

Assessing Community-Based Outreach and Enrollment Activities and Outcomes Relative to Need in Los Angeles County

October 2006

Prepared for:



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**COMMUNITY
HEALTH STUDIES**

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This report was developed by Eriko O. Wada, MPP; and Michael R. Cousineau, Dr. PH of the University of Southern California, Keck School of Medicine, Center for Community Health Studies. We would like to thank Gregory D. Stevens from the Center for Community Health Studies for his input and assistance. We wish to acknowledge the Los Angeles County Department of Public Health for their assistance in providing data, the California Endowment for providing investment data, and L.A. Care for providing enrollment data. We additionally thank our evaluation partners from the Urban Institute for their input, including Ian Hill, Embry Howell, Jenny Kenney, Joshua McFeeters, and Anna Sommers. The authors are also grateful for the guidance provided by our funder, First 5 LA—specifically Will Nicholas and Laura Ojeda. Lastly, we would like to thank all of the DHS outreach and enrollment contractors who completed the survey for this report and who create and input the outreach and enrollment data we have used in this study.

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INTRODUCTION

The Los Angeles Healthy Kids program was implemented in July 2003 extending health coverage to uninsured children in families with incomes below 300 percent of the federal poverty level (FPL) who are ineligible for Medi-Cal or Healthy Families. The program was funded with an initial allocation of \$100 million from First 5 LA for children ages 0–5 years old. Subsequent fundraising efforts by the Children’s Health Initiative (CHI) Coalition of Greater Los Angeles expanded the program to children through age 18 beginning in May 2004.

The implementation of the Healthy Kids program in Los Angeles County was accompanied by additional funding from First 5 LA and The California Endowment dedicated to support outreach and enrollment activities for children and families in the county. The outreach program was intended to close gaps in children’s health insurance coverage by identifying and linking uninsured, eligible children and their families with an appropriate health insurance program for which they are eligible. First 5 LA partnered with Los Angeles County’s Department of Health Services (DHS) to coordinate and carry out these outreach and enrollment efforts. DHS then subcontracted with 15 community-based organizations (the contractors). During the same period, The California Endowment (TCE) funded 16 community-based organizations to conduct outreach and enrollment assistance county-wide, with half of these agencies also receiving grants from DHS.

The Healthy Kids program has shown remarkable success in Los Angeles. By 2005, more than 42,000 children were enrolled, 35,000 of whom are ages 6–18. While funds remain available for the continued enrollment of children ages 0–5, funds to cover premiums for older children ages 6–18 were quickly exhausted causing the CHI to put a temporary enrollment hold

in place and create a waiting list for children ages 6–18 beginning in June 2005. Recent new funding has allowed the program to slowly enroll children off the waiting list.

A four-year evaluation of the Los Angeles Healthy Kids Program is currently being conducted by The Urban Institute and its partners—the University of Southern California, the University of California at Los Angeles, Mathematica Policy Research, Inc., and Castillo & Associates. A broad range of activities are being conducted over the span of the evaluation, including case studies of implementation, focus groups with parents, a longitudinal household survey, and ongoing process monitoring of the outreach, enrollment, and service delivery systems.

The purpose of this paper. Funders and health planners are often faced with the problem of where to invest in programs to maximize effectiveness and reach communities with the highest need. The success of the Children’s Health Initiative of Greater Los Angeles similarly is linked partially to the efficient and effective allocation of limited outreach and enrollment resources to maximize the number of uninsured children enrolled in health programs. From the beginning the Los Angeles County Department of Health Services attempted to systematically deploy its limited outreach and enrollment resources based on the number of uninsured.¹ But they also considered agency experience, promise of innovation, and performance (Balaoing et al. 1995). Yet DHS recognized the challenge in quantifying the number of uninsured because data are often unavailable at the sub-county level. It also challenges evaluators seeking to quantify the effects of community based programs in achieving outcomes (Nutt 1984; Patton 1987; Aday et al. 2004).

¹ Funds were distributed to the contractors by SPA based on population data using the following criteria: (1) share of uninsured children eligible for public programs, (2) share of immigrant children ages 0–18 below 300 percent not eligible for public programs, (3) children ages 0–18 below 300 percent FPL for whom parents report health access barriers.

This study asks whether the resources devoted to outreach activities and the subsequent enrollment services are aligned with need. Specifically, we examine whether current investments in outreach and enrollment (contract amounts and distribution) and activities (outreach contacts, applications) and outcomes (Healthy Kids enrollments) are proportionately distributed relative to the number of uninsured children. Also unknown are differences in productivity and efficiency among the agencies providing these services. Information from these analyses will enable funders to better determine how to more efficiently allocate limited resources and maximize the number of uninsured children and families reached and enrolled in health coverage. This study is a continuation of a similar analysis developed as part of the Step by Step project funded by the California Healthcare Foundation.

