Annual Impact Report

December 1, 2016 – November 30, 2017

Contra Costa CARES

Acknowledgements

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Executive Summary

Contra Costa CARES (CARES) enrolls low-income residents of Contra Costa County who are ineligible for other healthcare programs into a primary care medical home. LifeLong Medical Care, La Clínica de La Raza, and Brighter Beginnings provide primary care services and a variety of ancillary services to CARES participants. From the program's inception to date, Contra Costa County, Kaiser Permanente, John Muir Health, Sutter Delta Medical Center, and Alta Bates Summit Medical Center have committed $3M in combined funding, providing primary care access to nearly 4,000 individuals countywide.

During its second year of implementation (December 1, 2016 – November 30, 2017), CARES made important strides in transitioning into a fully operationalized pilot program; and continued to play a valuable role in the Contra Costa County healthcare system through providing a coordinated model of primary care coverage for the county's remaining uninsured.

Key Findings

From the program's inception to-date (December 1, 2015 to November 30, 2017), 3,996 individuals have enrolled in CARES, accounting for over 10,000 visits. Forty-nine percent of CARES participants who have been seen for visits are living with chronic conditions. The most common diagnoses include asthma, diabetes, hypertension, and chronic pain of the back, joints, and muscles. Twenty percent of all CARES visits were related to diabetes diagnosis and management, and 29% of CARES participants with visits were seen six or more times while enrolled. CARES continued to act as an on-ramp to comprehensive coverage for participants. To date, 580 CARES participants have transitioned to full-scope Medi-Cal.

In the program's second year, 1,496 participants renewed their enrollment, or re-enrolled, into CARES. Between June and November 2017, 897 new participants were enrolled into the program. To increase program visibility, the Consortium, in partnership with health centers and partner organizations, launched widespread outreach and enrollment efforts to educate the community on CARES.

Emergency Department Utilization

Emergency Department (ED) usage, among a cohort of 2,523 continuously enrolled CARES participants, was studied pre and post-CARES enrollment to examine whether visits to the ED were considered necessary. Data from Contra Costa Regional Medical Center, John Muir Health, and Kaiser Permanente was included. Key findings include:

- Few avoidable ED visits – The majority of CARES participants (96.6%) were seen in the ED for non-avoidable visits (true emergencies) in the pre or post periods of the study. Only 1.9% had an avoidable visit while enrolled in CARES (52 visits). Only three patients had an avoidable visit both pre and post enrollment.

- Concurrent use of primary care – Patients with an avoidable ED visit post-enrollment also accessed primary care at a higher rate (6.1 visits) than the entire cohort (4.1 visits). A smaller subset of 20 patients had both at least one avoidable *and* one non-avoidable ED visit and could potentially benefit from targeted intervention.

- Findings are consistent with national trends – Aggregate hospital data shows that both non-avoidable and avoidable ED visits increased post-CARES enrollment. This finding reflects national trends that demonstrate an increase in ED usage among newly insured-individuals.

Participant Feedback

Interviews with a small, select group of CARES participants revealed more about the program's impact:

- All participants interviewed reported that Contra Costa CARES has had a positive impact on their lives. They were better able to access medical care due to the elimination of co-pays for appointments, which reduced stress levels. CARES has been particularly effective at helping enrollees manage chronic illness. Participants reported feeling a high level of trust with their doctor and hope after receiving treatment at their primary care homes.

- Most participants who were interviewed reported having a difficult time accessing and following through with health care before enrolling in CARES due to financial barriers. Participants said they rarely sought treatment when they felt sick; did not always adhere to recommended use of prescription medications; self-medicated; and regularly missed scheduled appointments.

- Participants cited possible barriers to full enrollment, including fear of deportation; a lack of awareness of the program; a lack of transportation; and an absence of current symptoms requiring medical attention.

Next Steps

- On-going Outreach Efforts – Going into the third year, the Consortium has trained volunteer health promoters from member clinics countywide. Health promoters serve as trusted community leaders who educate their peers about a variety of health topics and resources. Additional communications approaches include working with media, traditional advertising strategies, and increased social media.

- Coordinated Hospital Referrals – The Consortium is looking into different access points for CARES referrals through hospital emergency departments. The goal is to strengthen existing systems to incorporate CARES referrals efficiently. A point-of-contact at clinics would facilitate a warm handoff.

- Increased Specialty Care Options – The Access to Specialty Care workgroup identified stress testing as a priority specialty care service to offer to CARES participants. A referral pathway and providers have been identified for implementation in year three.

- Review of Income Eligibility Guidelines – Feedback from enrollment counselors indicates that some patients' incomes are only slightly higher than the program's income eligibility threshold, leaving them ineligible for CARES, and without any coverage options. The Consortium and program stakeholders are reviewing income eligibility guidelines and practices for comparable programs throughout California to ensure broad and equitable coverage for low-income individuals.

- Expanded Qualitative Analysis – Qualitative surveys will be implemented in year three to better evaluate CARES enrollee experiences and patient satisfaction.

