist provided services in more than one fiscal year (2005-06 to 2006-07). Besides the inherent challenges of retraining, this turnover makes it difficult to assess the success and challenges of the on-site BHC services over time. Hiring of both new and replacement staff has also been difficult. For example, although the contract with CMC was approved in winter 2008, the organization has yet to hire a behaviorist.
- **Extent and nature of focus on the broader PCP community appears unclear.** Moving forward, it is unclear the extent to which the workgroup will prioritize and incorporate activities designed to reach the broader PCP community, as opposed to just those PCPs at the clinics with on-site BHCs. While the Supervising Mental Health Clinician addressed this need during his tenure (through outreach/education activities and curbside consults for the broader physician community), interviews with workgroup stakeholders indicate that there may not be consensus on how or whether to balance these two needs. Whether the workgroup focuses primarily on on-site services or the broader PCP community would obviously have implications for the workgroup's specific activities moving forward (e.g., more sponsored trainings vs. more funding for on-site services) as well as its composition and attendance.

- **There has been considerable turnover in workgroup leadership.** During the 2007-2008 fiscal year, the leadership for the Behavioral Health Workgroup has changed considerably. At the beginning of the year, the co-chairs switched from Rod Kennedy and Nadine Harris to Nadine Harris and Michael McGlathery. In the middle of the fiscal year, Michael McGlathery retired, leaving one co-chair position vacant. Toward the end of the fiscal year, due to significant professional and out-of-office commitments, the remaining co-chair was unable to attend two or three workgroup meetings. Support for the workgroup also switched from county to SCBH staff. These factors may have affected the continuity of the workgroup's strategic thinking and ongoing activities.

Recommendations

We have developed two rather detailed recommendations related to Strategy 3, discussed below.

- **Create and distribute a map of workgroup's future priorities, activities and associated data collection activities.** Some of the behavioral health strategies of the 2008-2011 Health Access Strategic Plan are relatively new—for example, (1) training not just primary care providers, but *prenatal* providers to screen, identify, assess, treat and refer for behavioral health conditions; and (2) advocating for changes in Medi-Cal to allow reimbursement for same day services for medical and mental health services. Currently, there are no obvious workgroup activities designed to meet these strategies. We recommend that the Behavioral Health Workgroup compare the 2005-2008 and 2008-2011 Strategic Plans, determine which strategies should be priorities, and map out the specific, associated tasks/activities, timelines, and point people. Such an exercise could also help resolve any question as to whether the workgroup can realistically incorporate a focus on the broader physician community, as discussed above. Mapping priorities and activities could also help reengage the most appropriate stakeholders at workgroup meetings. In the broader interest of accurately capturing the progress of the Behavioral Health Workgroup on all fronts (even those not being tracked by the evaluation), we also recommend mapping all workgroup activities against all information the workgroup wishes to track (e.g., number and attendance of trainings, number of unduplicated clients served by on-site BHCs). The document would also list the established or planned mechanisms for collecting that data; time points for data collection; and reports to be generated.
- **Revisit quarterly reporting template for BHC services and apply to all sites.** In light of the challenges detailed in the previous section, we recommend that the quarterly reporting template be revised. Specifically, we recommend adding identifier fields for both clients as well as the BHCs providing services. We also recommend revising the template after a careful consideration of the prioritized outcomes for this evaluation as well as of what the workgroup really wishes to know. For example, would the workgroup find it helpful to know the PCP of the client served, so that they could have a better idea of which physicians tend to have stronger referral linkages with the onsite BHCs? As another example, would

the workgroup find it valuable to know the insurance status of clients served? This information would help speak to the Health Access Strategic Plan's concern with serving the most vulnerable populations in Solano County. We also recommend that all sites be required to use the quarterly reporting requirements so that data is consistent and comparable and there should be one, clearly identified county staff person who is the source for this data across sites.

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

Strategy 5 is included in the 2005-2008 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.

Ongoing Interventions Related to Strategy 5

The primary intervention related to Strategy 5 and supported with MSA funds is a small pilot project serving frequent users in Solano County. 'Frequent Users'[1] are referred by participating hospitals (NorthBay Medical Center, VacaValley Hospital and Sutter Solano Medical Center) to project staff who attempt to link those individuals to a critical on-going services such as a primary care physician (PCP), mental health and/or substance abuse treatment, housing and disability benefits. The aim of these linkages is to decrease those clients' inappropriate use of emergency and hospital services. Project staff are employed and supervised by the Solano County H&SS Department.

Between April 19, 2006 and July 13, 2007, the Frequent User Project received 53 referrals[2] of frequent users; 19 from North Bay and 28 from Sutter Solano.[3] Of the 48 Frequent User clients for whom we have data, the average age was 48, with four clients

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[1] According Frequent User Workgroup notes for 10/26/07, Frequent Users are defined as individuals who are "medically compromised, have a mental illness, and are homeless or in an unstable living situation."

[2] Not all of these referrals were served by the project: a few individuals refused to participate in the project while others were immediately referred to services that were more appropriate.

[3] The numbers of referrals from each hospital system do not match the total number of referrals because for the five referrals made to the project between 3/12/07 and 7/13/07, no data other than the date of referral and the patient's name were recorded in the project's spreadsheet. Also, after 7/13/07, no further data was entered into the project spreadsheet, so we have no information about project activities or new referrals after that point.

under 30 and five over 61. Seventy-three percent (35) of referred clients were enrolled in Medi-Cal (including three who had Medi-Cal pending), 19% (9) were enrolled in CMSP, and 8% (4) were uninsured or their enrollment status was unknown. The most common chronic conditions suffered by clients were congestive heart failure (CHF) or other heart conditions, followed by diabetes, pancreatitis, and cellulitis. Sixty-nine percent (33) of the 48 clients were identified as having substance abuse issues, most commonly related to alcohol, methamphetamines, cocaine, speed, marijuana and opiates. The average length of time a patient was served by the project was 3.6 months.

Changes to the Frequent User Project in 2007-2008

During the first year and a half of operation (March 2006-September 2007), the Frequent User project was staffed by a full-time Licensed Clinical Social Worker. However, following the departure of the original project clinician in September 2007, the Frequent User Workgroup reconfigured staffing and supervision for the project. Because of concerns by the workgroup that having only a single Frequent User staff person did not provide adequate support for the previous project clinician and led to burnout and her departure, the project will now have two staff members. However, due to insufficient funding to hire two LCSWs, the project is planning to hire two Mental Health Specialists II and rely on county mental health clinicians to provide therapeutic services to Frequent User clients. Consequently, a major focus of the specialists' assistance to Frequent Users will be to connect them to county mental health services. This greater focus on connecting Frequent User clients with the county's mental health system will address a concern by some workgroup members that the project's first clinician did connect clients with that system as quickly as would have been optimal.

Another change for the project is that the two Mental Health Specialists will be supervised by the same H&SS staff person who oversees case management services for patients being released from psychiatric in-patient facilities. According to the Frequent User Workgroup chair, this structure for supervision seems to be a better fit than in the past when the project's clinician was supervised by the same county staff person who supervised behaviorists located at primary care clinics for the behavioral health/primary care integration project described in the chapter on Strategy 3.

Although decisions about the reconfiguration of the project's staffing and supervision were made by early 2008, as of the writing of this report, the two Mental Health Specialists who will staff the project have yet to be hired and are not expected to come on board until after the beginning of the new fiscal year. According to the SCBH staff person assigned to the workgroup, hiring for the positions has been held up because of the lengthy process involved with gaining an exemption for the positions from the County's hiring freeze and obtaining approval for the positions from the County Board of Supervisors. Although county staff tried to speed up the process by hiring staff temporarily as "extra help" with no benefits, they were unsuccessful because there was no interest by qualified applicants in being hired for a temporary, non-benefitted position.

According to the Frequent User Workgroup Chair, the near six-month delay in being able to bring new project staff on board has been "hugely frustrating" for the workgroup. This

delay is also the primary reason that Strategy 5 had expended just over a quarter of the MSA funds allocated to it by the Health Access Committee as of May 31, 2008 and expects between $71,000 and $90,000 to go unspent by the end of the fiscal year.

As a way to provide very limited services to Frequent User clients until new project staff are hired, the project's supervisor is handling referrals of clients from the hospitals to the shelters for transitional respite housing. As of the end of May, he had worked with two clients, referring one to the shelter operated by Mission Solano and one to the shelter operated by the Community Action Council.

Frequent User Workgroup Activities 2007-2008

According to the chair, the Frequent Users Workgroup was quite active during the first half of the year but skipped some meetings this spring because the project was basically on hold due to delays in hiring new project staff. However, when the workgroup has met, the chair said that it has had good attendance and participation from key stakeholders, including Sutter Solano Medical Center, NorthBay Health Care, the two shelters, Solano County H&SS and SCBH. The workgroup also benefited from a designated SCBH professional staff person and her support staff this year.

The major issues discussed by the workgroup during 2007-2008 included the following:

- Reconfiguration of the Frequent User Project's staffing and supervision based on feedback from the project's clinician on best practices and challenges. For example, workgroup members discussed whether to keep project staff with the county or to locate them with a nonprofit organization or a clinic. The group eventually decided to keep project staff with the county because they thought that would make it easier for staff to connect project clients with the county's mental health system (changes to the project were discussed in more detail above).
- Delays experienced by the county in the hiring of new project staff.
- Adoption of the Addiction Severity Index (ASI) as the primary means of evaluating project success in future years. The ASI is comprised of a six-page instrument that assesses the severity of potential treatment related to medical, employment, alcohol, drug, legal, family/social, and psychiatric problems. New Frequent User clients will be assessed with the ASI at intake and after being served by the project.
- Development and finalization of a contract with Mission Solano and the Community Action Council to use MSA funding to provide limited 24-hour supervision in shelters to clients being discharged from the hospital who continue to need low levels of on-going care.
- Development of a contract with skilled nursing facilities to use MSA funding to cover any additional costs related to serving CMSP clients due to the clients' multiple issues or until Medi-Cal coverage becomes effective.

- Recommendations to the Health Access Committee about how to re-allocate unspent MSA funding.
- Development of next year's budget for the Frequent User Project using MSA funding.

Strategy 5 Budget and Expenditures for 2007-2008

Exhibit 5-1:

MSA Budget and Expenditures for 2007-08 for Strategy 5[4]

	Recipient	Expense	Approved Budget	Expenditures as of May 31, 2008	Percentage Expended
Strategy 5: Frequent Users	Solano County	Staff (.35 FTE – Sup MH Clinician)	$33,579	$22,931	68%
	Solano County	Staff (1 FTE – MH Clinician)	$87,021	$20,316	23%
	Solano County	Mission Solano/Community Act. Cncl.	$20,000	$2,640	13%
	Solano County	Skilled Nursing	$17,000	$0	0%
	Solano County	Services and Supplies	$15,945	$1,752	5%
Total			**$164,675**	**$46,207**	**28%**

As shown in Exhibit 5-1, $164,675 in MSA funds were allocated to Solano County for implementation of Strategy 5 in 2007-2008. The largest portion of this funding was $87,021 allocated to cover the costs of a clinician for Frequent User Project, which is the primary intervention related to this strategy. However, because, as described above, the Frequent User Project clinician left her position in September 2007 and has not been replaced, only approximately 20% of this allocated amount had been spent by May 31, 2008. Similarly, because of the absence of project staff for most of the fiscal year, only five percent ($1,752) of the $15,945 allocated to services and supplies for the project had been spent.

