Contra Costa CARES

Annual Impact Report

December 1, 2017 – November 30, 2018

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ACKNOWLEDGEMENTS

This report was prepared by the Community Clinic Consortium (special thanks to Charley Yan and Laura Sheckler), and independent consultant Laura Hogan. We want to thank key stakeholders who provided critical data to produce this report: Contra Costa Health Plan, LifeLong Medical Care, La Clínica de La Raza, Brighter Beginnings, John Muir Health, Kaiser Permanente, Sutter Health, Contra Costa Regional Medical Center, and Operation Access.

This project was made possible thanks to the generous support from Contra Costa Health Services, Contra Costa Health Plan, Kaiser Permanente, John Muir Health, Sutter Delta Medical Center, Alta Bates Summit Medical Center, John Muir/Mt. Diablo Community Health Fund, The California Endowment, The California Wellness Foundation, Sunlight Giving, and Blue Shield of California Foundation.

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EXECUTIVE SUMMARY

Contra Costa CARES (CARES) provides low-income community members in Contra Costa with primary care medical home services. Three community health centers – La Clínica de La Raza, LifeLong Medical Care, and Brighter Beginnings – provide primary care services to CARES enrollees. From the program's inception to date, Contra Costa County, Kaiser Permanente, John Muir Health, and Sutter Delta Medical Center have committed $4.5M in combined funding, providing primary care access to more than 5,000 individuals countywide. Annual reports are developed to illustrate program impact, share findings regarding the health status of participants, and demonstrate program advancement towards its goal of providing access to quality healthcare for the remaining uninsured living in Contra Costa County.

As the program finishes its third year (December 1, 2017 – November 31, 2018), CARES has established itself as a valuable resource for low-income community members ineligible for other healthcare programs, offering coordinated primary care services to more than 5,000 individuals and accounting for over 18,000 visits to date. Approximately 60% of CARES enrollees had one or more primary care visits and more than half of these patients have a chronic disease related diagnosis. Moreover, 20% of CARES enrollees are high utilizers (6+ health center visits), indicating the program is addressing a demand for care services in the community.

In year three, CARES showed continued its pattern of consistent growth. Overall enrollment in the program increased by 29% to ~3,300 and continues to grow into 2019. Reenrollment in the program has also risen from 46% to 54%. These numbers are especially impressive given the current political climate that has created heightened concern among immigrants about utilizing public programs.

Recognizing that a patient's health extends beyond a clinical visit, CARES has added new evaluation tools to better evaluate CARES enrollees' experiences and determine major unmet needs. Two different surveys have been administered to capture social determinants of health (SDOH) data, as well as financial impact among enrollees and outstanding health care needs. In addition to SDOH data, the program continues to trend emergency department (ED) data using the Oregon Health Authority's analysis framework established in year two. The number of ED visits continued to increase in year three, however the ED utilization rate is slowing overall. The percentage of avoidable ED visits has declined to 9% (from 11% in year two), showing progress towards one of the primary goals of CARES to reduce avoidable ED visits. The program will continue to prioritize CARES enrollment assistance at the ED and additional efforts to target ED high utilizers.

Overall, data continues to reveal high levels of sustained enrollment for the targeted population as well as high primary care utilization for individuals with chronic illness. Results also identify system improvements as partners refine program practices to improve health outcomes and cost efficiencies. Thanks to the efforts of its partners, the program continues to be an important model for primary care coverage in uninsured communities throughout California.

Participant Feedback

Surveys and patient perspectives brought forward some key insights regarding the program's impact:

- All participants reported that CARES has had a positive impact on their lives and is providing a high level of care. In a survey of 95 patients, 100% reported that they were receiving a satisfactory level of care or better. While improvements can still be made to the program to offer access to more services, the following illustrates that the program is trending in the correct direction.

- Participants reported that CARES is helping reduce their overall healthcare spending. Off the 88 patients reporting that they had issues affording healthcare prior to CARES, 96% stated CARES helped them address care costs. Participants pointed out that prescription medication, dental care, and vision remain their largest concerns.

- Participants in the program noted that there was some confusion surrounding program eligibility. Many worried that enrollment into CARES would lead to deportation due to federal policy changes to public charge. Other reasons for not enrolling indicated a lack of knowledge about the program's existence, which we have begun to address in the past year with increased outreach events and pathways into the program.

Health Center Leadership Feedback

Interviews with four CARES health center leaders revealed more about the program's impact on services:

- Health Centers reported CARES funding has allowed for their clinics to treat more patients, providing them with greater access to their primary care services. In addition, the funding has been used to hire an unspecified number of providers and support staff to tend to CARES patients.

- CARES has become a pipeline into Medi-Cal at the health centers. Screenings for the CARES program has increased enrollments for Medi-Cal, helping eligible patients to be able to afford essential services without having to pay. To date, 937 CARES patients have been transferred onto Medi-Cal.

- CARES plays an important role in establishing pipelines of care for medical indigent populations. Certain health centers have also used this opportunity to provide additional Social Determinants of Health (SDOH) screenings to determine previously unidentified needs of the CARES population.

Next Steps

- Expanded Population Health Initiatives: In year three, we began to survey the CARES population to understand their SDOH. We hope to continue this effort in year four while we begin working to address these identified issues by exploring possible solutions. As our dataset grows, we plan to run additional analysis to see if trends found between SDOH and patient diagnoses continue into year four. Population health and addressing our patients SDOH remains one of our top priorities, as we recognize a patient's health extends beyond a clinic visit.

- Bolstering data analysis with Quality Improvement (QI) metrics: While adding qualitative data from SDOH surveys has provided a new perspective on the challenges CARES patients face, the Consortium is working with its partner clinics to collect data on validated measures for the CARES population. We will begin working with clinics to explore a pilot and continue improving its current metrics and dashboards by including additional screening data.

- Continued and Expanded Community Outreach and Education: We believe outreach efforts played a large role in helping CARES expand while insurance programs such as Covered California saw drops in enrollment. In year four, CARES partners will look to continue outreach by providing more targeted and coordinated campaigns to deepen our connection with the eligible population. Events include on-going public charge trainings and generating additional enrollment pipelines for eligible participants.

- Improvement of ED Analysis: While ED visits saw a slight increase in year three, our current data indicates that there is an opportunity for the development of targeted interventions among patients with avoidable ED visits. In year four, the Consortium will look to explore the data transfer process and continue to analyze trends for patients with frequent avoidable ED visits.

I. PROGRAM OVERVIEW

Contra Costa Cares (CARES) connects low-income individuals living in Contra Costa County with primary care services. The program partners with LifeLong Medical Care, La Clínica de La Raza, and Brighter Beginnings to provide a variety of primary care services to program participants. Payment is administered by Contra Costa Health Plan (CCHP) on a per-member-per month basis. Specialty care, emergency and inpatient care, vision, and dental care do not fall under the purview of CARES. Patients requiring these services are referred to access programs which may assist them. CARES has partnered with Operation Access to also provide a direct pipeline to certain specialty care services, such as stress testing for cardiology. Approximately 50,000 individuals in the county are estimated to qualify for the program.[1]

CARES 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. The program was expanded in April 2017, creating additional enrollment slots, bringing total program capacity up to 4,100 participants. An additional $1.5M was committed for FY 18/19, sustaining the availability of primary care coverage for more than 4,000 individuals countywide. A majority 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.

In its third year (December 1, 2017 – November 30, 2018), the program looked to address several next steps outlined in the previous CARES Impact Report: improving specialty care options, continued outreach and communications, and expanded qualitative analysis. To meet these goals, the program has relied heavily on its collaboration between CCHP and the community health centers (CHCs). These partnerships have allowed the program to provide uninterrupted quality primary care coverage and services, as well as tackle new challenges such as responding to federally proposed public charge rule changes. As it has evolved, CARES has also garnered recognition from other counties and organizations as a model for expanding primary care coverage for the remaining uninsured.[2] In addition, the program's data sharing initiative has generated data regarding the utilization patterns and health status of a historically underserved immigrant community.