I. Program Overview

Contra Costa CARES (CARES) enrolls low-income residents of Contra Costa County who are ineligible for other healthcare programs into a primary care medical home. LifeLong Medical Care, La Clínica de La Raza, and Brighter Beginnings provide primary care services and a variety of ancillary services to CARES participants. Member health centers receive a per-member-per-month payment for program participants. Specialty care, emergency care, mental health, vision, and dental care remain outside the purview of the program. Approximately 28,000 individuals in the county are estimated to qualify for the program.[1]

The CARES Program launched in November of 2015 and received $1M of combined funding from Contra Costa County, Kaiser Permanente, John Muir Health, and Sutter Delta Medical Center. The program's goal was to provide coverage for a 12-month period to approximately 3,000 individuals. In April 2017, the Contra Costa County Board of Supervisors approved CARES funding for fiscal year 2017/18, and expanded program funding by fifty percent. This funding commitment was matched by local hospitals. Expansion funding created additional enrollment slots, bringing total program capacity up to 4,100 participants. An additional $1.5M has been committed for FY 18/19, which will sustain the availability of primary care coverage for more than 4,000 individuals countywide. One hundred percent of CARES funding goes directly to the provision of primary care services. Contra Costa Health Plan (CCHP) provides pro bono program administration and a 24-hour Nurse Advice Line, while the Consortium provides ongoing data collection and evaluation; outreach and communications; and convenes program workgroups out of general operating expenses.

During its second year of implementation (December 1, 2016 – November 30, 2017), Contra Costa CARES made important strides in transitioning into an efficiently operationalized pilot program. The CARES Year One Report highlighted several next steps including data collection, patient education, increased access to specialty care, and sustainable funding. Over the past year, the program incorporated new strategies to meet these goals, and has continued to demonstrate the effectiveness of a collaborative system that connects community health centers (CHCs) with the Contra Costa Health Plan (CCHP) to enroll residents in a primary care medical home. The program has taken on unique challenges and has continued to fill a valuable role in the Contra Costa County healthcare system by providing a model of primary care coverage for the county's remaining uninsured. Furthermore, the program's extensive collaboration and data sharing among health system partners creates an opportunity to learn more about the health status and healthcare utilization patterns of a community that has been historically underserved and faces multiple barriers to accessing care due to immigration status, language barriers, and financial constraints.

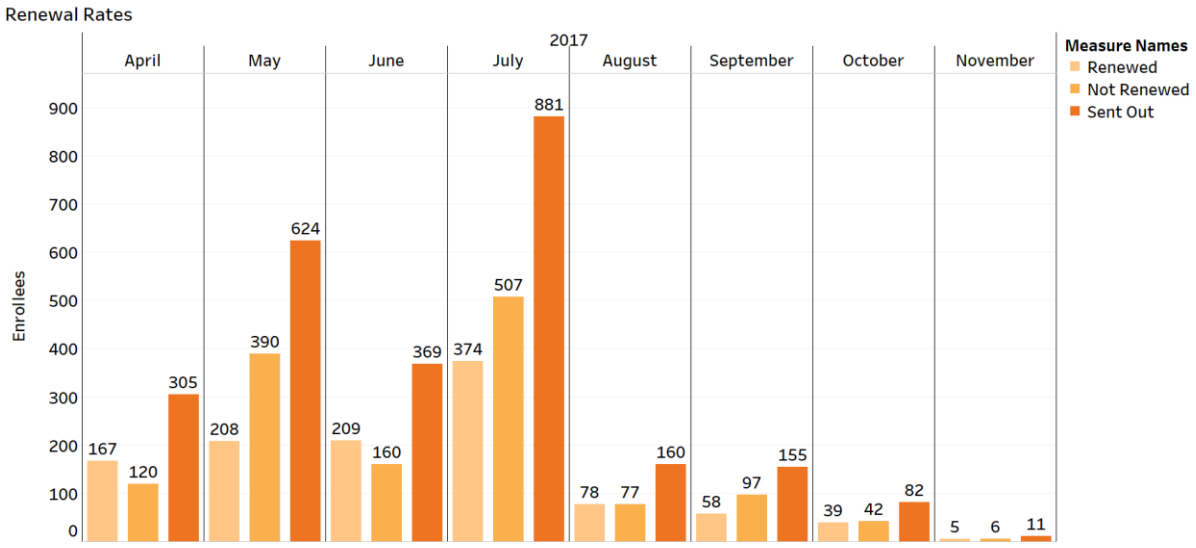
II. Year in Review

Outreach and Enrollment

The extension of program funding initiated the first redetermination period for CARES enrollees. Program enrollment happens on a rolling basis, and benefits are granted for 12-months. Participants receive a renewal notice 60-days in advance of the end of their benefit period. If an individual fails to apply for program renewal, or no longer meets the program's criteria, their enrollment status is terminated and the slot becomes available for a new participant. Participants who do not complete their renewal application before their termination date must complete a new enrollment application. If they meet eligibility criteria they are admitted into the program, provided slots are available.

From June through September 2017, an average of 436 CARES enrollees were due to renew each month. Enrollees received a letter from CCHP with their renewal date and requirements to renew, then CHC staff followed up with each patient up to three times to schedule an appointment for program re-enrollment. Given the pace of re-enrollment over a short period, the process required significant staff time. Participating CHCs did not have dedicated funding to support the renewal process. Through the end of the 2017 program year there was a 46% renewal rate across participating health centers.