At the start of the fiscal year, the amount allocated to cover the cost of the project's clinician was even higher, but because the Frequent User Workgroup realized that a portion of this money would likely go unspent, it allocated some of the funding to other activities. For example, the amount of MSA funds allocated to support the supervising

[4] This chart captures expenditures paid out by the County as of 5/31/08 and does not reflect claims submitted for services during May. Workgroups have until 6/30/08 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 2007-2008 fiscal year (August 2008).

mental health clinician (who will eventually supervise new project staff) was increased to $33,579 to cover .35 FTE of his time. In addition, the workgroup approved $20,000 to spend on contracts with shelters run by Mission Solano and the Community Action Council for transitional housing for Frequent User patients. However, likely due to confusion about the authorization and payment process for those contracts and because new project staff had not been hired, as of May 31 only 13 percent ($2,640) of that amount had been expended. Similarly, as a result of the CMSP Task Force, a sub-group made up of hospitals, the county and SCBH has been working to set up contracts with skilled nursing facilities to use MSA funding to cover the gaps or additional funding needed to serve these patients. However, because of lengthy processes, these contracts were only being finalized at the end of the fiscal year and consequently no MSA funding has thus far been expended on this item.

Outcomes

Prioritized Outcomes for 2007-2008

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

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

Results for 2007-2008

Outcome (1) 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[5]

Results[6]

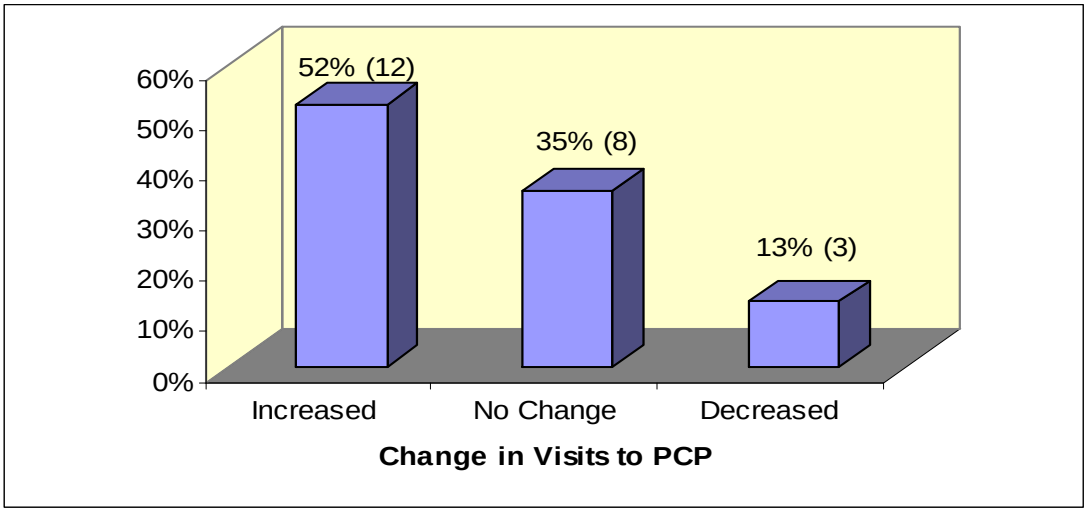
- For the 23 frequent user clients on Medi-Cal who were enrolled in the Frequent Users Program for at least one month between the program's inception and February 2007:

[5] 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.

[6] Because no new data on Frequent User clients was available for this year's evaluation, the results for Outcome 1 are the same as those presented in last year's evaluation report.

- **Twelve (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.
- **Three (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.
- **Eight (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



- 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

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.

Data Limitations

There were several data limitations related to this analysis:

- One of the most important limitations 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:

  - We could not collect data on PCP visits by CMSP or uninsured clients, and therefore excluded them from our analysis. This reduced the total number of frequent user clients we could track from 48 to 34.
  - Of these 34, only 28 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.
  - Five of the 28 clients on Medi-Cal who we submitted to PHC for data could not be found in PHC's MIS, reducing the number of clients in our analysis to 23.
- Another limitation was due to our evaluation design. Although we considered implementing a more rigorous design involving the selection of a comparison group, due to the added cost and difficulties in accessing the data needed to do this, we instead opted for a simple pre- and post- test design using data for project clients.[7] Because we essentially had data on the entire population of clients who were served by the project, we used the data to evaluate whether there was a difference in the number PCP visits for the clients served over the time period measured. However, we cannot use these results to readily make

[7] Of course, the most rigorous design would have involve an experimental evaluation where treatment and comparison groups were randomly selected. However, this design was also judged to be infeasible.

inferences about whether the project will be successful with other future clients or even be successful with the same clients in different time periods.[8]

- 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.

Outcome (2) Fewer and shorter Frequent User client "administrative" or "avoidable" hospital stays

Indicators

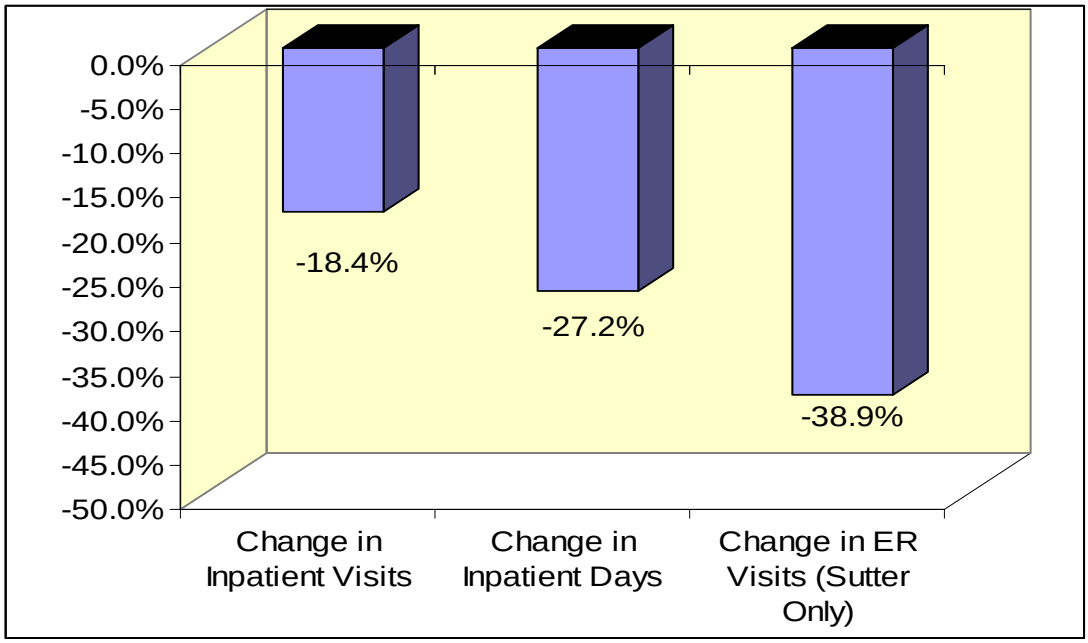
1. ***Number of inpatient visits six months prior and six months after being referred to the Frequent User Project***
2. ***Number of inpatient days six months prior and six months after being referred to the Frequent User Project***

Results

- For the 34 Frequent User clients who were included in our analysis, there was an 18.4 percent (80 vs. 98 visits) decline in inpatient hospital visits and a 27.2% (538 vs. 739 days) decline in inpatient days when comparing the six months prior to referral with the six months post referral (Please see Exhibit 5-3). Based on data solely from Sutter Solano Medical Center, Frequent User clients experienced a dramatic nearly 40 percent decrease (226 vs. 138) in ER visits.

[8] Because of the changes to how the project will be staffed in the future, even with an experimental design, we could not use these results to make predictions about the future success of the project, since the project will be operated in a different manner.

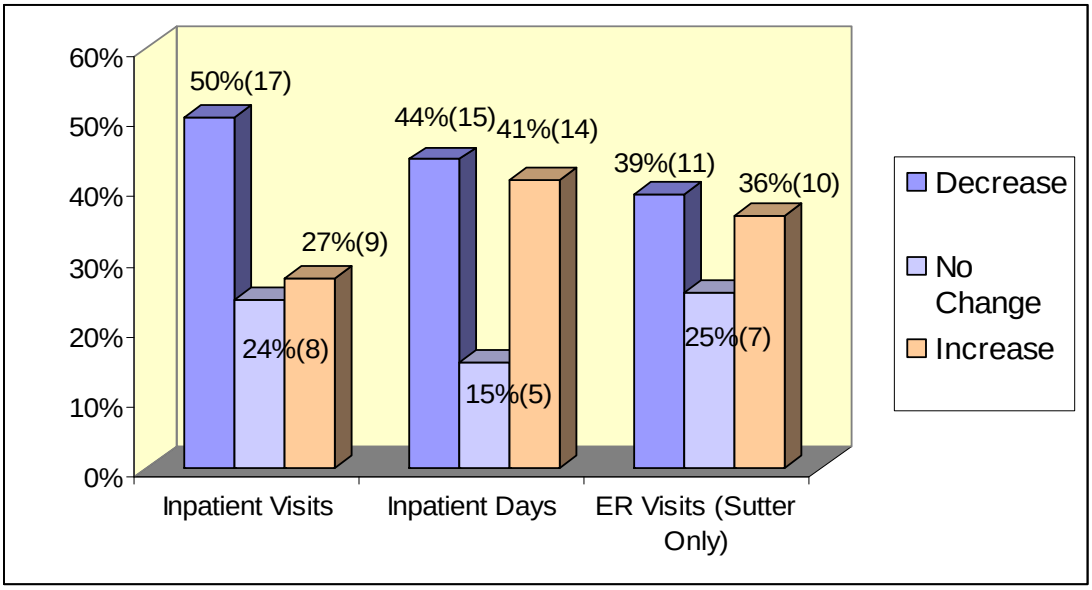
Exhibit 5-3
Percentage Changes in the Number Inpatient Days and Visits and ER Visits (Sutter Only) by Frequent User Clients Post Referral as Compared to Pre-Referral



  - These declines overall were primarily caused by a small number of patients who experienced major decreases in both the visits and days. For example, one patient alone experienced 24 fewer inpatient visits and 270 fewer inpatient days in the six months after being referred to the Frequent User Project. Another patient visited the Sutter Solano Emergency Room 109 fewer times during the six months following referral. Excluding the few patients with very large decreases, for most patients, changes either way were relatively small, with a median change of one inpatient visit, five inpatient days and one ER visit in either direction.