II. YEAR IN REVIEW

Political & Health System Delivery Landscape

Healthcare and immigration issues continued to be a central foci of federal and state policies and administrative actions in 2018. At the federal level, the Administration maintained a focus on restricting immigration, increasing detention and deportations, and limiting services and resources for immigrant communities. A particular action with widespread implications for health and social service program enrollment was the publication of the Notice of Proposed Rule Making (NPRM) on public charge rules introduced on October 10th, 2018 to the federal register. If put into effect, these proposed changes would drastically change the definition and scope of public charge, making the process of becoming a lawful permanent resident more difficult while deterring individuals from accessing critical health and social services such as coverage through non-emergency Medicaid.

The Department of Homeland Security leaked drafted versions of the proposal in the two years preceding the publishing of the final NPRM. As a result, some news outlets reported the wrong information about the possible changes to public charge, which may have contributed to a chilling effect; a studied phenomenon in which eligible individuals decide to disenroll, not renew, or continue to go without benefit programs, because they have the wrong information, are confused, and/or fear that their use will trigger harmful legal ramifications in the future.[3] Researchers began using the term "chilling effect" after several analyses emerged to understand the behavior change in immigrants following welfare reforms of the mid-1990s.

The Community Clinic Consortium's member clinics anecdotally reported a decrease in patient's willingness to participate in benefit programs, show up to scheduled appointments, and engage with the clinics, as the political climate became hostile towards immigrants. Throughout the country, reports surfaced that detail providers' concerns over the steep decline of patient activity in clinics that predominately serve immigrants.[4] Patients' behavior is consistent with several analysis published in 2018; A Kaiser Family Foundation analysis estimated that anywhere from 2.1 million and 4.9 million beneficiaries living with at least one noncitizen may disenroll from Medicaid/CHIP, due to the chilling effect.[5] The UCLA Center for Health Policy and Research estimates that as many as 860,000 CalFresh recipients may be impacted by the chilling effect.

The chilling effect is also impacting enrollment and renewals of benefit programs that are excluded from the NPRM. The Women Infants and Children (WIC) Program, will not be counted as a negative factor during the public charge determination; yet, some clinic enrollment staff report a portion of their immigrant clients decide to go without WIC because their clients are afraid and believe it is risky to use any benefit program.[7] Locally funded programs such as CARES were also excluded from the NPRM on public charge. However, the proposed rule changes are complex, leaving many immigrant individuals and families unsure of how to proceed with enrollment in any health or social service options.

The Consortium was at the forefront of advocacy efforts against the NPRM on public charge by actively joining the Protecting Immigrants Families (PIF) campaign, creating and disseminating educational materials, and facilitating educational presentations to reduce the chilling effect and stop the DHS proposal from becoming effective. Final public charge rules are anticipated to be released in mid-2019.

Meanwhile, the California legislature and county governments have proactively responded to protect Californian's access to comprehensive health coverage and continue advancing equity-driven policies and programs. In 2018, SB 974 and AB 2965 were introduced to expand full-scope Medi-Cal to income-eligible undocumented adults. Both bills were placed on suspense file due to budgetary concerns and were not signed into law. However, similar "Health4All" efforts have continued into the 2019 legislative session with the introduction of two new full-scope Medi-Cal expansion bills in both the Senate and Assembly. Additionally, in November 2018, Gavin Newsom was elected as Governor after running on a platform that prioritized healthcare, setting the stage for further healthcare policy and budget items to advance at the state level in 2019. On his first day in office Governor Newsom introduced a budget item to expand full-scope Medi-Cal to undocumented young adults. While this is a positive step forward, the action would have a minimal impact on the population served by CARES, as only 3% of the CARES enrollees are under the age of 26.

While state legislation to broadly cover all Californians regardless of immigration status has yet to advance, counties and local health systems have continued to lead efforts to expand coverage and access to care. In early 2018, the Community Clinic Consortium led a state-wide campaign to advocate for the County Medical Services Program's (CMSP) to extend primary care coverage for undocumented adults. In May 2018, the CMSP Governing Board voted to develop the Path To Health program to expand access to primary care to undocumented adults, joining 11 other Californian counties that provide coverage for "Medically Indigent Adults" (MIA) regardless of their immigration status. In 35 CMSP counties, contracted providers were invited to apply to the Path To Health program. Eleven health centers in 13 CMSP counties were approved to provide primary care coverage for up to 25,000 adults through a 2.5-year pilot program. CARES data played an instrumental role in CMSP advocacy, and the CARES program was used as one of the models for Path To Health program development.

Program Data

The Consortium has continued to work with partner health centers and hospitals to improve the CARES data infrastructure. In data sharing meetings, partners work together to troubleshoot technical issues and implement best practices for data exports. As the program rolled into its third year, it faced ongoing enrollment challenges created by the current political climate. Through ongoing training, continuously evolving enrollment strategies, and robust patient education efforts, the program was able to increase enrollment over the course of the year. Since the beginning of the program (December 1, 2015 to November 30, 2018), a total of 5,558 individuals have joined CARES. Of these patients, 3,474 (63% vs. 54% in year 2) have had a primary care visit with a total of 18,386 visits since the inception of the program. In addition, 1,120 patients have had 6 or more primary care visits since program inception, indicating a high rate of engagement with enrolled patients. The data is evidence that the program is on track to meet one of its original patient outcomes: Increased access to continuous, coordinated primary care services.[8]

Demographic trends remain consistent in year three with most CARES participants being working age, female identifying adults, who live in family sized households. 57% are between 35-50 age (Figure 1). 61% of the CARES population are female, while 39% are male and 98% are Latino. 60% live in household sizes of 4 or more individuals (Figure 2). Based on their reported zip codes, most program participants live in districts 1 and 5 (Figure 3).

While anecdotal evidence from community health centers anticipated that external circumstances such as federal immigration policies and proposed public charge rule changes would dampen enrollment rates, the engagement of patients that are enrolled is at an all-time high. In year three, CARES has established itself as a fully operational primary care program and the community has recognized this by taking advantage of services at an increased rate. As seen in Figure 4, the number of monthly visits from 2017 to 2018 increased on average by 54%.

Figure 1: Age of CARES Enrollees
(December 1, 2015 to November 30, 2018)

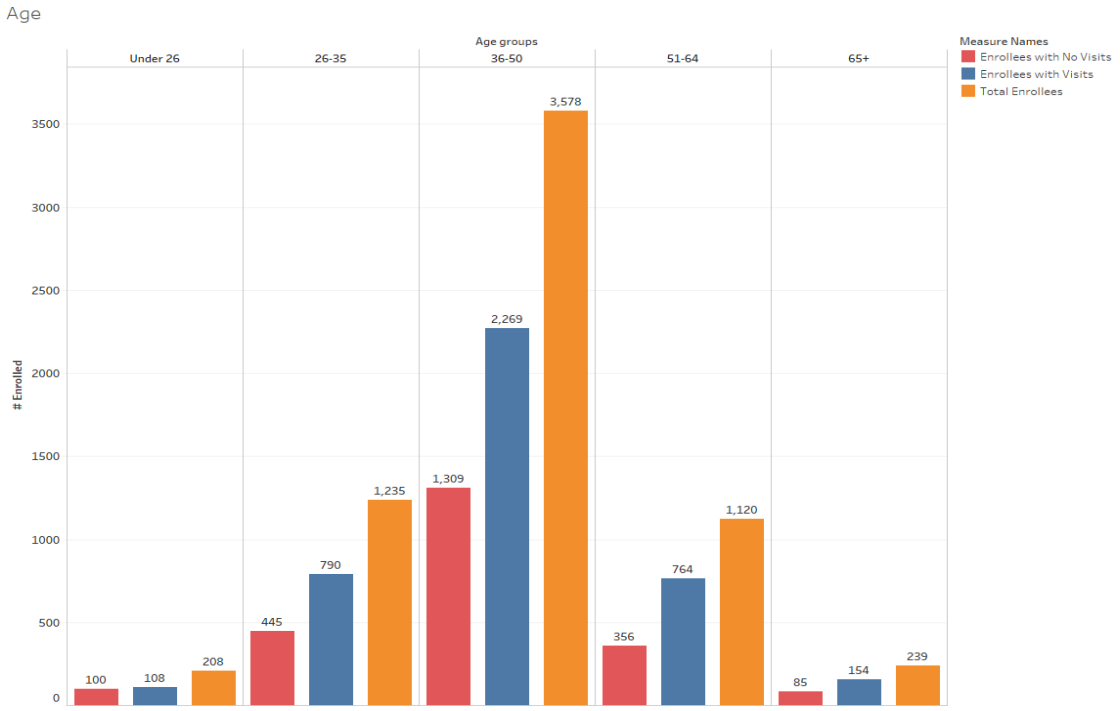


Figure 2: Household Size of CARES Enrollees
(December 1, 2015 to November 30, 2018)