Figure 1. CARES enrollees scheduled to renew from April 2017 to December 2017



**Note – Renewal notices were sent out 30 days in advance of a participant's renewal deadline from April – June (due to renew from May – July). This was changed to 60-days advanced notice in July 2017.*

CHC enrollment counselors tracked primary reason codes for program terminations and found that the majority of terminations resulted from participants not completing the renewal process or enrollment counselors not being able to contact them. In addition, 18% of terminated participants were ineligible for program renewal because they had gained coverage through Medi-Cal, or other health coverage options; 8% of participants had income over the income eligibility threshold of 138% ($33,600 for a family of 4); and, a smaller fraction of participants moved out of the area.

The Consortium facilitates monthly outreach and enrollment calls with member clinics and county analysts to discuss renewal and enrollment concerns and create strategies to address challenges. During such calls, a common concern was the immigrant community's fear of deportation. The Consortium learned that anxiety throughout the community was affecting renewal and enrollment rates for both CARES and other benefit programs. Health center enrollment counselors reported incidents of participants who were due to renew, but declined, citing fear of deportation and concern that their personal information would be shared.

Recently published reports have substantiated this anecdotal pattern.[2] During the program year, a new administration was ushered into Washington D.C., bringing a shift in the goals and priorities of federal immigration authorities. Federal actions included widespread detention and deportation of undocumented immigrants, the rescission of DACA, and seeking to restrict safety net services for non-citizens. These actions have perpetuated a fear-based narrative that has reverberated throughout immigrant communities, including the local community served by Contra Costa CARES. Due to the

anticipated and implemented changes in federal immigration policy, many undocumented individuals and mixed-status families have begun to minimize their public exposure for fear of deportation. This has resulted in fewer individuals accessing services and, in some cases, opting to drop health care and other social services. In a survey on immigrant children's and families' access to care and overall health, conducted by The Children's Partnership and the California Immigrant Policy Center, California health care providers reported: a 90% increase in anxiety and fear due to detention and deportation; a 42% increase in skipped scheduled health care appointments; a 50% increase in anxiety and depression symptoms; and a 67% increase in concerns about enrollment in Medi-Cal, WIC, CalFresh and other public programs, while 40% expressed interest in opting out of these programs.[3] This trend is expected to continue and increase based on further anticipated actions at the federal level.

In the first year of the program, CARES remained relatively unknown within its target community. The program reached capacity quickly, so outreach was not a priority until expanded funding and the first renewal period created an opportunity for more community education around CARES. During the program's seconds year, the Consortium began working closely with CARES program collaborators and community partners to create a comprehensive, and on-going communications campaign. The campaign seeks to educate Contra Costa community members about the program and the safety of sharing their personal information when enrolling.

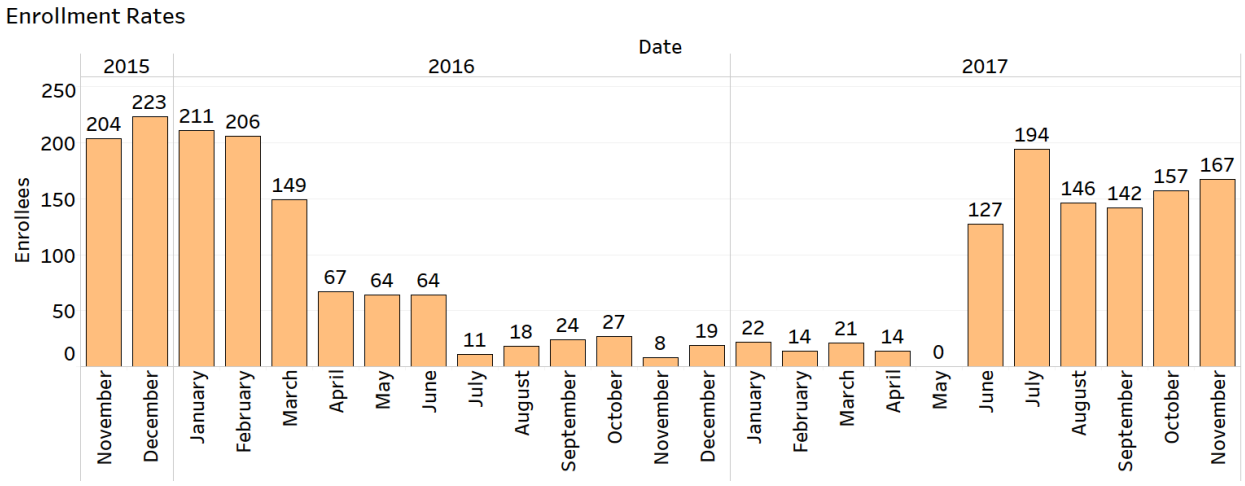
In 2017, the Consortium led grassroot outreach efforts in West Contra Costa County in collaboration with LifeLong Medical Care's health promoters. The Consortium and health promoters distributed information and presented to local community-based organizations, places of worship, and public and charter schools. All materials used in outreach initiatives were bilingual, available in Spanish and English. Positive feedback was provided by both the institutions and community members where outreach was conducted. Other communications strategies included the creation of streamlined CARES print collateral such as brochures, posters, and buttons, as well as Spanish-language social media pages to share information about CARES (and other health-related topics). Entering the third year of the program, planned outreach includes a greater focus on Central and East Contra Costa County, paid advertising, and a partnership with Stand Together Contra Costa – a rapid response legal service and community education project for immigrant families.