- Looking at how individual Frequent Users fared, rather than at the overall numbers of days and visits, we saw more mixed results. For example, only half of all Frequent Users in our analysis experienced decreases in the number of inpatient visits in the six months following referral compared to the six months prior, while about a about a quarter experienced either no change or increases in the number of visits (Please see Exhibit 5.4). Similarly, only 44 percent experienced decreases in inpatient days, while 41 percent experienced increases in numbers of days and 15 percent had no change. Based only on data from Sutter Solano Medical Center, 11 (39%) Frequent Users experienced a decrease in ER visits, 10 (36%) had increased visits and seven (25%) no change.

Exhibit 5-4
Frequent User Clients Who Experienced Decreases, Increases or No Change in Inpatient Visits, Days and ER Visits (Sutter only) Post Referral



- Interestingly, few Frequent Users experienced either decreases or increases in all three indicators. It was fairly common, for example, to have Frequent Users show a decrease in inpatient visits, but a slight increase in days, and no change in emergency room visits.
- Because of the small number of individuals included in this analysis, no strong correlations between client characteristics and decreases in inpatient or ER visits or inpatient days were observed.

Data Sources

The information analyzed for this outcome was based on data from NorthBay Health Care and Sutter Solano Medical Center. Using to the Frequent User spreadsheet provided by H&SS, SPR requested data on the number of inpatient hospital stays and days for six months prior to the patient's referral to the Frequent User Project and six months after from the project's two participating hospital systems.[9]

SPR decided upon a six-month pre- and post- referral date time period because this would provide an adequate amount of time for clients' post-referral date to show the effects of the project, but not too long so that clients might move out Solano County and no longer be trackable.

[9] We also received data on ER visits from Sutter Solano Medical Center that we had not requested.

Data Limitations

The analysis of this outcome comes with several limitations. Principal among these is the very small number of Frequent User clients for whom we were able to obtain data on hospital visits and days. Out of the 53 clients who were originally referred to the project, the number of individuals in our analysis declined to 34 as follows:

- Eighteen patients were not found in either hospital's database. The vast majority (14) of these patients lacked a Social Security number in the Frequent User spreadsheet, making it very difficult for the hospitals to find them in their data systems. Six of these clients also lacked a date of birth, making them impossible to locate. Nearly all of these clients were referred in the latter months the project operated, when data collection appeared to become inconsistent.
- We excluded one other client who had a discharge data less than 30 days after his referral date. We felt 30 days was the minimum length of time necessary for a client to be impacted by the program and therefore included in our outcomes analysis.

Another limitation was due to our evaluation design. Although we considered implementing a more rigorous design involving the selection of a comparison group, due to the added cost and difficulties in accessing the data needed to do this, we instead opted for a simple pre- and post- test design using data for project clients.[10] Because we essentially had data on the entire population of clients who were served by the project, we used the data to evaluate whether there was a difference in the number of stays and inpatient days for the clients served over the time period measured. However, we cannot use these results to readily make inferences about whether the project will be successful with future clients or even with the same clients in different time periods.[11]

The small number of clients and relatively short amount of time included in the analysis is another limitation that decreased the statistical power of the findings. This is another reason to view the results cautiously as only preliminary indicators of the effectiveness of the project.

Because NorthBay was unable to identify individuals in their data system without a Social Security number, we may have also underestimated the number of visits and stays, both pre and post, for the six clients who lacked a Social Security number. These

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[10] Of course, the most rigorous design would have involve an experimental evaluation where treatment and comparison groups were randomly selected. However, this was infeasible as the project was no longer operating.

[11] Because of the changes to how the project will be staffed in the future, even with an experimental design, we could not use these results to make predictions about the future success of the project, since the project will be operated in a different manner.

clients were included in the analysis because Sutter Solano Medical Center was able to identify them in their data system based on a date of birth alone.

Finally, another limitation was that we should have collected data on ER visits from both Sutter Solano Medical Center and NorthBay Health Care. We did not request these data initially from either hospital system because they were not part of one of the prioritized outcomes in the three-year Evaluation Plan.[12] However, Sutter Solano Medical Center voluntarily included this information with their data on inpatient visits and days. After analyzing these ER visit data, we decided to present them because we thought the workgroup would find the results interesting. However, because we have data only from Sutter Solano Medical Center, the number of visits both pre and post may be underestimated for clients who used the ER in both hospital systems.[13]

Assessment of the Frequent User Project by Hospital Staff

To provide a deeper understanding of the limited quantitative data on the number of inpatient stays and days presented above, we also conducted a survey of hospital staff who worked with the Frequent User Project during its first year and a half of operation. We chose our 12 survey respondents (seven from Sutter Solano and five from NorthBay Health Care) based on recommendations from the supervising social worker at each hospital. We then sent each of these respondents an invitation to an eight-question survey regarding their experiences with the project and the vast majority responded.[14] The results of the survey are detailed below.

In contrast to the somewhat mixed results from the quantitative data, survey respondents from both hospitals were full of accolades for the project, calling it "vital assistance" and writing that "...[the project] really made a difference…" and that it "reduced lengths of stay and the frequent use of ER or hospital admissions." Respondents were also unanimous in reporting that overall they found the project either effective (30%) or very effective (70%).

There were numerous explanations provided by respondents for why the project was effective. One oft-cited reason why the project was effective in shortening hospital inpatient stays was that it assisted patients with finding housing so they could be safely discharged. While these housing placements often started out as temporary, the clinician was able to move a number of clients into more permanent housing over time. For example, respondents shared several anecdotes about specific situations where the

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[12] A decrease in ER visits was one of the possible outcomes presented to the Frequent User Workgroup in November 2006, but the outcome was not prioritized high enough by the group to be included in this three-year Evaluation Plan.

[13] Forty-seven percent of clients in our analysis were found in both hospitals' data systems.

[14] Ten of the 12 staff members who were sent invitations responded, resulting in a survey response rate of 85%. Staff who responded included six hospital social workers, three RN case managers, and one M.D.

clinician was eventually able to assist clients with moving into an apartment, a board and care facility, or a boarding house.

Respondents also noted that the project's clinician was effective in preventing new hospital admissions or ER visits through her case management efforts. By connecting clients to needed services and supports, she could keep them stable and out of the hospital. As soon as a client was referred to her, the project clinician conducted a thorough assessment of the client's needs and barriers. She then assisted clients with meeting those needs, including accessing needed outpatient medical, mental health and substance abuse services. Because the clients often lacked even basic resources, the clinician not only had to assist them scheduling appointments with PCPs and therapists, but she also often transported clients to those appointments and then accompanied them to fill any needed prescriptions. The clinician also commonly helped Frequent User clients to meet basic needs, such as food and clothing, and worked with them to apply for SSI and Medi-Cal.

Several respondents noted that it was very useful to have a single "point person" coordinating services for the Frequent User clients. For example, one wrote that "it [the project] gave patients one person they could speak with and get assistance with their issues/concerns." This same respondent also wrote that the clinician was "well connected," while another commented that she could often find a placement for a client just by making a few calls. Another respondent wrote that the project's clinician often worked closely with the staff person from the Health Care for the Homeless program, and the two became a "well developed team…"

Other reasons for the effectiveness of the project in general were attributed to the project clinician's style of providing services. For example, one respondent reported that the clinician was "very caring" and "very open and direct and patients responded to her so she was able to develop a very good working relationship with them." This same respondent noted that one way the clinician was able to develop trust with the clients was by focusing on the client's priorities before working on treatment issues. For example, the respondent told of one case where the clinician assisted a woman who was too worried about her cat to focus on obtaining needed substance abuse or mental health treatment. However, once the clinician was able to assist the woman with finding her cat and having it spayed, the woman was willing to begin necessary treatments. In another case, a client was living in his car with his dog because he couldn't find a place that would take pets. After the clinician found an apartment that would take pets, the client moved in and began participating in treatment.

Other respondents commented that the clinician was "very hands on," "pro-active," and "went out of her way" to provide clients with the services and assistance they needed. For example, several respondents commented that the clinician was "always available" to meet with a new client immediately, or if she was busy working with other clients when a call came, she would arrange to meet with the client the next day. In addition, others commented that the clinician was creative in trying to solve problems for clients. In one example, a respondent spoke of a disabled client on parole that needed to be in a skilled nursing facility, but none in Solano County would take him because of his bad

reputation. The client also wanted to be near family in another county, but thought he could not leave Solano County. Learning of this, the Frequent User Project clinician checked with the client's parole office who informed her that the client could leave Solano County, so the clinician was then able to place the client in a facility close to his family. Eventually, the clinician's reputation for effectiveness even began to make it easier to find placements for clients. One respondent told of a skilled nursing facility that was only willing to take a client with serious substance abuse problems because the client was part of the Frequent User Project and would be assisted by the project's clinician.

Despite the many successes of the project, survey respondents also noted several challenges. The primary challenge noted by several respondents was that the project was too small to serve all the clients who needed assistance. As one respondent wrote, "Difficult patients require a great deal of time and energy. One person to handle all their needs appeared overwhelming and hard to handle." The other challenges mentioned had to do with the fact that the resources available to transport, house and serve these patients are very limited, making it extremely difficult for the project's clinician to secure what clients needed.

Outcome for 2008-2009

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

2008-2009 Prioritized Outcome:

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

Conclusion

Based on very small analyses, there were nearly 20 to 40 percent declines in inpatient visits and days and ER visits by about half of all Frequent User clients included in this evaluation six months after referral to the program. Similarly, about half of all Frequent Users on Medi-Cal experienced increased visits to their PCP following referral to the project. For 10 of these clients, the number of PCP 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 finalization of a contract with local homeless shelters for short-term, limited 24-hour care.** The Workgroup has discussed the need for short-term, limited 24-hour care for homeless patients at area shelters for several years. This fiscal year a contract was finalized and services were delivered to a small number of clients.

- **Consistent participation of Frequent User Workgroup members.** The Frequent Users workgroup had consistent participation by core necessary members, namely representatives from North Bay Health Care and Sutter Solano Medical Center, SCBH, the County and the shelters. Workgroup members were engaged in important discussions this year, particularly related to re-configuring the project to address the challenges identified by the previous project clinician.

Challenges

- **Lengthy delays in the county's hiring process resulted in this project being on hold for much of the year.** The fact that the county has been unable to hire new Frequent User Project staff for nearly six months has been extremely frustrating for workgroup members, particularly hospital staff who regularly encounter clients who could benefit from project services. The long hiring delays will likely result in approximately $71,000 to $90,000 in MSA funds allocated to Strategy 5 going unspent this year.
- **Inconsistent or incomplete data collection and records storage on project activities and outcomes.** Although the project has been on hold since the previous project clinician left in the fall of 2007, between April and September, 2007, the project served at least five new clients and likely more. However, because of problematic data collection processes, no information on clients served after March 2007 was recorded in the project's database. Consequently, SPR was only available to request data on inpatient stays and days from participating hospitals for clients who were served by the project over a year ago and could not request data from PHC for any clients served since the last evaluation report was published. The lack of updated information has decreased the amount of data available to analyze, seriously affecting the statistical power and validity of the analysis, particularly for clients served over the last six to nine months of the project.