METHODS

This study combines different data sets to identify the geographic distribution of uninsured children in the county and compares this with investments, activities and outcomes resulting from these investments. We provide descriptive data regarding the number of uninsured children ages 0–17, funding for outreach and enrollment assistance, outreach contacts, applications completed, and enrollments in Healthy Kids by Service Planning Area (SPA) and health district. To better understand how these data vary by geographic regions, we calculate a distribution and a rate defined as the number of outreach contacts, applications completed and enrollments per 1,000 uninsured children.

Geographic subunits. Analyses are done by the eight SPAs in Los Angeles County. SPAs were defined for planning purposes by the Los Angeles Children’s Planning Council in 1995 and have since been used as a planning tool for many departments (see appendix 1). SPA 1 is the Antelope Valley, SPA 2 is the San Fernando Valley, SPA 3 is the San Gabriel Valley, SPA 4 is

the Metro or Central Los Angeles area, SPA 5 is West Los Angeles, SPA 6 is South Los Angeles, SPA 7 is East Los Angeles, and SPA 8 is the South Bay including Long Beach. To address some problems, even a SPA may be too large of a geographic area for assessing need since most SPAs have populations over 1.2 million, larger than most of the other counties in California. This has led evaluators to attempt to observe variations at the health district level of which there are 26 in Los Angeles County with populations averaging 300,000.² When possible, these analyses are done by health district. It should be noted that, because health districts are considerably smaller geographic units of the population, estimates of the uninsured provided in this study, while the best available, are derived from small samples of respondents living within those districts. Therefore, some of these estimates are unstable, and thus some caution is urged in drawing conclusions based on these estimates.

A. Measures

Based on four data sources, the following measures are used in this study:

1. *Uninsured Children.* Estimated numbers of uninsured children ages 0–17 years at the SPA and health district level were calculated from the 2002–2003 Los Angeles County Health Survey (2002–2003 LACHS).³ The data were re-weighted in March 2006 and estimates may differ from those previously released. The percentages and numbers provided are the best estimates of uninsured children in the population. Health district data are derived from small

² See Appendix A for a map of SPAs and health districts in Los Angeles County.

³ The 2002–2003 Los Angeles County Health Survey (LACHS) is a biennial population-based RDD telephone survey. Data from LACHS are used to develop a distribution of uninsured children at the health district and SPA level. An algorithm, developed by DHS, aligns zip codes and other geographic identifiers to designate an individual to a health district and SPA, which allows LACHS data to be broken down and analyzed at the SPA and health district level. This allows estimates of uninsured children to be derived in smaller geographic areas, limited, however by sample size. Estimates on uninsured children based on LACHS data provide a denominator with which health district and SPA level outreach and enrollment data and DHS funding allocations are compared. For more information, contact LA County Department of Public Health, Office of Health Assessment and Epidemiology, <http://LAPublicHealth.org>.

samples of respondents living within those districts. Due to these small sample sizes and possible sampling bias, estimates for some health districts may be statistically unstable and when used for purposes of planning and examining any trends over time should be interpreted with caution.

2. *Funding.* Funding data are calculated by summing all contracts and grants from DHS and TCE and allocated to a health district based on an online survey completed by these agencies in the Fall 2005. DHS and TCE provided information on the amount of funding that was awarded to each contractor and grantee from July 2003 through June 2005. While data on funding from TCE excluded agencies that were not also funded by DHS, some TCE funds⁴ were included to better examine enrollments, a key outcome indicator. We could not distinguish enrollments by funding source therefore, L.A. Care enrollment data for the Healthy Kids program is a reflection of all outreach and enrollment investments in the county. Because funding was allocated by agency and not health district or SPA and because contractors serve multiple health districts and SPAs, an online survey was administered by evaluators to the DHS contractors asking them to estimate the percentage of their activities spent in each of the health districts. These estimates were then used to approximate the distribution of funding across health districts and SPAs. SPA funding levels are determined by summing health district allocations in the SPA.

3. *Outreach Contacts.*⁵ Data on outreach contacts were extracted from the Children's Health Outreach Initiatives (CHOI) Database. An outreach contact is formally defined by DHS as a five-minute, person-to-person contact between an individual and an outreach worker. DHS developed the CHOI Database system to enable contractors to document activities carried out

⁴ TCE dollars included in this study, for agencies also funded by DHS, account for approximately 17 percent of all outreach and enrollment funds examined in this study.

⁵ Defined by the Los Angeles County Department of Public Health, Children's Health Outreach Initiative, Maternal Child and Adolescent Health Program.

under the First 5 LA-funded outreach and enrollment effort. The CHOI Database captures an array of detailed information on outreach, enrollment, utilization and retention activities. Data are entered into the system by zip code and using an algorithm developed by DHS, outreach contacts were assigned to their corresponding health district.