Program Data

In the second program year, the Consortium worked with partner health centers and hospitals to build a sustainable infrastructure for sharing CARES data. HIPAA training and compliance procedures were developed to ensure security for more complex data sharing. Quarterly data sharing meetings, and one on one troubleshooting sessions allowed for greater communication and strategies between the Consortium, CCHP, health centers, and hospitals. The Consortium invested in data visualization software to create health center-specific dashboards that display CARES enrollment totals, participant demographics, regional distribution, and encounter-level data. This enables Consortium staff to learn from frequent monitoring and dashboarding of data and troubleshoot program barriers more fluidly.

Despite the very real impacts the current political climate has had on immigrant communities, a significant number of residents have enrolled at each health center. From the inception of the program (December 1, 2015 to November 30, 2017), a total of 3,996 residents have enrolled into CARES: 1,685 participants at LifeLong, 1,996 at La Clínica, and 324 at Brighter Beginnings.[4] Over the course of the program, participating health centers have provided 10,413 primary care visits to enrollees. To date, 580 CARES participants, or 31% of individuals who were no longer qualified for the program, transitioned to full-scope Medi-Cal. Medi-Cal provides more comprehensive coverage for patients, yet participants are

Figure 2. Monthly CARES enrollment from December 1, 2015 to November 30, 2017.



**Note – Full program capacity was reached in June 2016. From July 2016 through May 2017, a minimal number of slots became available monthly due to program terminations, primarily from participants who transitioned onto full scope Medi-Cal. Because extension funding was granted through May 2017, some participants received 18-months of benefits before their first renewal was required. The first month of eligibility redeterminations took effect in June 2017.*

still able to remain in the primary care medical home they were originally enrolled at for CARES, allowing for continuity of care. In year two, 1,496 CARES participants retained primary care coverage through successfully renewing their enrollment. Between June and November 2017, 897 new participants were enrolled into the program.

Most CARES participants are working age, female identifying adults, who live in family sized households. Fifty-seven percent of enrollees are ages 36-65, 60% are female, and 94% are Latino. Fifty percent live in households of 4 or more people, while 13% live in single-person households. Ninety-seven percent of CARES enrollees are working age adults.

Figure 3. Age of CARES enrollees (December 1, 2015 to November 30, 2017)

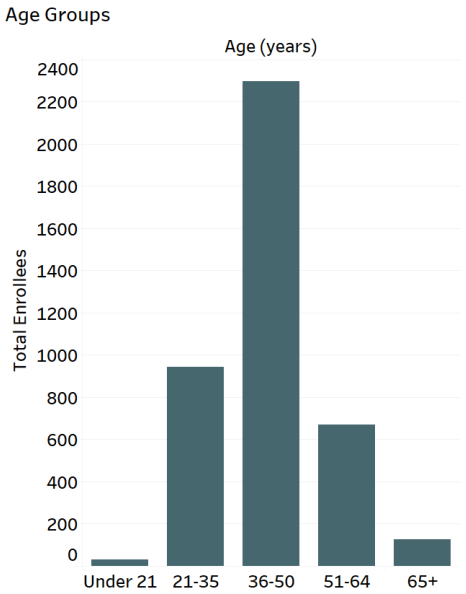
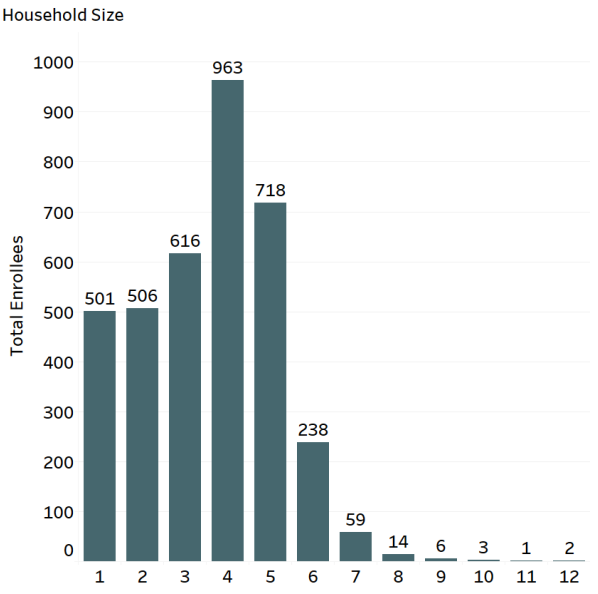
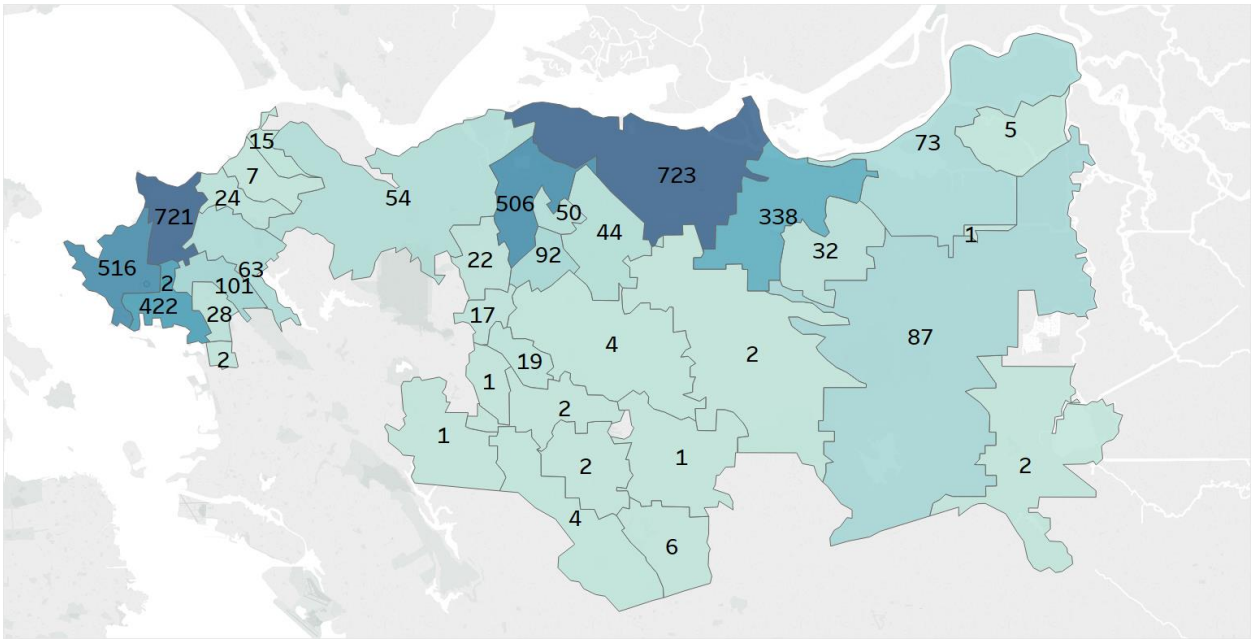