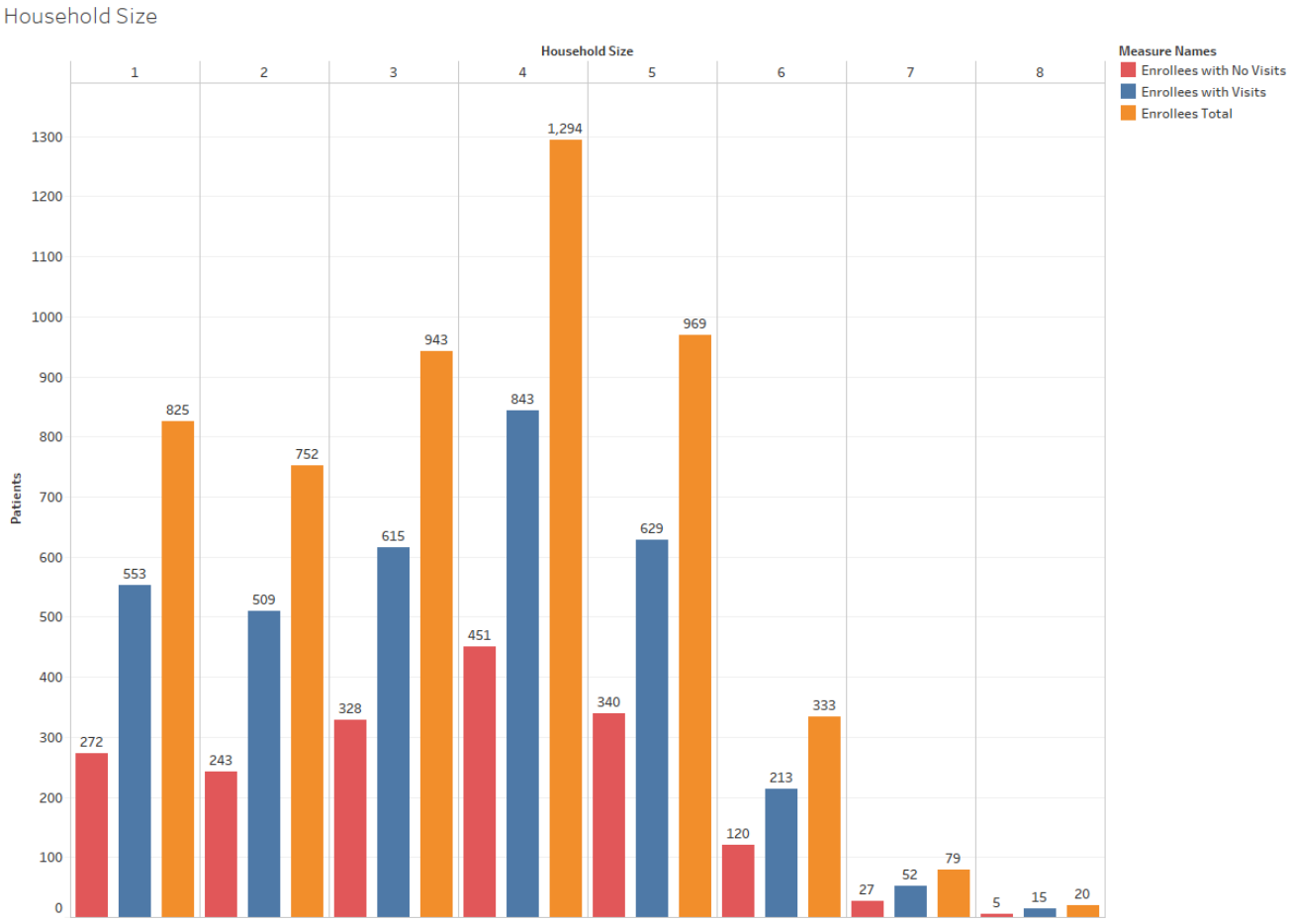


Figure 3: Zip Code Distribution of Program to Date CARES Enrollees
(December 1, 2015 to November 30, 2018)

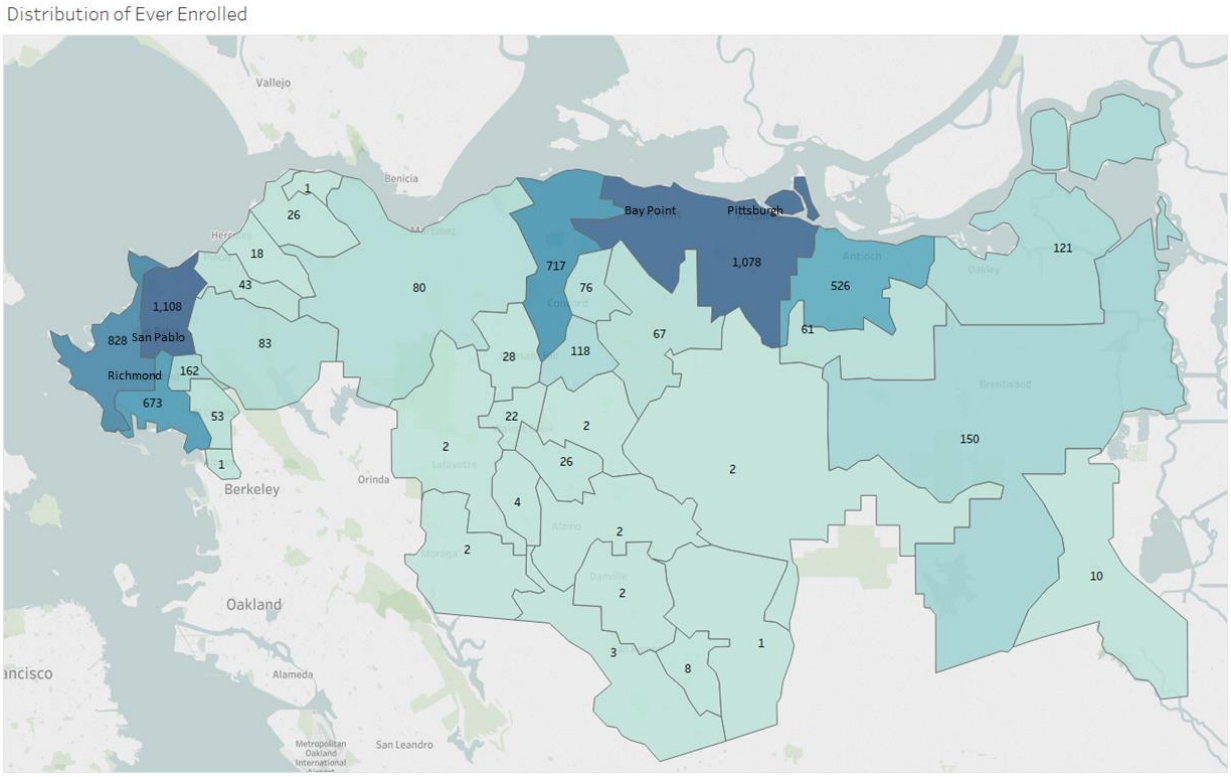
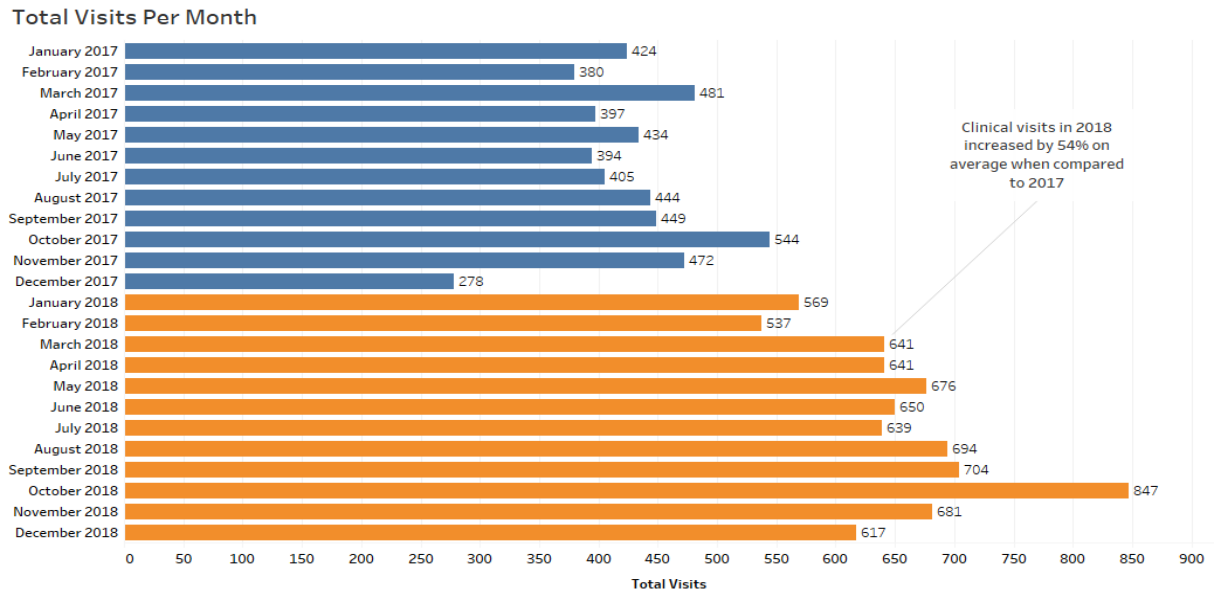