Recommendations

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

- **Streamline future project hiring processes.** To avoid future problems related to lengthy hiring processes and paperwork, the Frequent User Workgroup and the Health Access Committee should work with the county to explore ways of streamlining county hiring processes for future project staff.
- **Improve project data collection and storage.** The Frequent User Workgroup should coordinate with project staff and their supervisors to develop clear data collection and storage procedures and point people to ensure that sufficient and up-to-date data is available for workgroup members to effectively evaluate the project's success.
- **Compare ER visits before and after referral to the project in addition to changes in inpatient visits and days.** After reviewing data received from Sutter Solano Medical Center on ER visits that was not originally requested (because our evaluation plan did not include an outcome related to ER visits), it

became apparent that an analysis of changes in numbers of ER visits would be useful to obtain a full picture of how the project has changed the way Frequent Users interact with hospitals in Solano County. A respondent from NorthBay similarly commented that more changes in Frequent User clients would likely have been observed if we had been able to include data on changes in ER visits from both hospitals.[15] For these reasons, we decided to analyze and present the data we received from Sutter Solano Medical Center on changes in ER visits.[16] However, because it was too late to request data from NorthBay Health Care on ER visits, the data presented in this report on ER visits may under-report those visits (both pre and post) for the 46 percent of shared clients. Consequently, we strongly recommend that if hospital data is analyzed in future years, data on ER visits should be requested from both hospital systems and included in the analysis.

[15] She specifically commented that a number of clients for whom NorthBay records showed no inpatient visits or days during the six months pre or post referral to the Frequent User project, did have ER visits during those time frames.

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

Strategy 6 falls under Goal 2 of the 2005-2008 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 are 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 Denti-Cal, an insufficient supply of pediatric dentists, and large areas of the county that lack adequate oral health services for un-insured residents. MSA-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:
MSA Budget and Expenditures for 2007-2008 for Strategy 6[1]

	Recipient	Expense	Approved Budget	Expenditures as of May 31, 2008	Percentage Expended
Strategy 6: Oral Health	Solano County	Staff (extra help—health assistant)	$27,000	$5,676	21%
	Solano County	Gap Funding—care coordination	65,000	18,126	28%
	Hill & Company	Public health campaign	65,000	23,809	37%
	Solano County	Services & supplies	3,000		
Total			***$160,000***	***$47,611***	***30%***

[1] This chart captures expenditures paid out by the county as of 5/31/08 and does not reflect claims submitted for services during May. Workgroups have until 6/30/08 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 2007-2008 fiscal year (August 2008).

As shown in Exhibit 6-1, in FY 07, $160,000 in MSA funds were allocated for activities related to Strategy 6. The majority of this amount was the $65,000 allocated for the Gap Fund and the $65,000 allocated to the public health campaign contractor (Hill & Company). As of May 2008, the workgroup expected to have approximately 37 percent of its allocated funds unspent, with plans to redistribute this amount to two other projects (discussed under Oral Health Workgroup Activities 2007-2008). However, as shown in Exhibit 6-1, with one month remaining in the fiscal year, 70 percent of the total allocated funding had not been expended. For every sub-category of the budget except one, less than one-third of the allocated funding had been expended. Some of this can be explained by delays in hiring a replacement care coordinator/health assistant and the fact that the approved public health campaign contractor did not begin work until winter 2008. In FY 2006, only 16 percent of the allocated funds ($150,000) were spent due to various administrative hurdles in establishing the Purchase Order (PO) process and lack of clarity around the Gap Fund workflow process (described in next section).

Oral Health Workgroup Activities 2007-2008

The Oral Health Workgroup's activities and discussion topics in 2007-2008 centered on the following:

- **Establishing purchase orders with oral health providers.** The workgroup successfully established POs with five individual oral health providers[2] as well as with the Fairfield county-run clinic in December 2007 and with La Clinica in spring 2008. Of note is the fact that only the Fairfield county-run clinic and one of the individual providers accept Denti-Cal. The Fairfield county-run clinic was seen as a particularly valuable addition not only because it accepts Denti-Cal, but also because it serves as a major source of referrals.
- **Working to hire a new health assistant for the oral health Gap Fund.** A previous health assistant/care coordinator was in place from May—December 2007.[3] A replacement—housed in the Children's Health and Disability Prevention (CHDP) program under the Solano County Health & Social Services Department—was hired in winter 2008.[4]
- **Making a revision to the target group served by the Gap Fund.** In addition to its original target group of children ages 6-18, the workgroup decided to use the Gap Fund to serve children ages 0-5 from Rio Vista and Benicia who are not served by School Readiness sites.
- **Clarifying the oral health/Gap Fund workflow and conducting oral health resource mapping.** The workgroup engaged in two lengthy processes this past fiscal year—clarifying the oral health/gap fund workflow, and conducting an oral health resource mapping exercise. The workflow process was triggered by

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[2] Drs. Clift, Fisher, Nutter, Wiley and Charito.

[3] Melissa Albaloss.

[4] Janice Vega.

frustration with the fact that no allocated Gap Funds were spent in the 2006-2007 fiscal year, largely because of a lack of clarity around how these funds were to be used and how to coordinate with the Children's Health Access Program (CHAP). The workflow process sought to clarify such factors as how children get identified and referred for Gap Funding, the criteria for determining that a child needs urgent care, where children get treatment, and various other issues about the process. As part of the workflow process, the workgroup partnered with an outside consultant to map all the oral health resources, services, programs and key contacts for Solano County children. The workgroup is still in the process of finalizing two documents that will illustrate the workflow and list oral health resources in Solano County.

- **Awarding and beginning work on the public health campaign contract.** The public health campaign contract was awarded in summer 2007, with Board approval given in October 2007. The contractor began work in winter 2008. Key tasks accomplished thus far include defining the campaign's target group (pregnant women, fathers, and children ages 0-5) and holding focus groups with parents of children ages 0-5 in order to discuss the potential content of campaign messages and the best way those messages might be communicated.
- **Reviewing potential uses of unspent dollars for FY 2007-2008.** The workgroup discussed how it might use its unspent dollars by the end of the fiscal year. As of May 2008, workgroup leadership thought that the following two efforts might absorb these unspent funds, though they are not reflected in the budget information presented in Exhibit 6-1:
  - **Program at Paden Elementary School in Vacaville.** Smile in Style provided oral health screenings to all students at Paden Elementary School in Vacaville. While some students had no cavities and required only sealants, some needed to see dentists because of cavities or broken teeth (level 2) or required urgent oral health care (level 3). As part of this new program, the workgroup is targeting level 2 students to get them linked to insurance and served with Gap Funding as needed (e.g., if a student requires sedation and Denti-Cal will not cover that service).
  - **Providing fluoride varnish for WIC children.** The workgroup acquired fluoride varnish for 1,000 WIC children. Solano County and La Clinica are responsible for screening children and applying the varnish.
- The workgroup met eight times over the 2007-2008 year (with a possible ninth meeting in June 2008). The workgroup chair characterized workgroup attendance as excellent, with group members described as particularly motivated and energetic. She offered a possible explanation for the strong attendance and engagement, noting that besides a passion for the oral health issues at hand, group members tend to be "closer to the issue" than is the case in other workgroups, because they see the clients on an everyday basis (e.g., as county and Kaiser nurses). The workgroup chair commented that oral health challenges have also been building up for years, and that this workgroup provides a much needed outlet and vehicle for addressing these issues. The workgroup chair, who

is a staff person for SCBH, said she feels that there is a need for a non-SCBH representative to serve as co-chair of the workgroup in order to facilitate a broader sense of ownership.

Outcomes

Prioritized Outcomes for Strategy 6 for 2006-2008

1) **Gap Fund is operational and a care coordinator is providing care coordination**
2) **Increased number of uninsured/underinsured children receiving needed urgent oral health treatment**
3) **Increased number of uninsured children served by care coordinator linked to comprehensive health insurance, including dental insurance**

Results for 2007-2008

Outcome (1) 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

- The Gap Fund is operational, with POs established with five individual oral health providers, one county-run clinic (Fairfield), and La Clinica. Children have received oral health services from the Gap Fund in FY 2007 (see next prioritized outcome). The current health assistant/care coordinator was hired in winter 2008 and is providing care coordination.

Data Sources and Limitations

- The primary sources for the data presented above were interviews with the chair of the Oral Health Workgroup and MSA project manager staff in Solano County's Health and Social Services Department.

Outcome (2) Increased number of uninsured/underinsured children receiving needed urgent oral health treatment

Indicator:

Number of uninsured/underinsured children served by care coordinator who receive urgent oral health treatment

Results

- In FY 2006, seven children were referred to the care coordinator/health assistant. However, in FY 2006, no children actually received urgent oral health treatment from the Gap Fund due to administrative hurdles in establishing POs with oral health providers as well as a perceived lack of clarity on the Gap Fund workflow process (described above).
- In FY 2007, 57 children were referred to the care coordinator/health assistant. The number of children who actually received oral health treatment from the Gap Fund increased from zero to 32.[5] This number included six children who were referred in the previous fiscal year, but did not actually receive oral health services until FY 2007. Not all children who were referred ultimately received services from the Gap Fund due to a variety of reasons such as families moving out of the area, parents who did not provide sufficient information about their child's insurance status and terms of coverage, and parents who did not wish to follow through with the oral health treatment prescribed for their children. Still other children who were referred were still pending for services, due to reasons such as the scheduling.
- Of the 32 children who received oral health treatment from the Gap Fund in FY 2007, nine of them had no insurance at the time of referral,[6] and an additional five were listed with pending insurance from Kaiser or Medi-Cal. According to CHDP staff, most children are referred from school nurses, who first refer the children/families to SKIP[7] before the oral health authorization/referral form is faxed over to CHDP. This may help explain why most children have insurance or insurance coverage is pending by the time they are referred and receive services from the care coordinator/health assistant.
- The cost of providing oral health treatment services in FY 2007 was $18,126.[8] Just over half of this amount was paid to Dr. Fisher, the only anesthesiologist with whom the county has a PO established. One-quarter of this amount was paid to Dr. Clift, the only individual provider to accept Denti-Cal.
- Oral health treatment was provided by all five individual oral health providers with established POs. The decision as to which oral health provider serves a child is based on a range of factors, including whether the child requires anesthesia, the

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[5] Thirty-two children had been served as of 6/02/08, according to CHDP staff and an oral health/Gap Fund database.

[6] This differs from original projections in the MSA Spending Plan for Oral Health to serve more uninsured children than underinsured children. Specifically, the expectations were to serve 40 uninsured children and at least 15 underinsured children by 6/30/08.

[7] SKIP staff then immediately attempt to enroll these children in an appropriate health insurance program such as Medi-Cal, Healthy Families, Healthy Kids Solano, or the Kaiser Child Health Plan.

[8] As stated in Exhibit 6-1, this figure reflects expenditures paid out by the County as of 5/31/08 and does not reflect claims submitted for services during or after May 2008. Therefore, the expenditure figure does not fully reflect the cost of all oral health treatment services provided in 2007-2008.

types of services required and offered by a particular provider, level of urgency, the time slots available at a particular provider, and the type of insurance accepted by the provider.