Figure 4. Household size of CARES enrollees (December 1, 2015 to November 30, 2017)



In the first year of CARES, enrollees were primarily residents of West Contra Costa County, followed by Central, then East. Overtime, the distribution of residents between West and Central County evened out, and there has been a modest increase in CARES enrollees living in East County.

Figure 5. Zip code distribution CARES enrollees (December 1, 2015 to November 30, 2017)



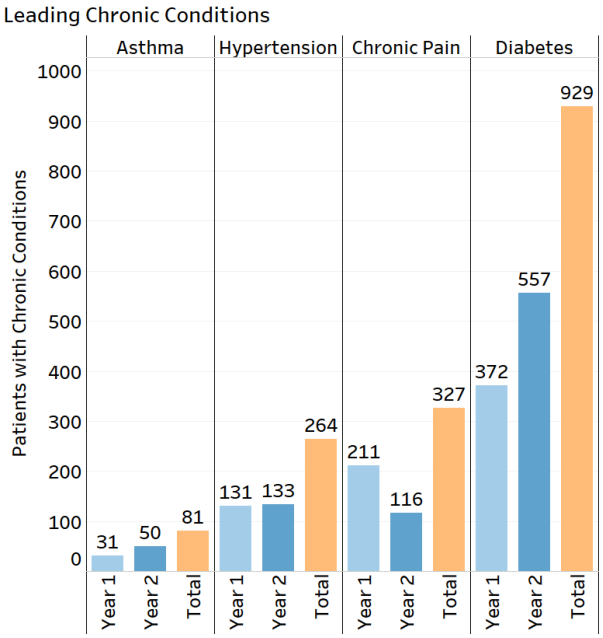
A current improvement effort is underway to assess continuity of care. Data indicates there are potentially 1,698 CARES enrollees without a documented primary care visit. It remains unclear, however, if these participants came in for a primary care appointment on the same day they applied for the program. If so, they are not reported in CARES data because their enrollment status technically began in the following month. Efforts to clarify the data and to improve primary care participation will continue in year three.

Health centers coordinated with CCHP, hospitals, and Operation Access to arrange pro-bono specialty care for program members. Specialty care is not currently covered by the CARES program, but Operation Access provides enrollees with specialty and vital surgical appointments. Since the inception of the program, Operation Access has provided 515 specialty care visits to CARES participants. The most common visits are related to gastroenterology, gynecology, ophthalmology, and general surgery for a cyst mass. Stakeholders are continuing to address how to provide specialty care needs for the CARES population.

Chronic Conditions

Forty-nine percent of CARES participants who come in for visits live with chronic conditions.[5] The most common CARES visits are related to asthma, diabetes, hypertension, and chronic pain of the back, joints, and muscles. Twenty percent of all CARES visits are for diabetes diagnosis and management. Nearly 20% of visits from the inception of the program involved prevention, monitoring, or immunizations, and 6% were related to mental health.

Figure 6. Most common chronic condition diagnoses for CARES enrollees with visits (December 1, 2015 to November 30, 2017).