Figure 4: Total Community Health Center Visits Per Month (2017 vs. 2018)



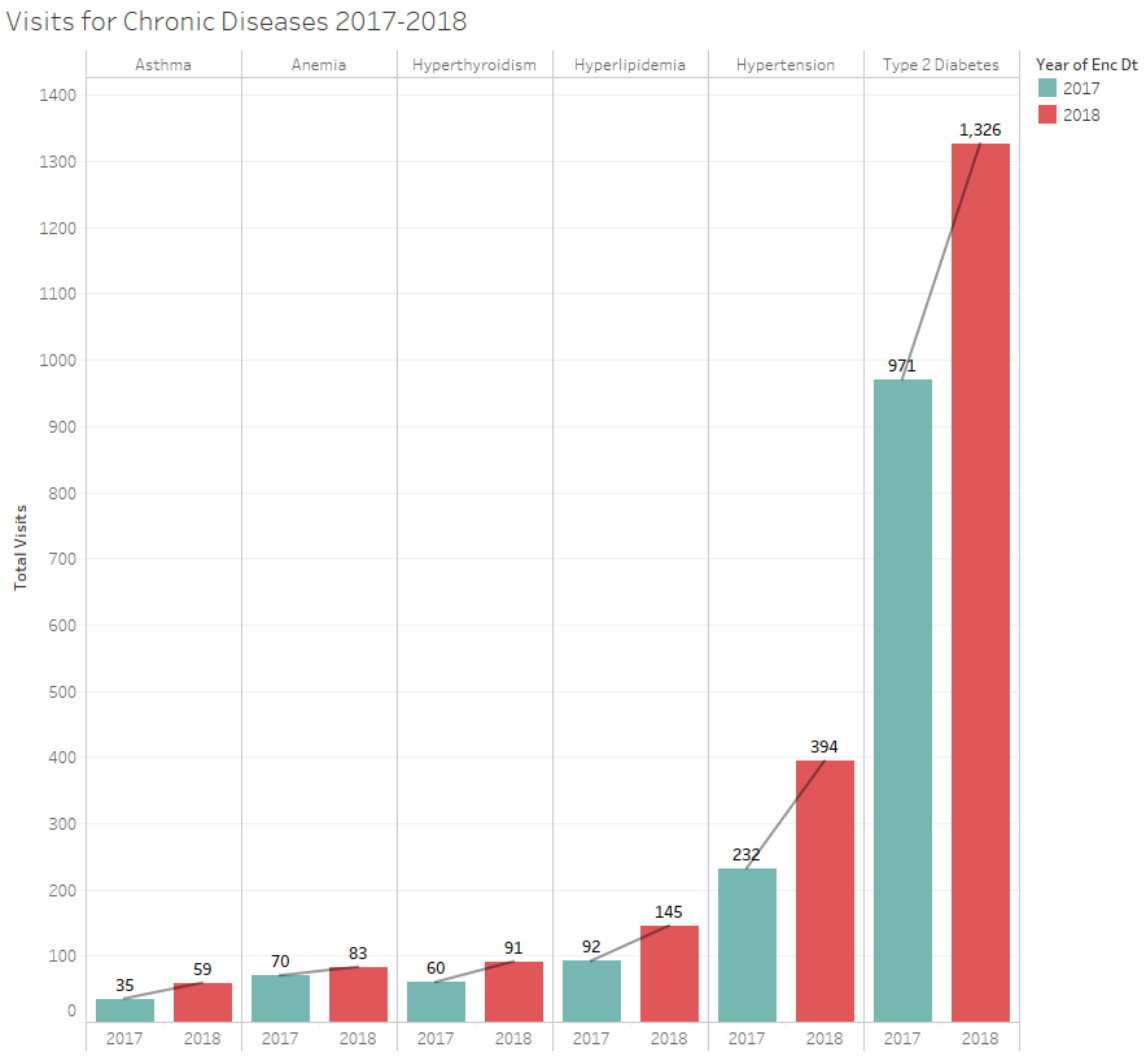
Chronic Conditions Supplementary Care

Chronic conditions, especially diabetes, remain prevalent among CARES patients. Visits for Type 2 diabetes increased the most with 300 more visits over the previous year. Increasing incidence of Type 2 diabetes in California has been noted in many health reports[9] with more than 11% of adults in California having some type of diabetes.

To date, CARES participants have received more than 770 flu immunizations and more than 220 mental health related visits. From 2017 to 2018, related appointments for immunizations and mental health visits have gone up by 250% and 50% respectively (Figure 5). This indicates an increasing demand for these services and the program will work with clinic partners to provide necessary outreach so that patients understand that they are available. Mental health is currently not a covered service under the CARES program, but clinics offer some screenings and counseling as part of their medical home structure.

In addition to primary care appointments, CARES providers partner with Operation Access (OA) to provide patient referrals to some specialty care services. In year three, OA coordinated 201 specialty care appointments for 75 CARES members. 89% of CARES members reported an improved quality of life after their OA experience. Future work could be done to ensure follow ups with CARES patients after an OA procedure involve education and best practices. Currently, 70% of CARES members interviewed six to nine months after their procedure reported a sustained behavioral change to maintain their health after the OA service. Education during subsequent follow-ups could improve this number and OA procedural outcomes.