Outcome (3) Increased number of uninsured children served by care coordinator linked to comprehensive health insurance, including dental insurance

Indicator:

Number of uninsured children served by care coordinator who are linked to comprehensive health insurance, including dental insurance

Results

- We were unable to track this outcome for the 2007-2008 fiscal year. While the Oral Health/Gap Fund Database includes a field for children's insurance status at the time of referral, as of yet, there are no additional data fields or notes to indicate what additional steps have been taken for and by those without insurance (e.g., SKIP helps family to fill out application, family actually enrolls in insurance). While the care coordinator/health assistant may ask questions about whether the family has actually enrolled in insurance as part of the overall follow-up process, this has not been done and/or documented in the database, possibly due to turnover in the care coordinator/health assistant position and associated delays in revising the database fields.

Data Sources and Limitations

- The data sources for outcomes 2 and 3 included the Oral Health/Gap Fund Database (database) provided by CHDP staff; the Oral Health Authorized Gap Funding Spreadsheet (spreadsheet) provided by Solano County Health and Social Services fiscal staff; and a telephone interview with CHDP staff held in order to receive updates to the database and clarify outstanding issues.
- Limitations to these data sources are primarily related to a certain degree of misalignment between the database and the spreadsheet, as well as what we perceive as some unclear or incomplete data fields in the database. These limitations made it difficult to cross-reference, for example, the number of children served and the dates on which they were served.[9] It was also unclear, until our phone interview with CHDP staff, that not all children listed in the database as served are actually served by the Gap Fund (i.e., their services may be fully covered by their existing insurance). The amount field was a point of confusion in that in some cases, it lists the amount actually paid for services, while in other cases it lists the amount approved but not actually paid (e.g., $500 approved to take away oral/dental pain but this entire amount was not actually

[9] This was made particularly difficult by the fact that—in the interest of client confidentiality—neither of the two data sources included children's names once submitted to SPR, and only the database included child identifier numbers.

used on the date of service). In the final recommendations section of this chapter, we discuss these limitations and suggestions for improvement in more detail.

Conclusion

With regard to the first two prioritized outcomes for Strategy 6, significant progress has been realized. The Gap Fund is operational with POs established with five individual oral health providers, one county-run clinic (Fairfield) and La Clinica. The current care coordinator/health assistant was hired in early 2008. Thirty-two children have received oral health services from the Gap Fund in FY 2007. With regard to the third prioritized outcome for Strategy 6, success cannot be accurately gauged with the current Oral Health/Gap Fund Database.

Other major successes and challenges of the workgroup are listed below.

Successes

- **The oral health Gap Fund process and community context was clarified.** By creating the workflow and resource mapping documents described earlier in this chapter, the workgroup addressed many of the administrative and logistical hurdles to serving children with the Gap Fund. These documents also helped the workgroup to understand the Gap Fund in the context of other county oral health programs and resources. The workgroup chair feels that these documents will help inform future decision-making with regard to workgroup activities.
- **A critical foundation was laid for the public health campaign.** By working with an outside consultant, the workgroup has identified the campaign's target group (pregnant women, fathers, and children zero to five). Potential campaign messages and communication vehicles were identified through a series of diverse community focus groups.
- **The workgroup partnered with Smile in Style and La Clinica to serve additional children.** The workgroup is targeting students with cavities and/or urgent oral health needs (as screened by Smile in Style at Paden Elementary School in Vacaville) for Gap Fund services and linkages to health insurance. The workgroup is also working with the county and La Clinica to screen children and apply varnish to 1,000 WIC children.

Challenges

- **There were challenges involved with re-hiring a health assistant to serve as care coordinator.** The workgroup experienced challenges related to the turnover of the care coordinator/health assistant who worked from May until December 2007, and the subsequent rehiring process. Finding the right candidate for the position proved challenging, particularly given initial requirements for a Spanish speaker, and the fact that there is a steep learning curve involved with the position. Ultimately, the person hired does not speak Spanish, but has a dental background, which has proved helpful.

- **The Oral Health/Gap Fund Database and Oral Health Authorized Gap Funding Spreadsheet are somewhat unclear.** As previously discussed, there are a few limitations to these two data sources that make it difficult to cross-reference the children served as well as other associated information. Definitions for certain data fields are also somewhat unclear. We provide specific recommendations for these data sources in the following section.

Recommendations

Our recommendations center on making revisions to the Oral Health/Gap Fund Database and aligning it better with the Oral Health Authorized Gap Funding Spreadsheet. To do this, we recommend that CHDP staff, the Care Coordinator/Health Assistant, and MSA Fiscal Analyst Staff meet in order to—to the extent possible—coordinate the data fields of the database and spreadsheet so that it is easier to cross-reference the children served as well as all of their associated information. Following are specific recommendations by data field:[10]

- **Race/Ethnicity.** Tracking this data would allow workgroup members and others to see which racial and ethnic groups in Solano County are being served by the Gap Fund.
- **Referral Date.** Different referral dates are sometimes listed for the same clients in the database and the spreadsheet. For example, the database has several clients with referral dates in April and May 2007. These clients either do not appear or have different referral dates listed in the spreadsheet.
- **School.** Currently the school field appears to contain a mix of cities, school districts, and specific schools. This field should be standardized.
- **Condition.** Currently this field appears to be a mix of presenting problem as well as required treatment (e.g., "cavity with infection" is listed for one child; "anesthesia" is listed for another child). This data field should be divided into two: Presenting Condition and Treatment Provided. The Treatment Provided data field should contain the same information as that contained in the spreadsheet's Work data field.
- **Service Date & Time.** This data field should also include a notation of "pending" for those clients who had to reschedule, or who are awaiting services for some other reason. The spreadsheet, not just the database, should include this data field to ease cross-referencing of clients served, particularly if multiple dates of service are involved for the same client.
- **Insurance.** This data field should be divided into "Initial Insurance Status" to document insurance at time of referral, and "Follow-up Insurance Status" so that

[10] Some of these recommendations were presented in an earlier form in a December 13, 2007 memo to the Oral Health Workgroup Chair.

the care coordinator/health assistant can enter notes on the subsequent dates of follow-up contact and the child's insurance status at that time.

- **Amount.** This data field should be separated into Amount Approved, Amount Paid, Gap Funds Used, and Status. The Amount data field as it is currently used is a mix of amounts approved and, in other cases, amounts paid. For example, some children have amounts listed as $500—an amount approved to "take away the pain"—but according to staff, did not actually use this full amount. There is no note or alternate field to indicate how much of the approved amount was actually used. Also, by having two separate Amount Approved and Amount Paid data fields, we can better track the costs of Gap Funded services over time. Because the children who received services do not always use Gap Funds (e.g., if insurance covers the whole cost), we also recommend a Gap Funds Used data field, that would be marked yes or no, to make clear whether a served child actually received Gap Funds. For example, one child listed in the database with two cavities was served by Drs. Clift and Fisher on 9/26/07; however, the Amount data field says $0. Only by interviewing CHDP staff did it become clear that the amount was paid in full by the child's existing coverage with Medi-Cal. A Gap Funds Used data field would also be helpful in noting what specific part of the treatment provided was specifically covered by the Gap Fund (e.g., "take away pain" services, anesthesia). Finally, a Status field would indicate whether services had been paid for or whether a claim had been submitted, along with associated dates.
- **Notes.** We recommend a Notes data field for any information that cannot be efficiently captured in other fields. For example, for those children who were referred and/or approved but did not receive services, it would be important to know why—e.g., moved away, parents did not follow up with insurance information—so that any necessary changes might be made to the way the Gap Fund is administered to maximize the number of children who are able to receive needed services.

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

Strategy 7 is under Goal 3 of the 2005-2008 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 giving individuals health insurance. Specifically, the strategy focuses on promoting utilization of services by addressing individuals' beliefs, attitudes, knowledge, and experiences with health services.

Ongoing Interventions Related to Strategy 7

The primary interventions related to Strategy 7 are to develop community health leaders and provide health education services to the African American community of Solano County, particularly focusing on diabetes education and awareness.

Exhibit 7-1:
MSA Budget and Expenditures for 2007-08 for Strategy 7[1]

	Recipient	Approved Budget	Expenditures as of May 31, 2007	Percentage Expended
Strategy 7: Community Education	Fischer Communications	$100,000	$53,178	53%

Although expenditures totaled only $53,178 by May 31, 2008, Fischer Communications stated that they anticipate spending all of their funding by the June 30, 2008 deadline. They explained that the low percentage expended by the end of May was due to the fact that the three community education events, which constituted the majority of their work, were not held until May and June. In fact, Fischer Communications estimated that because the $100,000 allocated will not adequately cover all of their project expenses, they have been donating approximately 20% of their time to the project.

Community Education Workgroup Activities 2007-2008

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 and key staff focused on developing plans for an intervention to provide health education services to the African American community in Solano County. In

[1] This chart captures expenditures paid out by the County as of 5/31/08 and does not reflect claims submitted for services during May. Workgroups have until 6/30/08 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 2007-2008 fiscal year (August 2008).

early 2007, a Request for Proposals (RFP) was developed to select a grantee who would carry out this intervention. The contract called for the grantee to:

- Create, organize, and facilitate a minimum of three diabetes-focused events, which build capacity and result in behavioral change among participants. These events would focus on diabetes education, care, and management that are appropriate for the African American community, and would be held in predominantly African American faith, fraternal, or sorority-based institutions within Solano County.

The contract award date was initially scheduled for early 2007 but was delayed because the County rescinded the original RFP in March 2007. SCBH and the County subsequently revised and reissued the RFP in June 2007. Proposals from three bidders were received in response to the re-issued RFP.

Community Education Workgroup activity declined significantly after the original February 2007 RFP was rescinded because its major objectives had been achieved: 1) identifying the target group for the community education activities, 2) targeting the health issue (i.e., diabetes), 3) identifying outcomes for the workgroup activities, and 4) designing the original RFP. The workgroup had no role in the development of the revised RFP or selection of a winning bid. However, once Fischer Communications was selected as the contractor for the re-issued RFP, the workgroup met four more times (October, November, February, and March) to provide support to Fischer staff for implementation of the intervention. During these meetings, Fischer Communications provided the workgroup with activity updates, asked for guidance, and requested introductions by workgroup members to key potential partners and potential speakers for the community events.[2] Because subsequent community education work will be sustained as part of the SCBH African American Disparities Elimination Project rather than HAC, the Community Education workgroup will likely be permanently disbanded after this fiscal year.

Community Education Intervention

The county awarded Fischer Communications the contract to carry out community education activities in November 2007. Fischer's proposed scope of work focused on individual behavior change and community sustainability. The scope of work included:

- Informal focus groups to inform program design and content.
- One training event for facilitators/hosts.
- Three community education events (Vallejo, Fairfield, and Vacaville).
- A list of organizations and leaders who will foster sustainability for the initiative.

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[2] This information is based solely on interviews with Fischer Communications and SCBH staff as no meeting minutes were recorded.

Information on the implementation of the community education intervention is described below under Outcome 1.