Chronic conditions are a primary driver of high costs of care in the US. The Centers for Disease Control and Prevention estimate that 86% of the nation's $2.7 trillion annual health expenditures are attributed to individuals with chronic and mental health conditions.[6] For diabetes alone, the total estimated cost of diagnosed diabetes was $327 billion in 2017. This includes $237 billion in direct medical costs, and another $90 billion in reduced productivity.[7] Studies show that patients with health coverage, and an established source of care are more likely to have their chronic disease diagnosed and in control, lowering costs across health systems.[8] Through their health home, CARES participants have access to multi-disciplinary teams and services to help manage chronic conditions. Along with primary care providers, these can include pharmacists, health promoters, health education classes, (e.g. diabetes management or healthy eating and nutrition), lab testing, and appropriate medications when necessary. Many disease management programs have shown success in improving self-care practices and reducing the use of a variety of healthcare services, such as hospital admissions and emergency department visits, decreasing the overall cost of care.[9]

Emergency Department Utilization

Partners formed a Hospital Data Sharing Workgroup to study CARES participant's Emergency Department (ED) utilization countywide. ED visits were analyzed for a cohort of 2,523 CARES participants continuously enrolled for at least 12 months (the study group). A continuously enrolled cohort method was used to improve the validity of the findings. With data provided by Contra Costa Regional Medical Center, John Muir Health, and Kaiser Permanente, ED visits for enrollees in the study group were compared over pre-enrollment/ post-enrollment time periods to determine overall ED utilization. Analyses also identified potentially avoidable ED visits for the study group.

There are multiple methodologies for identifying potentially avoidable ED visits and there was no single methodology already in use across participating hospitals. Therefore, for the current inquiry, potentially avoidable visits are reported using a method developed by the California Department of Health Care Services Statewide Collaborative Quality Improvement Project Reducing Avoidable Emergency Room Visits, and subsequently implemented by The Oregon Health Authority (the state health department). The methodology focuses on 165 diagnosis codes that made implementation feasible without an additional data analysis burden on local partner hospitals, and targets diagnoses useful to a quality improvement effort. Hospitals were active participants in developing the data collection protocol and discussing findings from analyses.

Figure 7. Total emergency room visits for CARES study group (Pre: June 1, 2014 to May 31, 2015; Post: June 1, 2016 to May 31, 2017).

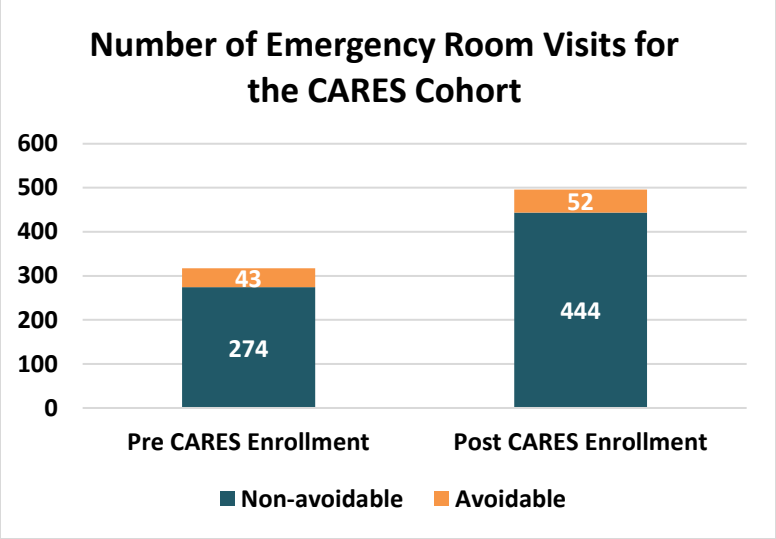


Figure 7 shows the total number of ED visits reported by the hospital systems for the study group of patients during pre-post enrollment periods and compares potentially avoidable to non-avoidable visits. This analysis found higher overall visits and higher potentially avoidable visits in the post-enrollment period. This finding reflects national trends that demonstrate an increase in ED usage for newly insured-individuals. While this phenomenon continues to be studied, a 2016 article from the New England Journal of Medicine estimates that newly insured individuals will "most likely use more health care across settings – including the ED and hospital – for at least 2 years and that expanded coverage is unlikely to drive substantial substitution of office visits for ED use."[10] Longer-term studies indicate that ED usage may decline over a period of several years after pent-up demand subsides. This pattern highlights the on-going importance of patient education on how to access primary care services, and care coordination between hospital and outpatient settings. Other documented findings include:

- Of all 2,523 study group cohort enrollees, 19% of enrollees utilized a hospital ED in the pre or post enrollment period (813 visits total).
- The majority of CARES participants (96.6%) were seen in the ED for non-avoidable (necessary) visits in the pre or post periods of the study. Few enrollees (3.4%) had an avoidable visit in the pre or post periods of the study (total of 95 visits) and only 1.9% had an avoidable visit while enrolled (52 visits). Most of the patients with at least one avoidable ED visit had only a single visit (~90%). Only three patients had an avoidable visit both pre and post enrollment.
- There is some data to suggest CARES includes a group of individuals who would benefit from targeted intervention. Within the cohort, patients with an avoidable ED visit post enrollment also utilized health centers with higher average visits (6.1 visits) compared to the entire cohort (4.1 visits). A smaller subset of 20 patients appears to be relatively frequent utilizers of services (both hospital and primary care). These patients had both at least one avoidable and one non-avoidable hospital ED visit and averaged 8.6 health center visits, indicating either higher health risk among these individuals, and/or a pent-up demand for health care services from delaying or foregoing care prior to gaining access to coverage.

Figure 8 displays the diagnostic groupings most often documented for avoidable and non-avoidable pre-post ED visits. Respiratory conditions were the most common grouping for avoidable ED visits.

Figure 8. Most common avoidable and non-avoidable ED visit diagnostic codes for CARES study group (Pre: June 1, 2014 to May 31, 2015; Post: June 1, 2016 to May 31, 2017).