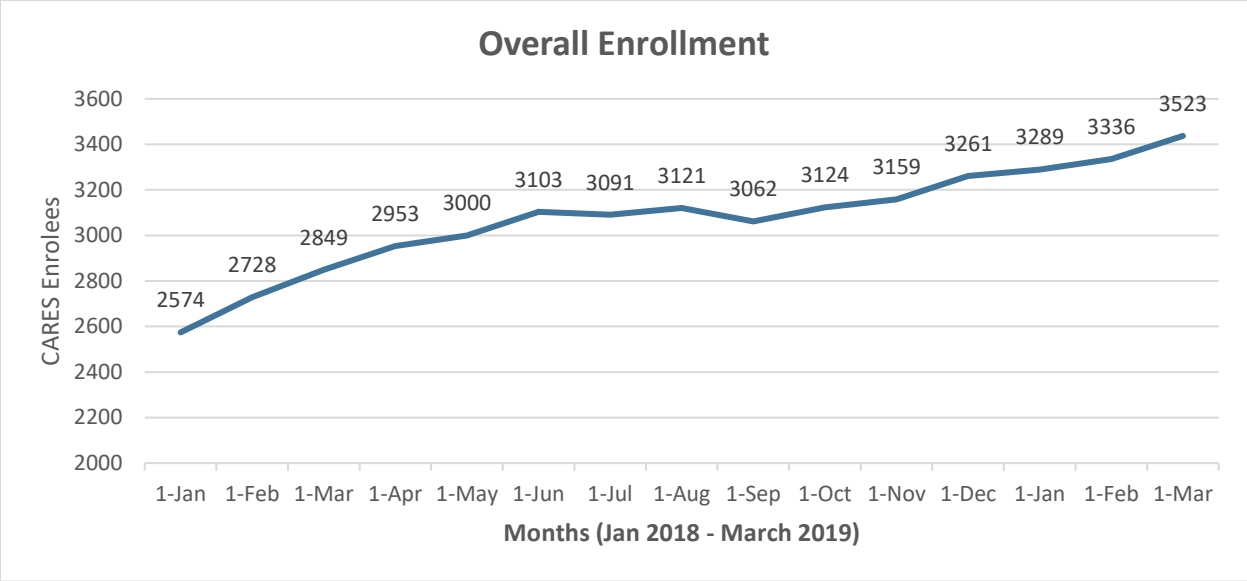
Figure 5: Chronic Disease Diagnosis



Outreach and Enrollment

In 2018, program partners anticipated a decrease in renewals due to changes in public policy. However, CARES saw a substantial increase in program enrollment in year three, with 3,289 enrollees as of January 1st, 2019 up from 2,574 enrollees in January 1st, 2018. Furthermore, patient engagement has increased substantially, with 60% of total enrollees having at least one visit with a primary care provider up from 49% last year. Patient engagement may also be larger than reported because we currently do not have the ability to count patients who have had an appointment on the day they enroll into CARES. This issue can be attributed to technical difficulties as there is a delay between signing up for the program and being logged into the CARES system.

Figure 6: Enrollment Rates



During monthly outreach and enrollment calls with member clinics and county Medi-Cal Analysts, the group worked to create strategies to address an anticipated drop in enrollment and engagement. The approach rolled out in year three included three strategies: trainings and advertising to address unique program concerns, identifying new pipelines of enrollment, and improving reenrollment into the program.

Recognizing patient fear of deportation and misinformation as a major issue, additional outreach and training workshops were rolled out to provide information to hospitals, clinics, and community members. The Consortium integrated CARES information into public charge trainings to help Contra Costa community members recognize CARES as a program that would not have detrimental impacts on immigration status upon enrollment. Health promoters from LifeLong and community health workers from La Clinica also distributed information to local community-based organizations, public and charter schools, and local health centers.

Building on year two outreach efforts, a comprehensive communications campaign to reach eligible participants through multiple strategies was sustained. CARES materials including brochures, posters, swag, buttons, and social media engagement via Twitter and Facebook were used. All materials were provided in a bilingual format. In addition, trainings served as an opportunity to provide health center staff with information about best practices and addressed staff turnover the program faced in year two. In year three, health centers and the Consortium established new pipelines for CARES enrollment. Health centers hired dedicated CARES staff to promote CARES and enroll patients into the program at several high traffic sites in Contra Costa. Health centers also partnered with external institutions such as John Muir mobile clinic and Saint Vincent de Paul's Rotacare clinic to create additional referral pipelines for mobile clinic patients. These actions helped maintain program enrollment at a time when other aid programs, such as CalFresh have reported significant decreases.[10]

Initially, the program's renewal process included a reminder mailed to members 60 days before they were due to renew. The letter instructs members to call their primary care clinic to schedule a renewal appointment. In addition, health center eligibility workers make three attempts to reach out to patients to schedule renewal appointments before their due date. Towards the end of year three, the program revamped the renewal process to include robocalls that go out to members 30 days before they are due to renew. Robocalls allowed the program to have a higher touch rate, increasing patient engagement. Staff were also more experienced with the reenrollment process this year, optimizing their procedures and contributing a large amount to the increase in patient sign ups. Calls were referred to the Consortium, where staff would triage patients to the correct health center. Adding additional touch points allowed for our reenrollment rates to increase from 46% in 2017 to 54% in year three.[11]

Outreach, enrollment, and renewal systems continue to evolve and improve in response to evaluation findings and community dialog. Overall, efforts have had a considerable impact on the program, increasing enrollment by 29% and reenrollment rates by 8% from year two to year three. Moving into its fourth year, we will continue to build on our outreach and enrollment processes to expand our enrolled population.

Survey Analysis and SDOH Impact on Healthcare Outcomes

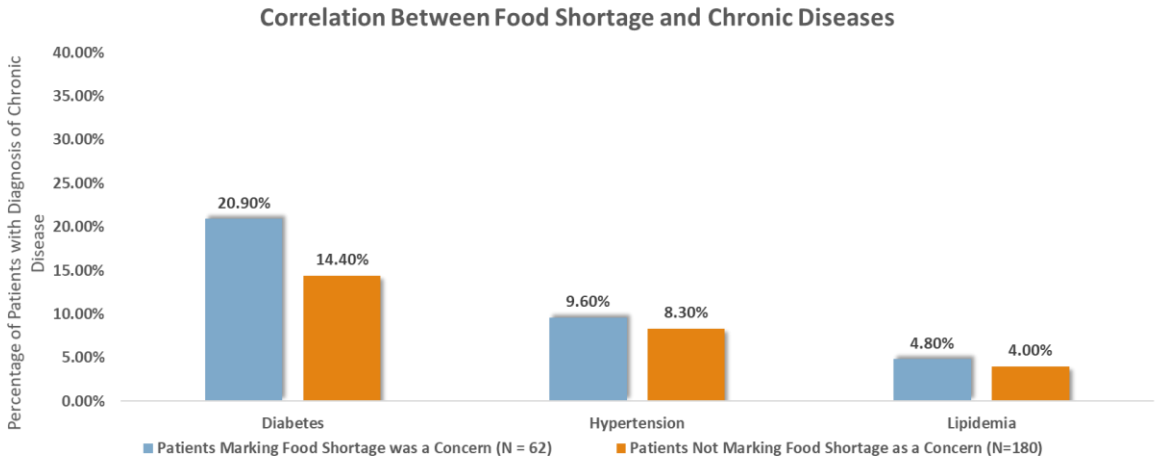
In year two, the Consortium developed a sustainable data infrastructure that consisted of health center and hospital data sharing workgroups, implementation of data sharing best practices, HIPAA trainings, and investment of data visualization software. Understanding that a person's health extends beyond a medical visit, the program prioritized the expansion of qualitative analysis efforts to better evaluate CARES enrollees' experiences and determine unmet needs. To that end, in year three the Consortium incorporated two surveys: a qualitative survey to better determine the impacts of CARES on patient healthcare costs and patient satisfaction, and a pilot screening program to gather social determinants of health (SDOH) data.

A. SDOH (PRAPARE) Data

A growing volume of evidence illustrates that a patient's health is influenced not only by medical treatment but a variety of social and environmental factors, such as food insecurity, safe spaces, and stable housing. Recognizing this, the Consortium partnered with La Clínica to administer the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), a validated tool used by health centers to better understand the upstream socioeconomic drivers of poor healthcare outcomes[20] By combining this information with our patient outcome data, we are working to identify the most frequent drivers and develop actionable solutions.