Outcomes

Prioritized Outcomes for Strategy 7 for 2006-2008

1) Grantee is funded and beginning program implementation

2) Increased knowledge by education program participants about diabetes, the role of the physician, the role of the healthcare system, and the role of the individual related to diabetes

3) Behavior changes that result in positive health outcomes related to diabetes for African Americans involved in health education effort

Outcome (1) 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

- Fischer Communications was awarded the community education contract starting December 1, 2007, eight months behind the Community Education Workgroup's initial timeline for hiring a contractor. As discussed above, the Community Education Workgroup initially issued an RFP for its Health Promotion and Education Campaign in February 2007, with the intent to select a contractor and finalize a contract by March 23, 2007. Potential contractors submitted proposals in response to this original RFP, but were notified by the Health and Social Services Department in late March that the County had cancelled the entire RFP. The RFP was then reissued in June 2007, but it took another five months to award the contract.
- A series of focus groups, facilitator trainings, and diabetes education events were held from February through June 2008. These events not only informed the design of the community education program, but developed community health leaders and educated community members around diabetes prevention and management.
  - Fischer Communications held two focus groups in February 2008 with nine to eleven participants in each group. The information gathered was used to inform the design of the diabetes education events. These focus groups

were specifically aimed at collecting more information on the targeted communities. Based on focus group results, the diabetes education curriculum was amended to have a stronger family orientation, and a competitive game of diabetes and nutrition bingo to interest men. Focus group participants also gave input regarding design of the outreach materials and strategies to market the diabetes education events to the community.

- Thirty-one African American facilitators were trained to host the community diabetes education events. Twenty were trained at an in-person training held in April, and an additional eleven hosts were trained during two additional teleconferences held in May. Although this total number of trained facilitators fell short of Fischer Communications' original goal of 80, they reported that the number trained was sufficient to carry out the diabetes education events.

- A publicity campaign was carried out to publicize the diabetes education events. This included three thousand postcard invitations that were printed and distributed by Kaiser, the Community Education Workgroup chair and Fischer Communications. Approximately three hundred small and large posters advertising the event were placed throughout the three different communities.

- Three diabetes education events were carried out in May and June 2008. The first diabetes education event, *Living the Good Life,* was held at Mount Cavalry Baptist Church in Fairfield on May 3, 2008. Approximately sixty-five people attended the event including participants, panelists, Fischer Communications staff and representatives from SCBH. However, only approximately 35 participants from the community attended, falling short of the original goal of 100 participants per community education event. At subsequent events, participation again fell short of Fischer Communication's goal of 80-100 participants per event. At the May 31 event, only 38 participants from the community attended, and only 28 people attended the June 7 event.

- Kaiser and NorthBay Health Care provided diabetes testing services at one of the resource tables during the Living the Good Life events. During the first event, 34 people were screened, several of whom were referred to doctors due to high glucose levels. These individuals were also given coupons for free meters to monitor their glucose levels.

- In addition to organizing and facilitating the community education events, Fischer Communications also provided certain follow-up services to participants. For example, each person who attended one of the community education events and filled out a "commitment card" received two follow-up calls from a diabetes health educator in June. These calls provided support, encouragement and answered any questions the receivers had about

diabetes. Fischer Communications also provided a diabetes hotline where callers could ask questions about diabetes and be directed to someone who could assist them. The number for the hotline was distributed at all of the community education events. Between the facilitator training event held April 29, 2008 and June 9, 2008, the hotline had received a total of 46 calls. After June 30, 2008, Fischer will discontinue providing the hotline, but via e-mail, will refer the community education event participants to a national toll-free diabetes hotline.

- In another type of follow-up resulting from the community education events, some participants requested presentations on diabetes to certain African American community groups. For example, SCBH was asked to conduct a diabetes awareness and education presentation for a men's group by the minister of a local church in Vallejo.

Outcome (2) Increased knowledge by education program participants about diabetes

Indicator:

The number and percentage of education program participants who exhibit increased knowledge and positive changes in beliefs and attitudes related to the role of the individual related to diabetes[3]

Results

- Most May 3rd event participants indicated increased knowledge about preventing and managing diabetes. At the May 3rd event, thirty-three participants completed a survey at the close of the session. On this survey, thirty-two (97%) indicated that they had learned more about appropriate diabetes care management and prevention behaviors that they could practice.[4] This percentage exceeded the goal Fischer Communications stated in its contract of a minimum of 50% of event participants indicating increased behavioral knowledge.[5]

  On the same survey, thirty-three (100%) respondents indicated that their knowledge about preventing and managing diabetes had increased as a result of the workshop. This percentage also exceeded Fischer Communications' goal as of a minimum of 50% of event participants indicating an increase in knowledge.

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[3] Indicators for Outcomes 2 and 3 have been revised from SPR's 2007 Final Report, based upon the revised performance measures in the Community Education RFP re-issued in June 2007.

[4] One respondent declined to answer this question.

[5] As of June 23, 2008, survey results for the May 31 and June 7 events were unavailable to SPR.

- Of those who filled out the survey at the May 3 event, twenty-five (76%) community participants discovered at least one belief or behavior that had prevented them from accessing appropriate medical care for preventing/managing diabetes.[6] This percentage exceeds Fischer Communications' goal of a minimum of 50% of event participants indicating identification of at least one personal belief or behavior that has prevented them from accessing appropriate care or appropriately managing their chronic condition.

Outcome (3) Behavior changes that result in positive health outcomes related to diabetes for African Americans involved in health education effort

Indicator:

Number and percentage of participants who make a commitment to a healthy activity or behavior

Results

- Twenty-seven percent (9 of 33) of community attendees at the May 3rd event indicated they would like to commit to further healthy living activities. Of these nine, three expressed interest in participating in the Solano Wellness Million Pound Challenge, a healthy eating/active living program that fosters unity and empowers community members to proactively "release" unhealthy weight and engage in more physical movement. Additionally, three respondents expressed interest in becoming Critical Mass Health Conductors,[7] and three indicated interest in participating in future African American Advocacy projects.[8] Although additional data has not been collected on whether or not these participants followed through with participation in these activities, their expression of interest does demonstrate a commitment to healthier behaviors (e.g. healthy eating while participating in the Million Pound Challenge) or learning more about health education issues (as a health conductor or participant in a health advocacy campaign).

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6 Five (15%) indicated that they had not made such a discovery and three (9%) declined to respond to this question.

7 The Critical Mass Health Conductor program is a health empowerment program designed to engage African Americans in becoming health advocates for themselves, their families, and communities.

8 The African American Advocacy project is a grassroots leadership development program aimed at providing African Americans with the opportunity to learn organizing and advocacy skills necessary to create a healthy African American community and a healthier Solano County.

- Of the fifteen participants at the April 29 facilitator training who completed a survey, fourteen (93%) committed to at least one healthy activity.[9] Six respondents expressed interest in participating in the Million Pound Challenge. An additional six indicated interest in becoming Critical Mass Health Conductors, and six were interested in participating in future African American Advocacy projects.[10] Again, no follow-up information was collected on whether these participants actually took part in these activities.

Non-Prioritized Outcome for Strategy 7 for 2007-2008

1) Increased number of community leaders identified and used to facilitate and/or present information on health education/support groups

Indicator:

Number of community leaders identified and used to facilitate or present information on health education/support groups

Results

- Fischer Communications, SCBH, and Community Education Workgroup members have established relationships with thirty to fifty community partners who expressed interest in supporting education on diabetes in the African American community. In addition, the June 2008 Diabetes Education Campaign newsletter lists 62 partners that have been involved in the community education initiative by playing "a critical role in the planning, promotion, and implementation of the activities staged in Fairfield, Vallejo, and Vacaville."
- Thirty-one community members were trained as event facilitators/table hosts for the community education events held in May and June. In addition, nine participants at the May 3 event expressed interest in being trained by SCBH as Critical Mass Health Conductors to promote the health and wellness of their family members, friends, and neighbors.[11]

Data Sources

- The primary data sources for these outcomes were two participant surveys developed by Fischer Communications with assistance from Solano County

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[9] One respondent declined to answer this question. As of 6/23/08, no survey results for the subsequent facilitator trainings were available to SPR.

[10] Some survey respondents expressed interest in more than one activity.

[11] Although results are not yet available, it is likely that at least some participants from the May 31 and June 7 training also expressed interest in becoming Health Conductors.

H&SS staff.[12] The first was a voluntary post-training survey administered to participants in the facilitator training held April 29.[13] The second was a survey administered to community attendees after their participation in the May 3rd community diabetes education event.[14] Raw survey results were analyzed by Fischer Communications staff, who shared only the results of their analyses with SPR.

- In addition to the two surveys, other information for these outcomes was based on interviews with the Community Education Workgroup staff person, Fischer Communications staff, and a review of relevant documents such as the re-issued Community Education RFP.

Data Limitations

There were a number of limitations related to the data for the outcomes evaluated for Strategy 7. These limitations are detailed below:

- **Limitation related to data from the event and training participants.** One of the main limitations is that data was collected from these participants only once, after participation in the training or event. Because no data on the participants' pre-event knowledge of diabetes or their commitment to healthy behaviors was collected, there is no way to tell whether participants' knowledge or commitment levels changed following the event or training. Instead, participants might have already been knowledgeable or committed prior to their participation. Another limitation is that participants were asked about future behavior changes or activities they thought they would participate in, but is unlikely that all will follow through and actually carry out those activities. Further, asserted knowledge gains by participants were self-ascribed, so it is unclear whether participants really increased their knowledge of diabetes or just thought they did. Another potential limitation is that these data were collected and analyzed by the contractor who carried out the events, rather than a neutral third party. A final limitation is that because participation in the surveys was voluntary, the attitudes of those who did not complete the survey were not collected. Approximately 25 percent (5 of 20) of the trainees at the April 29th facilitators training and 6 percent (2 of 35) of participants at the May 3rd event did not complete a survey.
- **Written information on the workgroup was unavailable.** We were not able to obtain any minutes or other written information regarding the Community Education Workgroup meetings. Instead, we had to rely almost entirely for information on the workgroup from only a few key interviews.

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[12] SPR staff were not involved in the development or review of this survey, although we had asked to be involved in the review.

[13] Survey results were unavailable for the two additional teleconference facilitator trainings held in May.

[14] At the time of this writing, survey results were still unavailable for the May 31 and June 7 community education events.

Conclusion

A major success for Strategy 7 during 2007-2008, was the implementation of a community education initiative involving numerous activities aimed at addressing the beliefs, attitudes and knowledge related to diabetes in the African American community. This is in contrast to 2006-2007, when delays in the RFP process prevented the implementation of community education activities under the auspices of Strategy 7. Other successes and challenges of note are detailed below.

Successes

- **Thirty-one community members were trained as diabetes education facilitators**. As outlined in the consultant's scope of work, Fischer Communications trained 31 community members to be facilitators for the diabetes community education events.
- **Three diabetes community education events held**. Approximately 101 community members attended at least one of the three community education events that focused on diabetes. Although this number fell short of Fischer's original goal of 100 participants per event, those who attended reported increased knowledge of diabetes and a willingness to make behavioral changes related to preventing or managing the disease. In addition, Fischer Communications and SCBH staff reported that after attending the events, participants were enthusiastic, and some immediately began spreading news of diabetes education activities available in the community to friends and peers via word of mouth. The hope is that the momentum generated from these events will continue through the activities of the Disparities Elimination project.
- **Thirty-four event participants were screened for diabetes**. While not an identified goal in the contractor's scope of work, 34 individuals were screened for diabetes, several of whom were referred to their physicians due to high glucose levels.
- **Numerous community partners were involved in the community education events and many others have expressed interest in being involved in future activities.** Sixty-two partners were involved in carrying out the three community education events and approximately 30-50 were identified by the project as being willing to be involved in future community health education efforts.
- **A number of community members were identified who expressed interest in being involved in future health education efforts**. At least[15] 23 community members were identified as interested in being involved with future community education work.