Non-avoidable			
Cohort	**Diagnosis Code**	**Code Description**	**Frequency**
Pre	789.00	Abdominal pain	7%
	789.06	Abdominal pain, epigastric	3%
Post	R07.89	Other chest pain	4%
	R10.9	Abdominal pain, unspecified location	4%
	R10.13	Epigastric pain	4%
Avoidable			
Cohort	**Diagnosis Code**	**Code Description**	**Frequency**
Pre	784.0	Headache	19%
	465.9	Upper respiratory infection	16%
	784	Headache	12%
	462	Pharyngitis	9%
Post	R51	Unilateral headache	17%
	M54.5	Low back pain	15%
	J06.9	Acute upper respiratory infection, unspecified	13%
	N39.0	Urinary tract infection, uncomplicated	13%

Participant Feedback/Interviews

Consortium staff conducted a series of interviews with a small, select group of CARES participants to learn more about the direct impact on participants' lives. Interviews were targeted to inform program improvement and offer informal, qualitative information about CARES; they were not a random sample.[11] Participants who frequently accessed primary care, and enrollees with no visits were selected for one on one in person interviews. Interviews were conducted at the patient's participating primary care clinics and were recorded for transcription later. All responses were translated from Spanish to English.

During the interviews, CARES Program participants shared their personal experience with access to healthcare. They highlighted the impact CARES enrollment has made on their health, especially relating to chronic condition management. Participants reported a positive experience accessing health care after enrolling in Contra Costa CARES and reported receiving more consistent medical treatment to manage their chronic health condition due to financial coverage of medical visits. Participants also reported that they felt a high level of trust with their primary care doctor, and that they received quality medical treatment. Many appreciated that their provider spoke Spanish. Half of CARES interview participants reported they used the emergency room before enrolling in CARES and did not go to the emergency room after enrolling in CARES.

Participants spoke about their difficulty accessing care prior to enrollment in the program, citing inability to make appointments, obtain preventive care, and afford medications. Comparing access to healthcare before and after CARES enrollment, participants said:

- *...there were times that I was ill and did not go to the doctor because I did not have the money to pay for the appointment. Sometimes I would come in, but I would have to make payments. I did not come to my appointments frequently. I would endure my illnesses, because there were times I did not have money.*

Access and adherence to medications remains a mixed story for CARES enrollees. Participants who receive discounted pharmacy pricing through their health centers report improved medication adherence. However, not all health centers participate in discount drug pricing programs, and not all medications are offered at a reduced rate. This context can create wide variations in the cost of medications for enrollees.

One patient put it this way:

- *I have this [program to purchase medicines at a discount] for my diabetes. I have two types [of medicine] that they have prescribed here [at Brookside] for my cholesterol… and it is very, very affordable, in comparison with other pharmacies. I have two medicines that I purchase from [another] pharmacy. [Those medicines] are still very expensive.*

Participants describe the emotional toll of living in the current political climate:

- *I feel really stressed out, like I can't go out. I don't want to go out, thinking that ICE will arrive. I feel worried, and when I go out, I feel traumatized. I can't sleep at night, thinking they are going to break into my house. I feel bad...that is why I don't [apply] for other programs, because I am scared that they will investigate me.*

When asked about improvements to the CARES program, some suggest adding coverage for vision or specialty care, but the overwhelming majority mentioned dental care as their greatest need.

- *It has been 12 years since I have had a teeth cleaning. One tries to take care of himself, to brush and floss, but a teeth cleaning is still needed. If the prices were more accessible I would go each year for a dental checkup. Look [showing a chipped tooth]. This tooth is chipped; I have some molars that hurt when I drink cold or hot beverages. I know something is wrong there. I am still*

here- uncomfortable. I am used to it now. When I lost that piece, I didn't want to laugh because I was embarrassed. Now, I forget that I don't have my tooth. But it is very difficult.

III. Next Steps / Conclusion

Over the past year, Contra Costa CARES grew into a fully operationalized pilot program. The Consortium and community partners prioritized a robust data infrastructure; patient and community education; in-reach and outreach strategies; streamlined renewal processes; and sustainable funding. The CARES program has continued to be a valuable resource for the remaining uninsured population in Contra Costa County, making an impact on the lives of residents who had no previous healthcare options. The program relies on the strength of collaborative relationships between CHCs, hospitals, CCHP, community members, the Board of Supervisors, and partner organizations, and exemplifies the importance of an integrated county-wide healthcare system in Contra Costa County.

Next steps for the program include:

- On-going Outreach Efforts – CARES experienced unexpected growing pains in its second year due to a changing political climate and limited staff capacity during the initial renewal process. The program continues to have available enrollment slots and will continue exploring new strategies over the next program year to ensure eligible individuals are connected to care. Going into the third year, the Consortium has begun training volunteer health promoters from member clinics in East and Central county. Health promoters serve as trusted community leaders who educate their peers about a variety of health topics and resources. As outreach opportunities grow, the Consortium is committed to building an infrastructure that allows several presentations to occur at once, by working in partnership with member clinics and their health promoters to realize this structure. More traditional forms of paid advertising and earned media will be tested as well in the coming year. It should be noted that a limiting factor to robust communications is a lack of on-going, dedicated funding stream available for CARES outreach and enrollment strategy implementation.