A total of 248 CARES patients across Contra Costa completed the PRAPARE questionnaire, with many CARES patients reporting a lack of access to basic needs such as housing, food, medicine, and transportation. Food insecurity was a major challenge with 25% of patients indicating they experienced food shortages in the past year. Recognizing that there are many social determinants of health that affect our observations, the Consortium has begun to build a relationship with the Food Bank of Contra Costa and Solano to begin thinking about a pilot project aimed at addressing health problems associated with food insecurity. To determine the direct impact of these factors on healthcare outcomes, the Consortium also connected PRAPARE survey results with patient claim data.

Figure 7: Food Shortage and Correlation to CARES Patient Health



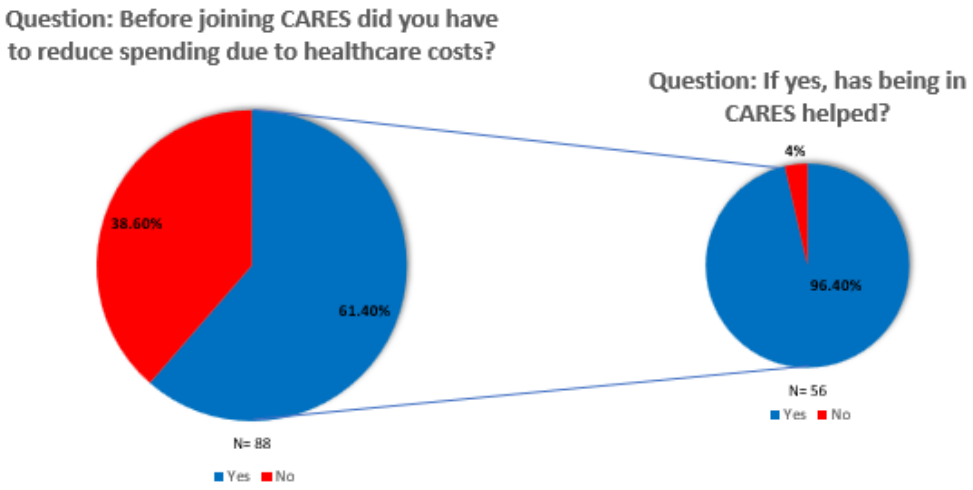
In figure 7, patients indicating they had trouble maintaining a source of food were also diagnosed with higher rates of diabetes, hypertension, and hyperlipidemia. Lacking a proper diet may have a large impact on a patient's ability to manage their chronic disease. This information helps the team determine what initiatives to focus on.

Using the data compiled by the PRAPARE survey, the Consortium partnered with La Clínica to lead an SDOH workgroup composed of health center, county health plan, and safety net service representatives, including the Food Bank of Contra Costa and Solano and 211. Since the issues are so widespread, the goal of the workgroup was to share best practices between groups and develop an idea of how we could work together to address identified pain points. Future meetings will work towards developing a pilot initiative, expanding collaborative partners and continuing to ensure tools are shared across organizations. The workgroup noted that improving referrals for patients across aid systems could be piloted through CARES patients. The Consortium plans to continue expanding SDOH initiatives and its unique position as a data aggregator allows it to help facilitate conversations between organizations.

B. CARES Impact on Participant Healthcare Costs

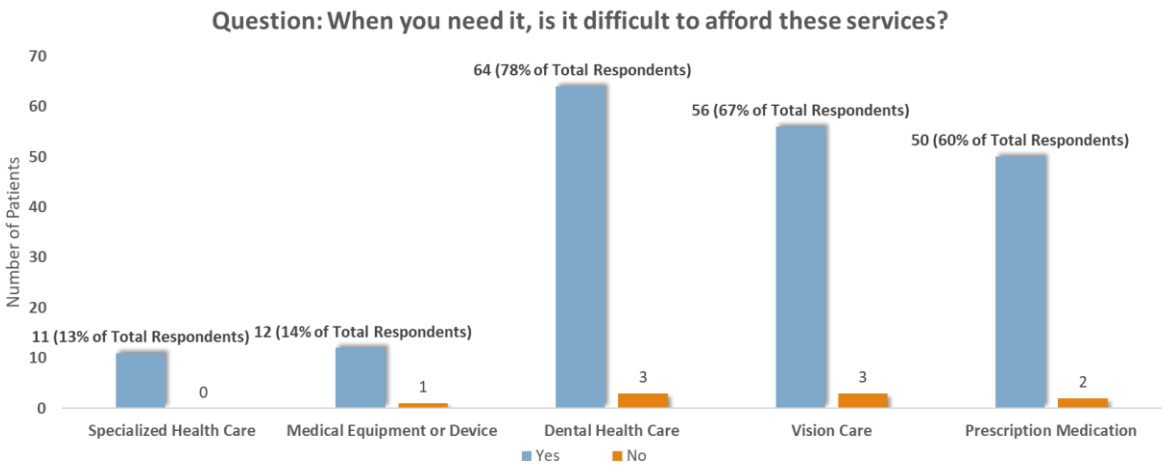
A common theme from patient interviews in year two was a concern about the cost of care and how it impacted patients' lives. To better understand the healthcare costs patients faced, the program rolled out an additional survey probing these issues. We aimed to get information from experienced CARES participants and more than 90% of the 95 survey participants were on CARES for more than 11 months and 70.6% came from District 1. Surveys were administered during clinical visits and over the phone. Anecdotally, CARES participants have indicated that the program has helped them with healthcare spending, but the program had no data to back this up. Figure 8 provides some additional evidence to support this claim, with a substantial number of patients indicating that CARES has helped supplement their healthcare spending.

Figure 8: CARES and Healthcare Costs



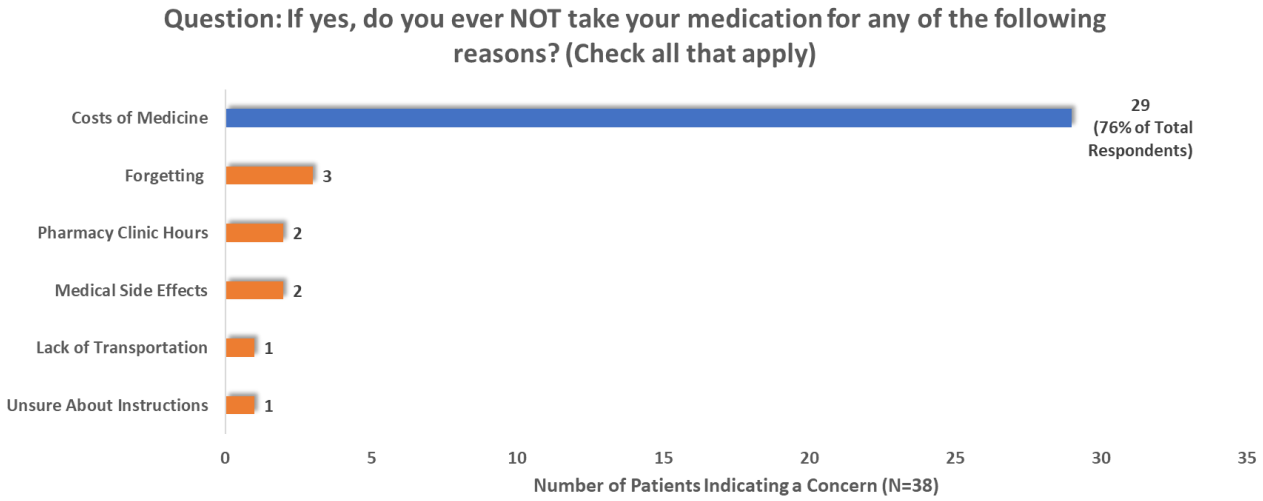
District 1 is primarily composed of West Contra Costa County residents and includes the city of Richmond. In figure 9, results indicate dental care is the most requested and difficult to afford service not provided by the program. Of the 83 patients who responded, 64 (78%) indicated that dental services were difficult to afford. In addition, 56 (67%) of those surveyed indicated vision care is a high need. Any program expansion should consider these services as a priority need.