[15] It is likely that this number would be higher if survey results from the second and third community education events were available.

Challenges

- **Lower than expected numbers of participants and facilitators**. While the facilitator training and community education events were successful, the number of participants at each event was significantly lower than targets set forth in the proposal. The main reason cited for low attendance at the first event was the short timeline for properly advertising the event and recruiting participants. The timeline was compressed by the delayed release of the RFP and subsequent award of the contract in December. Work on the project was further delayed into January due to the holiday season. Progress continued to be slow until after Fischer Communications held focus groups in February to inform the project's design and hired a full-time project director in March. All of these delays created a compressed timeline for recruiting and training facilitators and conducting an effective advertising campaign before the first diabetes education event took place. However, since the second and third events took place nearly a month after the first event, it is less clear why they also had relatively low attendance numbers.
- **Slow use of SCBH's established relationships with African American communities and health education knowledge.** While Fischer Communications was hired because of its social marketing expertise and experience working in African American communities, it was noted that this firm lacked familiarity and relationships with the African American communities of Solano County and within the health education field. All parties seemed to underestimate the amount of upfront time necessary to build rapport between Fischer Communications and Solano County communities. Even though SCBH and its Disparities Elimination Project already had well-established relationships with the County's African American communities, these relationships were initially not well-leveraged. However, as the project progressed, SCBH's relationships with and knowledge of Solano County's African American communities, as well as its knowledge of community health education, were better utilized to advance project goals.
- **Initial communication challenges slowed project implementation**. Communication between the Community Education Workgroup staff person and Fischer Communications was initially a challenge. This resulted in ambiguous expectations around roles and responsibilities, particularly in terms of recruitment support for identifying focus group participants, event facilitators, and community partners. However, following completion of the facilitator training event, communication between the two parties improved significantly, positively impacting the project's implementation.
- **Documentation of the Community Education Workgroup meetings is lacking**. The Community Education Workgroup met monthly from October through March 2008, but no meeting minutes or recorded information were kept. Therefore, our understanding of workgroup activities and its role in addressing the goals of Strategy 7 is not comprehensive, and is almost solely based on interview data from two respondents.

- **Sustainability plans for diabetes community education efforts were not clear to all stakeholders.** The Community Education Workgroup staff person indicated that future diabetes education work within the African American community in Solano County would continue under the auspices of SCBH's Disparities Elimination Project after this fiscal year. However, this was not made clear to Fischer Communications, as Fischer indicated that it planned to offer a set of recommendations to SCBH for additional resources needed, and suggestions for subsequent activities to support continued community diabetes education efforts. Had they been formally notified of SCBH's sustainability plans for diabetes education work, Fischer Communications might have better aligned its activities with those of the Disparities Elimination Project.

Recommendations

- **Streamline or improve the county's RFP process.** The cancellation of the original RFP in March 2007, and subsequent delays that prevented a contract being signed until December 2007, caused frustration for members of the Community Education Workgroup as well as SCBH and contractor staff. These delays also significantly slowed the process of providing diabetes education to the Solano County African American community. A more streamlined and improved RFP process, including stronger communication between the Community Education Workgroup, SCBH and Solano County's H&SS Department, might have allowed the project to begin much earlier.
- **Include communication protocols in the initial contract.** According to all parties involved, communications between SCBH, the Community Education Workgroup, and Fischer Communications were initially challenging and insufficient, resulting in project implementation delays, which at least partially contributed to low attendance at the community events. Communication challenges were partly due to lack of clarity around proper lines of communication, roles and responsibilities designations, and lack of regularly scheduled check-ins. While some of these items may have been outlined verbally, written documentation of these roles and responsibilities might improve communications between future contractors and SCBH or county staff.

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 the progress, successes, and challenges faced in the implementation of the seven MSA-funded strategies. In this final section, as we did in the 2006-2007 report, we will focus on the extent to which the five major goals of the 2005-2008 Health Access Strategic Plan are met by the seven strategies. We will first provide an update of our findings on the overarching successes and challenges related to the contribution of these strategies in 2007-2008 to achievement of the 2005-2008 Strategic Plan goals. We will then offer some feedback on the relationship of the MSA-funded strategies to the newly adopted Strategic Plan for 2008-2011. Finally, we will conclude by providing recommendations to supplement the recommendations already made in the sections focused on individual strategies.

Goal by Goal Assessment of Effects of the Strategies on the 2005-2008 Plan

Overall, as we found last year, the MSA-funded strategies have both directly and indirectly contributed to all five Strategic Plan goals. However, a few content areas and one broad group within the Plan's target population—low-income adults—continue to receive little direct focus by the strategies in 2007-2008. Although there are three strategies that 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. Further, there are three objectives related to adults that appear to be less emphasized: (1) enroll adults in health insurance and other health programs (under Goal 1); (2) retain adults and children in health insurance (under Goal 1); and (3) advocate 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.

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

The MSA-funded strategies, especially 2 and 4, have had a major effect on the County's ability to successfully achieve Goal 1, particularly children, ages 0-17. However, the funded strategies have been much less focused on increasing the number of adults enrolled in health insurance or linking them to affordable healthcare services.

- **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 Solano County is very low (4%), and in all likelihood, this success is due at least partly to the efforts of SKIP, which is supported by Strategy 2 and overseen by the Enroll and Retain Workgroup. Although the CHIS data was collected too early to reflect the effects of Healthy Kids Solano (HKS) (partially funded by Strategy 4), it is also likely that HKS is also increasing the percentage of insured children in the county, particularly among undocumented children. Through the efforts of SCBH staffing the Enroll and Retain Workgroup and HAC, Strategy 1 also contributed significantly to the efforts to set up HKS and generate additional funding for SKIP.
- **Due to major funding cuts, SKIP has been unable to focus on retention for more than a handful of children**. Despite attempting to significantly increase the number of children followed up with for retention purposes, SKIP was forced to cancel further implementation of those plans when the state cut a major OERU grant last summer. Consequently, for most of 2007-2008, SKIP staff were only able to conduct follow-up calls for retention and utilization purposes with 100 zero to five year-olds, representing less than six percent of all children assisted with enrollment between July 2007 and March 2008.
- **No funded strategies 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 are 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 estimated that 90.9 percent of Solano County adults 18 and over were insured as compared with 96% of children 0-17.

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[2] It is beyond the scope of this evaluation to directly connect 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] Between July 2007 and March 2008, SKIP assisted 156 adults with enrollment in Medi-Cal, two 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 July 2007, 53 adults had been referred to the Frequent User Project. An unknown number of these were assisted with enrolling in a health insurance programs such as Medi-Cal or CMSP. However, the project ceased operating at the beginning of October 2007 and is unlikely to begin operations until early in the next fiscal year.

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 this goal's breadth, all but Strategy 7 included activities that contributed to this goal. While several 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. This strategy operated for only the first three months of the 2007-2008 fiscal year.[4] The objective that was less directly related to MSA-funded activities was the one 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 effect on Objective a:** ***increase 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 except 7 is likely to have made a contribution, as follows:
  - Strategy 1: HAC and SCBH are annually involved in multiple efforts related to improving the county's primary care system.
  - Strategies 2 and 4: Enrolling uninsured residents 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 is aimed at helping the county health care system become more efficient and coordinated in treating patients suffering from chronic illnesses, behavioral health problems and housing instability. However, this project operated for only about a quarter of this fiscal year due to problems with hiring replacement staff.

[4] Strategy 1, through its support of SCBH's numerous activities, cuts across all of these areas.

- Strategy 6: The oral health care coordinator increases coordination between providers and payors by assisting children with obtaining needed oral health care.

- **Both Strategy 3 (expand behavioral health services), and Strategy 5 (Frequent Users) have likely had some effect on Objective b: *expand integrated behavioral health services at primary care sites and increase 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 only during the first three months of this fiscal year, made a small but important contribution to this objective. One of the main tasks of the project's clinician was 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,[5] 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) had an indirect effect on this objective.

- **SCBH efforts related to Strategy 1 are beginning to have an effect on Objective c: *increase the availability of medical specialty care services***. In 2007, SCBH received a grant from Kaiser to review the specialty care needs of the County and to develop a plan to resolve some of the specialty care access issues in Solano County. Kaiser will provide $147, 00 for the first year and approximately $300,000 for a possible second year. SCBH is planning to work with the Clinic Consortium and other community partners to develop such a plan.[6]

- **Strategy 6 is having a major effect on Objective d: *increase the availability of dental services* over the past year.** Through the implementation of numerous Strategy 6-funded activities, including the care coordinator and Gap Fund, the oral health public health campaign, oral health screenings at Paden Elementary, and fluoride varnish application for WIC children, MSA funds have been used to increase the availability of dental services in 2007-2008.

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[5] Of those clients for whom we have data.

[6] SCBH also added s strong focus on increasing access to specialty care to the 2008-2011 Health Access Strategic Plan. This is discussed in more detail below.

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.

Four MSA-funded strategies, Strategies 1, 2, 6, and 7 are likely to have contributed to Goal 3. In general, the activities implemented under these strategies mostly focused on providing accessible and appropriate educational materials, increasing cultural competency, and addressing beliefs, attitudes, knowledge, and experiences. There has been less focus on ensuring that health services are linguistically accessible. The contributions of the strategies to specific objectives are detailed below.

- **Strategy 2, via SKIP services, contributed to Objective a:** ***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.
- **Through SCBH's African American Disparities Elimination Project, Strategy 1 indirectly contributed to achievement of Objective b:** ***increase the cultural sensitivity and competency of key personnel throughout health system***. Although not funded directly by MSA, SCBH co-sponsored with the Solano County Medical Society the first ever Continuing Medical Education credit (CME) workshop for physicians and practitioners targeted at providing more effective services to the African American community. In addition, SCBH continued to partner and work with U.C. Berkeley and Touro University to develop programs for African American residents of Solano County interested in the healthcare field.
- **Strategies 2 and 6 both carried out activities in 2007-2008 related to Objective c:** ***provide 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 as well. In addition, as part of the oral health public health campaign, Strategy 6 will develop materials that are ethnically and

culturally appropriate for different populations and translated into various languages.

- **Strategies 1, 6 and 7 all conducted activities in 2007-2008 related to Objective d: *address beliefs, attitudes, knowledge, and experiences that negatively impact appropriate utilization of health services*.** Under Strategy 7, Fischer Communications held three events for the African American community aimed at addressing beliefs, attitudes, knowledge and experiences related to diabetes. Under Strategy 6, Hill and Company also began implementation of a public health 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 African American Disparities Elimination Project continued implementation of numerous activities related to addressing beliefs, attitudes, knowledge and experiences among African Americans that negatively impact appropriate utilization of health services. These included implementation of the Critical Mass Health Conductors (CMHC) project, carrying out the third annual *Champions for Healthy African Americans* event, and securing a grant to design a community health promotion campaign, including the *Million Pound Challenge.*

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.