- Coordinated Hospital Referrals – The Consortium is also looking into different referral access points for CARES at hospital emergency departments. The goal is to strengthen existing referral systems to incorporate CARES referrals efficiently. Future meetings with hospitals and CHCs will inform the structure of the referral process.

- Increased Specialty Care Options – Going into 2018, Operation Access will be accepting Contra Costa CARES participant referrals for stress tests. This was accomplished through the Access to Specialty Care workgroup meetings, in which Operation Access was able to create a referral workflow chart to streamline the referrals. Stress tests are provided by volunteered doctors, and John Muir Hospital. Providers identified and prioritized specialty care treatments and departments so that the workgroup could focus on one item at a time. The workgroup will continue to meet to expand access to specialty care services for CARES participants.

- Review of Income Eligibility Guidelines – Feedback from enrollment counselors indicates that some patients' incomes are just above the program's income eligibility threshold, leaving them ineligible for CARES, and without any coverage options. Based on the high cost of living in Contra Costa County, along with a rising minimum wage, many Bay Area individuals and families can struggle to make ends meet while making well over the Federal Poverty Level (FPL). Additionally,

because CARES offers a limited scope of benefits, many patients are required to cover significant medical expenses out of pocket such as medications and dental care. The Consortium and program stakeholders are reviewing income eligibility guidelines and practices for comparable programs throughout California to ensure broad and equitable coverage for low-income individuals. Possible solutions could include raising the income eligibility threshold or implementing a standardized monthly deduction to off-set additional monthly medical expenses not covered by the program.

- Expanded Qualitative Analysis – In the second year of CARES, the Consortium prioritized a sustainable data infrastructure. This infrastructure consisted of regular data meetings, implementation of data sharing best practices, HIPAA trainings, and the investment in data analytics and visualization software for CHC and hospital dashboarding. The current data focuses on quantitative measures and, in the future, the Consortium plans to analyze more qualitative findings. One next step includes the incorporation of qualitative surveys to better evaluate CARES enrollees' experiences. Additionally, the Consortium will work toward continued improvement of CHC dashboards. Data will be updated in the dashboards more frequently to allow for consistent program feedback and analysis. The program will continue to improve on both quantitative and qualitative CHC and ED cohort data collection, with the goal of beginning to document health outcome measures, along with the program's contribution to the capacity of the safety net.

Contra Costa CARES continues to be a valuable program for the county and its residents. In the past year it has been regarded as a successful model of primary care coverage for undocumented adults,[12] who make up the majority of California's remaining uninsured.[13] The Consortium and program partners are committed to building on the program's success as it enters its third year of operation to ensure that this population continues to be integrated into the broader healthcare delivery system in Contra Costa County.

Notes:

1. Indiana University, Kelly School of Business, Indiana Business Research Center using data from 2014 Census: American Community survey.

2. Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: a literature review. *Risk management and healthcare policy*, *8*, 175.

3. *California Children in Immigrant Families: The Health Provider Perspective.* [PDF]. (2018, April 12). Los Angeles: The Children's Partnership. www.childrenspartnership.org. Retrieved 12 Apr. 2018, www.childrenspartnership.org/wp-content/uploads/2018/03/Provider-Survey-Inforgraphic-.pdf.

4. Discrepancy is due to nine residents who re-enrolled at a separate clinic and are, therefore, counted once at each clinic they enrolled at. All other data points are from the sample of 3,996 non-duplicated participants.

5. Chronic Conditions Data Warehouse. (2018). Retrieved from https://www.ccwdata.org/web/guest/condition-categories; Chronic conditions experienced by CARES participants include: acute hyperthyroid-ism, anemia, asthma, atrial fibrillation, diabetes, chronic pain, heart disease, hypertension, kidney disease, depression, benign prostatic hyperplasia, hyperlipidemia, osteoporosis, arthritis, and stroke.

6. Chronic Disease Prevention and Health Promotion. (2017, June 28). Retrieved from http://www.cdc.gov/chronicdisease/overview/index.htm#ref17**.**

7. American Diabetes Association. (2018). Economic Costs of Diabetes in the US in 2017. *Diabetes Care*, *41*(5), 917-928.

8. Wilper, A. P., Woolhandler, S., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2009). Hypertension, diabetes, and elevated cholesterol among insured and uninsured US adults. *Health Affairs*, *28*(6), w1151-w1159.

9. "Disease Management Programs: Improving Health While Reducing Costs?" *Health Policy Institute | Georgetown University*, Jan. 2004, hpi.georgetown.edu/agingsociety/pubhtml/management/management.html.

10. Finkelstein, A. N., Taubman, S. L., Allen, H. L., Wright, B. J., & Baicker, K. (2016). Effect of Medicaid coverage on ED use—further evidence from Oregon's experiment. *New England Journal of Medicine*, *375*(16), 1505-1507.

11. Thirty-seven CARES enrollees were contacted for interviews, with participants from each primary care medical home. Six individuals participated in interviews: five were frequent users of primary care, and one was enrolled in CARES, but had not been seen for a clinical visit.

12. *County-Based Coverage for Adult Immigrants: A Proposal for Counties in Washington State. Northwest Health Law Advocates*, 19 Apr. 2018, nohla.org/index.php/county-based-h-c-adult-immigrants/.

13. *Fact Sheet: Remaining Uninsured in California*. www.itup.org/wp-content/uploads/2017/08/ITUP-Remaining-Uninsured.pdf.