Figure 9: Health Services Impacted by Cost of Care



As the following charts reflect, surveyed CARES patients indicate that the cost of medication is an ongoing challenge. In fact, 50 CARES patients reported medications were difficult to afford. Of these 50 patients, 29 of them (76%) reported they did not adhere to their treatment plan due to prescription medication costs.

Figure 10: Medication Cost and Impact on Adherence



Medication adherence plays a major role in healthcare outcomes, especially given many CARES patients tend to be diagnosed with chronic diseases. In 2005, a retrospective analysis of 137,000 patients under the age of 65 showed that diabetes, hypercholesterolemia, and hypertension hospitalization rates were significantly lower for patients with higher medication adherence[14] Claims data from the study shows that higher medication costs were more than offset by medical cost reductions, producing a reduction in overall healthcare costs. Since prescription price is the major driver for non-adherence, it is possible that addressing this issue with targeted programs for chronic disease medications could result in overall healthcare cost-savings.

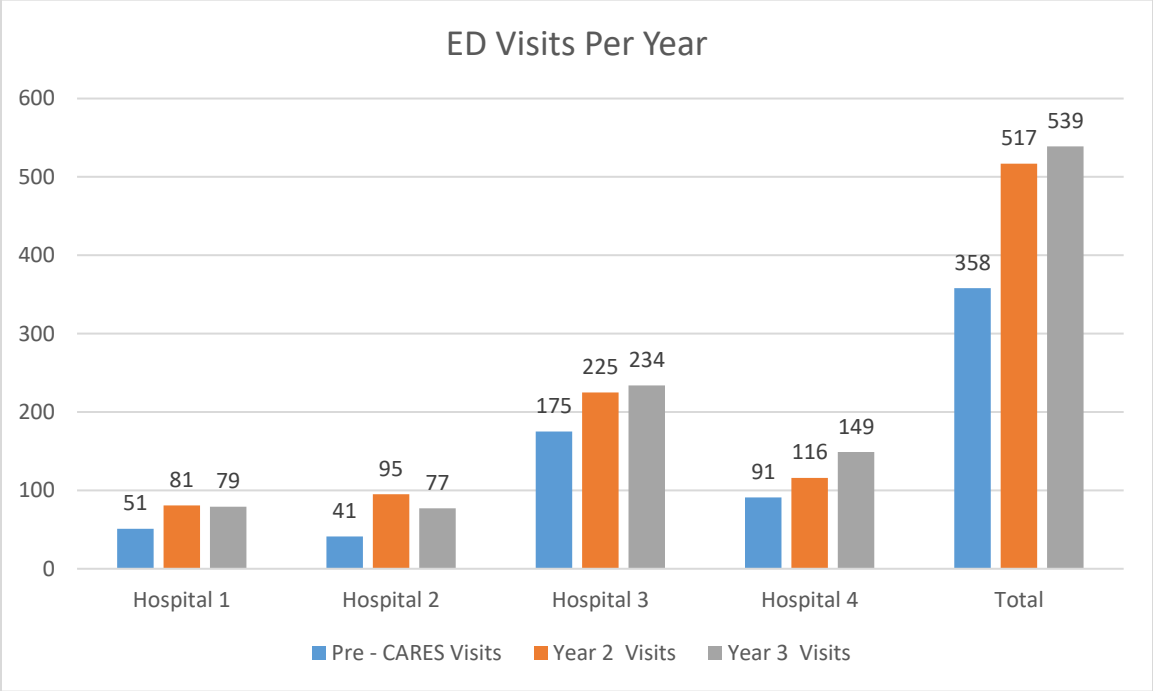
Emergency Department Utilization

The Hospital Data Sharing Workgroup formed early in the program's development to formulate data collection methods, discuss data definitions and review analysis for Emergency Department (ED) utilization data. The Workgroup adopted a cohort analysis approach, reviewing ED utilization data for 2,523 continuously enrolled CARES participants from May 30, 2016 – June 1, 2018 as a way of focusing this analysis on those most likely to have benefited from ongoing access to primary care. We compared these two years to pre-CARES ED visits to see if the program had an impact on visit numbers. ED visits from four different hospital partners, Contra Costa Regional Medical Center (CCRMC), John Muir Health, Kaiser Permanente, and Sutter Health were compared across three enrollment periods to determine overall ED utilization.

Within overall ED utilization, visits were categorized as avoidable and unavoidable visits, using a methodology created by the California Department of Health Care Services Collaborative Quality Improvement Project Reducing Avoidable Emergency Room Visits and The Oregon Health Authority[21] Direct links to the analysis methodology can be found in the references section. While there were a variety of methodologies discussed, the workgroup agreed the 165 diagnosis codes in the adopted methodology was both feasible and relevant to the group's purpose.

In year two, the program saw an increase in the overall number of ED visits for CARES enrollees. As a benchmark, multiple studies have shown patients initially have higher ED utilization over several years when enrolled into coverage programs. These studies have noted a pent-up demand will cause a sharp increase that remains elevated for a period after the introduction of an expansion of health care services.[15,16] While the increase in visits would seem to reflect the trend reported in these studies, data indicates a smaller growth rate in ED utilization that may indicate ED utilization patterns are beginning to level off.

Figure 11: ED Visits per CARES Program Year



Data indicate a 4% increase in overall visits from year two to year three vs. a 30% increase reported between year one and year two. While overall visits did increase, there was variation among reporting hospitals, with some reporting a drop in the number of ED visits. In addition, because most of the increase in year three was concentrated in a single hospital with 75% of the increase coming from hospital 4. Targeted intervention with patients causing this increase may facilitate improvements in the coming year.

Figure 12: Avoidable Visits vs. Non-Avoidable ED Visits for High Utilizers and Other Patients in Year Three

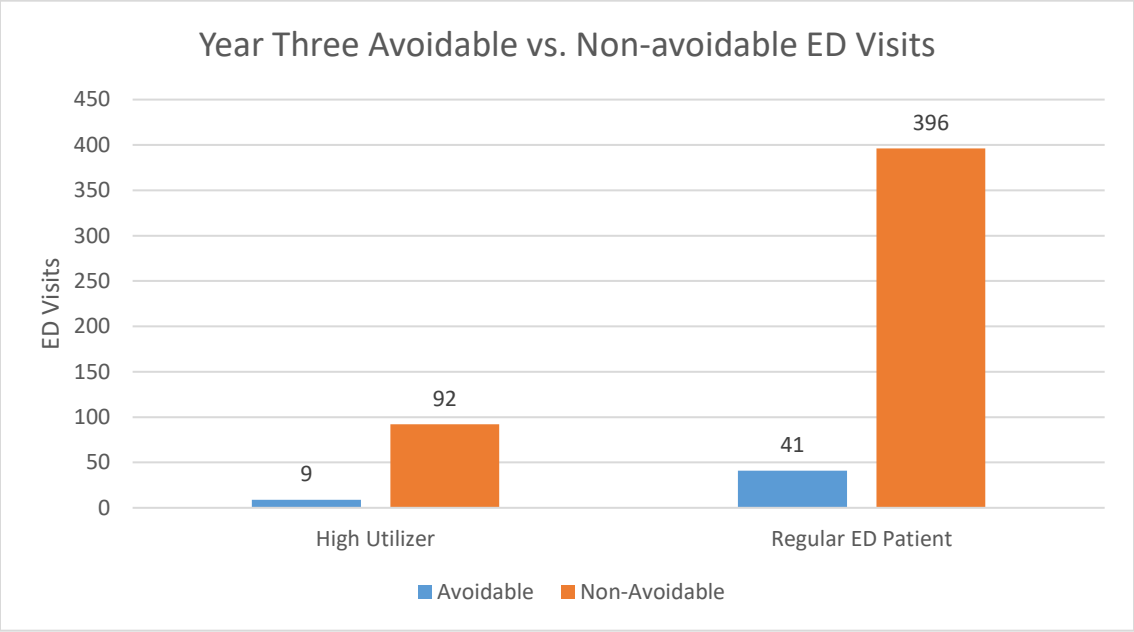


Figure 12 shows the total number of non-avoidable and avoidable visits reported by hospital systems in year three with ED high utilizers (3+ ED visits)[1] broken out into a separate section. The percentage of avoidable visits remained consistent across all categories with only ~9% of visits being considered preventable. Compared to an estimated 13.7% of avoidable visits found in research studies, our ~9% indicates that CARES patients are generally being seen for non-avoidable issues.[17]

Other Findings Include:

- Of all 2,523 cohort enrollees, 16% of enrollees utilized a hospital ED in the third year of the CARES program (539 visits total). In addition, only 1.1% of the cohort were determined to be high utilizers (3+ ED visits).