Three MSA-funded strategies (Strategies 3, 5, and 6) contributed to attainment of Goal 4. In general, the activities of the funded strategies were aimed more at 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 a small group of adults with overcoming this challenge.

- **Strategies 3, and to some extent Strategy 6, involved activities that contributed to Objective a: *assure that there are adequate primary care services located throughout Solano County*.** Through its support of onsite behavioral health consultants at county clinics in Fairfield and Vallejo and at La Clinica in Vallejo, Strategy 3 has helped to ensure that basic behavioral health services are available in these communities. In addition, the oral health screenings provided at Paden Elementary in Vacaville ensured basic oral health services were available in that Vacaville community.
- **Strategy 5, in a small but critical way, helped achieve Objective b: *decrease transportation barriers which prevent residents from timely healthcare*.** For the first three months of this year, due to the efforts of the Frequent User Project

clinician who often drove clients lacking transportation to health care appointments, Strategy 5 decreased the transportation barriers faced by 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 MSA funding since they were carried out by SCBH and occurred outside of HAC and its workgroups. Objective d seemed to receive less focus than the other advocacy objectives.

- **Strategy 1, through its support of HAC, SCBH and the Health Access Strategic Plan, is the primary strategy that affected Goal 5 in FY 2007-2008.** Numerous activities undertaken by SCBH, both directly funded with MSA money, and leveraged from other sources, were related to each of Goal 5's objectives.
  - SCBH supported SKIP's efforts to *increase community awareness and understanding of the value of health insurance for all* (Objective a).
  - As part of the recommendations from the 2007 Safety Net Study, SCBH and its partners have begun to develop a plan to meet the projected demand for primary care throughout the county, which will likely include a need to *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 CHIs, such as HKS, throughout the state (Objective c).
  - Through its coordination of the Safety Net Study, to some extent, SCBH has also *advocated for expanded healthcare options for adults* (Objective d).
  - Finally, a prime focus of Strategy 1 has been *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 2007-2008 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.

Current MSA-Funded Strategies and the 2008-2011 Strategic Plan

Although this evaluation has focused primarily on the effect of the MSA-funded strategies on the 2005-2008 Strategic Plan, it is also useful to look ahead at how well the current MSA strategies fit with the new Strategic Plan for 2008-2011. This new Strategic Plan was developed in the summer and fall of 2007 and approved by HAC in January 2008. In general, the new Strategic Plan is fairly similar to the previous one, although it is somewhat re-organized and more focused. For example, instead of five objectives, the goal to advocate for increased healthcare access now has only two: one on the impact of health reform efforts and one aimed at ensuring that MSA funds continue to support the Strategic Plan. Additionally, the new Strategic Plan acknowledges the progress that has been made by workgroups over last three years. For example, some strategies in the new Strategic Plan call for on-going activities to continue (such as the Frequent User project) or be maintained (such as "health coverage for Solano County children who do not qualify for Medi-Cal or Healthy Families").

In addition to the continuity between the new Strategic Plan and the previous Strategic Plan, there were also three somewhat major additions to the new Strategic Plan that are not fully addressed by the current MSA-funded strategies. These include an increased focus on improving access to specialty care and pre-natal care, and decreasing inappropriate emergency room (ER) usage.

1) Focus on specialty care. One of the major additions to the new Strategic Plan is an increased focus on improving access to specialty care. While the previous Strategic Plan, included an objective under Goal 2 that called for an increase in medical specialty care services, in the new Strategic Plan specialty care has been made part of the Plan's "Global Aim." In addition, a new Goal 5, has been created that is focused entirely on increasing timely access to specialty care. This new goal has four separate objectives related to accessing specialty care. While Objectives 2 and 3 under Goal 5 (*increase access to specialty mental health services* and *increase the availability of specialty*

dental services for children), fit fairly well as part of the on-going activities of the Behavioral Health/Primary Care Integration Workgroups and the Oral Health Workgroup, Objectives 1 and 4 do not clearly relate to the work of any of the current MSA-funded strategies.[7]

2) Focus on pre-natal care. Another change in the 2008-2011 Strategic Plan is a new focus on pre-natal care. While pre-natal care was not mentioned in the 2005-2008 Strategic Plan, the new Strategic Plan contains an objective under Goal 2 to *Strengthen the network of prenatal care services* (Objective #4). In addition, under other Strategic Plan objectives, there are new strategies related to increasing access for pregnant women to behavioral health and oral health services. As with specialty care, the current MSA-funded strategies and workgroups focusing on behavioral care and oral health are well-positioned to address the strategies related to those areas. Indeed, the Behavioral Health/Primary Care Integration Workgroup has already begun to discuss how to train and support pre-natal providers to deal more effectively with behavioral health issues. However, no MSA-funded strategy is currently focused on strengthening the county's network of pre-natal providers, as called for in Objective 4, under Goal 2 of the new Strategic Plan.

3) Reducing inappropriate use of ERs. Finally, a third new component of the 2008-2011 Strategic Plan is a new objective under Goal 3 (*Increase appropriate use of health services*) to "Reduce inappropriate use of the emergency room." This new objective includes strategies to conduct an analysis of inappropriate ER use, study best practices related to preventing such use, and adoption by the county of one or more of those best practices. The only MSA-funded strategy with somewhat of a focus on reducing inappropriate ER use is Strategy 5. However, as only a portion of inappropriate ER usage is due to Frequent Users, the bulk of the work related to this new objective is not completely addressed within the current work of the Frequent User Workgroup.

Overall, the new Strategic Plan makes few major changes and thus most elements are effectively addressed by the MSA strategies. However, three new areas – specialty care, pre-natal care and inappropriate ER use – do not appear to be completely addressed. Consequently, HAC should review these new additions to the Strategic Plan and consider shifting MSA funds or other resources to ensure that they are addressed by either one of the existing workgroups or by other entities.

Overall Successes and Challenges

Overall, fiscal year 2007-2008 was a largely positive year for the implementation of the seven MSA-funded strategies. The Health Access Committee and its five workgroups were able to achieve important successes although, as detailed above, some

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[7] Objective 1 calls for an overall increase in the availability of specialty services while Objective 4 is aimed at increasing the capacity of primary care providers to effectively manage selected specialty care conditions.

challenges remain. In this final section, we discuss a few broader successes and challenges.

Successes

- **Most strategies were implemented as planned**. By the end of the year, most strategies had implemented at least some of the interventions and activities as planned. In addition, a majority were planning to expend all of their MSA funding. Given the significant challenges related to implementing new and innovative projects such as the MSA-funded strategies, this is an important achievement.
- **SCBH, HAC and four 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 1, 2, 4, and 5, the data highlight the effectiveness of health access-related programs in the county such as the Solano Kids Insurance Program, the Frequent User Project, and SCBH as a whole.

Challenges

- **Hiring staff and finalizing contracts was sometimes extremely challenging.** During fiscal year 2007-2008, several strategies faced significant delays in hiring staff or finalizing contracts to expend MSA funding. For example, both Strategies 5 and 6 faced delays in hiring county replacement staff, resulting in unspent MSA funds. For Strategies 3, 6 and 7, delays and problems with finalizing contracts between providers and the county also led to late implementation and unspent MSA funds. These delays and challenges have meant that Solano County residents did not have access to important health access services for much of the 2007-2008 fiscal year.
- **Turnover in staff has been challenging for implementation and data collection.** Staff in charge of implementation or data collection for several of the strategies left during the 2007-2008 fiscal year. This staff turnover, in some cases, caused both interruption of service delivery and data collection efforts, sometimes for extremely lengthy periods. Consequently, as in the case of Strategies 3 and 5, important data were not available for the evaluation.
- **Data collection practices continue to be problematic for strategies with relatively new interventions.** For Strategies 3, 5 and 6, data collection instruments and processes continued to be somewhat problematic in 2007-2008. For example, data reporting spreadsheets or templates for Strategies 3 and 6 lacked important information. In addition, data collection activities for on-site behaviorists for Strategy 3 were inconsistent. In other cases, data was simply not recorded or retained, as in the case of data on Frequent Users after March 2007 or academic detailing and consultation services under Strategy 3.

Overall Recommendations

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

- **Consider increasing focus on health care retention and utilization and consider focusing more on adults.** Due to the county's continuing success in achieving nearly 100 percent insurance coverage for children, HAC and the Enroll and Retain Workgroup should consider focusing more on retention and utilization in the future. Further, it might be appropriate for the county to increase its focus on increasing the percentage of adults with health insurance at some point.
- **Determine how to address the additions to the new Strategic Plan.** Because the current MSA-funded strategies do not fully address increasing access to specialty care, pre-natal care or reducing inappropriate ER use, the Health Access Committee should appoint appropriate groups and allocated required resources to focus on these new efforts.
- **Consider whether there are more expedient means of hiring staff or distributing funds to appropriate service providers or grantees.** Due to the issues related to finalizing contracts or hiring county staff for new projects, MSA, HAC, SCBH and the county might want to consider whether or not there are more expedient means of hiring staff or distributing funds to appropriate service providers so that valuable MSA resources are spent and unnecessary time does not pass. A major question for the county to consider is, are there alternative mechanisms for bringing staff on board and distributing the funds while still maintaining close county oversight and involvement for public accountability purposes?
- **Ensure data collection processes and instruments are complete and well-defined.** To ensure that both HAC and its workgroups have access to all data needed for program planning and management purposes, workgroups should ensure that data collection instruments and processes are clearly defined. Point people in charge of data collection should also be appointed and times for regular reporting of data at HAC or workgroup meetings should be scheduled.

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APPENDIX A:
Organizational Listing of Partners

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Appendix A.
Listing of Health Access Coalition Organizational Partners

California Dental Association Foundation
American Cancer Society
BARHI
Black Infant Health
Caminar Inc.
Child Start Inc.
Children's Network (CBO)
Clinic Consortium
Community Medical Centers
Daily Republic
Delta Sigma Theta
Dixon Unified School District
Fairfield Unified School District
Faith in Action
First 5 Solano
Kaiser Permanente
Kaiser Permanente/ Delta Sigma Theta
La Clinica de La Raza
Law Enforcement
Solano County Maternal Child Health Bureau
NorthBay Healthcare
Omega Boys and Girls Club
Pac Health
Partnership HealthPlan of California
Planned Parenthood
Smile in Style
Solano Coalition for Better Health
Solano County Department of Health and Social Services
Solano County Office of Education
Solano Kids Insurance Program (SKIP)
Solano Medical Society
Sutter Health
Sutter Solano Medical Center
Touro University
Tri-City Branch NAACP
UC Berkeley School of Public Health
United Way of the Bay Area
Vallejo Unified School District
VCUSC – Student Health Services
Youth & Family Services

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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.	Mental Health (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
	MH- 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
	Public Health (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
	Substance Abuse (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 PH- Black Infant Health	317,000
	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 Services 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

2005-2008 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.