- Most patients with at least one avoidable ED visit had only a single visit (~80%).

- Within the high utilizer group, there appears to be a smaller subset of 6 patients who are relatively high utilizers of services. These patients had more than 4+ visits in an ED and an average of 6.5 health center visits.

A 2019 Health Affairs study showed a sharp drop in acute primary care office visits and an increase in avoidable ED visits from 2002-2015 after Medicaid expansion.[18] The study looked at adult Medicaid patients across several states, including California. Since its establishment, CARES has seen an increase in primary care visits, bucking the trend established in the Health Affairs report. With significantly slower rates of increase in ED visits for year three, a possible care coordination effort across a spectrum of partners can assist in lowering the number of ED visits in future years.

[1] 3+ ED visits was chosen as the benchmark for ED "high utilizers" because patients in this category were more than 2.5 standard deviations from the mean[19] In total, only 1.1% of the 2523 patients were determined to be high utilizers.

III. NEXT STEPS / CONCLUSION

As it enters its fourth year, Contra Costa CARES has continued to grow thanks to the collaborative relationships between CHCs, hospitals, CCHP, community members, the Contra Costa County Board of Supervisors, and partner organizations. For Contra Costa's uninsured, CARES has become a valuable resource, connecting patients to more established care and providing essential coverage. The program continues to demonstrate the positive impact community partners have when they come together and are committed to addressing health issues in Contra Costa County.

In 2018, CARES grew despite a challenging political climate and limited enrollment staff capacity. We believe our success is due to prioritizing the establishment of outreach infrastructure with our partners to ensure program pipelines remained stable. Moving into 2019, CARES will continue to expand its outreach initiatives by developing new referral pathways and continuing community education efforts.

With a well-defined infrastructure, the program is poised to address additional challenges. In 2019, CARES will continue trending ED data and create more CARES referral points at emergency departments in the county. We believe through more proactive intervention in the primary care setting, we can work to reduce the rate of ED visits next year.

Recognizing that a person's health extends beyond an office visit, CARES improved its data infrastructure to also include SDOH data. In addition to regular data meetings, Tableau dashboards, HIPAA trainings, and data tracking improvements, the SDOH data will provide another component to helping our partners understand the unique challenges the CARES population faces. Our next step includes creating workgroups with interested partners to better address our patient's SDOH.
Contra Costa CARES continues to be an important program for the county's health care safety net. Neighboring county and state initiatives have looked to CARES as a model for how primary care coverage for undocumented adults and uninsured in California can be implemented. As it moves into its fourth year, the program and its partners are committed to ensuring that all Contra Costa community members continue to receive coverage and care.

NOTES

1. https://itep.org/wp-content/uploads/CA-UnDOC-State-and-Local-Taxes.pdf

2. P.13-15 http://nohla.org/wordpress/img/pdf/County-BasedReport2018.pdf

3. CARES Program Proposal Framework

4. Gutierrez, Melody. "Gov. Gavin Newsom Proposes Healthcare Mandate, Medi-Cal Expansion to More Immigrants without Legal Status." Los Angeles Times, Los Angeles Times, 7 Jan. 2019, www.latimes.com/politics/la-pol-ca-gavin-newsom-healthcare-proposal-20190107-story.html.

5. "U.S. Diabetes Surveillance System." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 2019, gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html.

6. Batalova, Jeanne, et al. "Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefits Use." Migrationpolicy.org, 26 Mar. 2019, www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families.

7. The Children's Partnership. "California Children in Immigrant Families: The Health Provider Perspective." Www.childrenspartnership.org, accessed 12 Apr. 2018, www.childrenspartnership.org/wp-content/uploads/2018/03/Provider-Survey-Inforgraphic-.pdf.

8. Covered California 2019 Open Enrollment Early Observations and Analysis. 2019, http://hbex.coveredca.com/dataresearch/library/CoveredCA_2019_Open_Enrollment_Early_Analysis.pdf.

9. "Chilling Effects: The Expected Public-Charge Rule and Its Impact on Immigrant Families." Migrationpolicy.org, 12 July 2018, www.migrationpolicy.org/events/chilling-effects-expected-public-charge-rule-and-its-impact-immigrant-families.

10. Hoffman, Jan. "Sick and Afraid, Some Immigrants Forgo Medical Care." The New York Times, The New York Times, 26 June 2017, www.nytimes.com/2017/06/26/health/undocumented-immigrants-health-care.html.

11. Artiga, Samantha, et al. "Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid - Key Findings." The Henry J. Kaiser Family Foundation, 11 Oct. 2018, www.kff.org/report-section/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaide-key-findings/

12. Ponce, Ninez, et al. “How Proposed Changes to the ‘Public Charge’ Rule Will Affect Health, Hunger and the Economy in California.” Https://Healthpolicy.ucla.edu, 2019, http://healthpolicy.ucla.edu/newsroom/Documents/2018/public-charge-seminar-slides-nov2018.pdf

13. Fleming, Paul J., et al. “Families Are Choosing between Their Health and Staying Together.” The Conversation, 17 Jan. 2019, http://theconversation.com/families-are-choosing-between-their-health-and-staying-together-108865

14. Michael C. Sokol; Kimberly A. McGuigan; Robert R. Verbrugge; Robert S. Epstein (2005). Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost. Medical Care, 43, 521-530.

15. O'malley JP, O'keeffe-rosetti M, Lowe RA, et al. Health Care Utilization Rates After Oregon's 2008 Medicaid Expansion: Within-Group and Between-Group Differences Over Time Among New, Returning, and Continuously Insured Enrollees. Med Care. 2016;54(11):984-991.

16. Fertig AR, Carlin CS, Ode S, Long SK. Evidence of Pent-Up Demand for Care After Medicaid Expansion. Med Care Res Rev. 2018;75(4):516-524.

17. Weinick RM, Burns RM, Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. Health Aff (Millwood). 2010;29(9):1630-6.

18. Primary Care Office Visits For Acute Care Dropped Sharply In 2002–15, While ED Visits Increased Modestly Shih-Chuan Chou, Arjun K. Venkatesh, N. Seth Trueger, and Stephen R. Pitts Health Affairs 2019 38:2, 268-275

19. Jiang, Joanna H, et al. “Covered California 2019 Open Enrollment Early Observations and Analysis.” Characteristics of Emergency Department Visits for Super-Utilizers by Payer, 2014 #221, 2014, https://www.hcup-us.ahrq.gov/reports/statbriefs/sb221-Super-Utilizer-ED-Visits-Payer-2014.jsp?utm_source=ahrq&utm_medium=en-1&utm_term=&utm_content=1&utm_campaign=ahrq_en3_7_2017

20. PRAPARE Methodology. http://www.nachc.org/research-and-data/prapare/about-the-prapare-assessment-tool/

21. Oregon Health Authority ED Analysis Methodology. https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/SHARE%20-%20Evaluating%20the%20Access%20Quality%20Health%20and%20Cost%20Impacts%20of%20CCOs%20in%20Oregon.pdf