4. *Applications Completed.* Data on applications completed are also collected from the CHOI Database. Applications completed are defined as those completed for Medi-Cal, Healthy Families and Healthy Kids for children ages 0–18 with the assistance of the contractors. Not all applications are submitted. Application numbers reported from the CHOI Database reflect total counts of children for whom applications were completed since all applications for the Medi-Cal, Healthy Families, and Healthy Kids programs are family applications.

5. *Healthy Kids Enrollment.* Enrollment data reflect counts of children ages 0-18 enrolled in the program by health district as of May 2006. Healthy Kids enrollment data by zip code were received from L.A. Care. An algorithm developed by DHS was used to convert enrollment data by zip code into health district and SPA level data.⁶ Enrollment totals are not exclusive to children assisted by the contractors.

B. Analysis Plan

Distributions. This analysis compares the distribution of funding devoted to outreach and enrollment to the distribution of the uninsured by SPA and health district. This enabled us to answer how the proportions of total investments and enrollments in an area compared to that area's need, defined as its proportion of the uninsured. For example, in this study we ask what percentage of the uninsured is estimated to live in a specific geographic area such as health

⁶ The algorithm was developed by LA County Department of Public Health, Office of Health Assessment and Epidemiology, <http://LAPublicHealth.org>.

district or SPA and how does it compare with the percentage of total dollars invested in outreach and enrollment in the same geographic area? We similarly compare the distribution of enrollments in Healthy Kids to the distribution of the uninsured by SPA and health district. These are presented in Exhibits 2 and 4.

Rates. We report the number of outreach contacts, applications completed and Healthy Kids enrollments, but also calculate these outcomes as ratios per 1,000 uninsured children in each SPA and health district. These analyses enable us to conduct more meaningful comparisons of inputs across health districts taking into account variations in the number of uninsured estimated across the 26 health districts.

FINDINGS

Using the methods described above we report the following findings:

1. Uninsured Children

The 2002–2003 LACHS estimates that 270,000 children ages 0-17 in Los Angeles County are uninsured, representing 10 percent of all children residing in the county (see Exhibit 1). In examining the distribution of uninsured children at the health district and SPA level, we find some disparities. SPAs 4 (Metro) and 6 (South) have the highest rates of uninsured children, approximately 13 percent and 15 percent respectively. Wider variations are seen across health districts with a low of three percent (CI 1–6 percent) in Bellflower to a high of nearly 18 percent in the South district (CI 11–24 percent) (see Exhibit 1).

2. Funding

During July 2003 to June 2005, roughly the first two years of the Healthy Kids program, \$8.7 million was invested by First 5LA and TCE in outreach and enrollment related activities,

excluding funds for training and technical or administrative support provided by DHS and TCE funding to agencies that were not also funded by DHS. Spending was highest in SPAs 4 (Metro) and 6 (South), (\$1.8 million and \$1.5 million respectively). SPAs 1 (Antelope Valley) and 5 (West) on the other hand, received the smallest amount of funding (\$304,000 and \$332,000 respectively). Current allocations in SPAs 2 (San Fernando) and 8 (South Bay) are lower than their share of the uninsured, while SPAs 3 (San Gabriel), 4 (Metro), and 7 (East LA) receive a disproportionately larger amount of funding (see Exhibits 1 and 3).

We conducted a similar analysis for spending by health district (see Exhibit 2). The health districts East (SF) Valley and West (SF) Valley in SPA 2, Pomona in SPA 3, San Antonio in SPA 7 and Torrance in SPA 8 have a disproportionately larger share of uninsured relative to their share of spending. For example, about two percent of all outreach dollars are spent in the East Valley health district, while it has six percent of the county's uninsured children. The San Antonio health district receives less than three percent of the total funds invested in outreach and enrollment, even though it has about eight percent of the county's uninsured. Conversely, the El Monte, East LA and Central health districts receive a disproportionately higher amount of funding relative to their share of uninsured. The El Monte and Central health districts each have approximately four percent of the, but receives 11 percent and nine percent respectively, of outreach and enrollment dollars (see Exhibit 2).⁷

3. Outreach Contacts

From July 2003 to June 2005, contractors made over 271,000 outreach contacts; approximately one contact for every uninsured child in the county. Over 36,000 contacts were

⁷ Health districts average about 300,000 people and estimates of the uninsured, while the best available, are derived from small samples of respondents living within those districts. Many of these estimates are unstable as denoted by asterisk in the corresponding exhibits, and thus some caution is urged in drawing conclusions based on these estimates.

made in each of five SPAs and over 20,000 contacts were made each in four health districts. Across health districts, total outreach contacts made ranged from 800 in the Torrance district to nearly 27,000 in the San Antonio district (see Exhibit 1).

Ratios of outreach contacts made per 1,000 uninsured children varied from 545 contacts per 1,000 uninsured in SPA 2 (San Fernando) to nearly three times that rate in SPA 1 (Antelope Valley) where nearly 1,400 contacts were made per 1,000 uninsured children (see Exhibit 4). The high rate of outreach contacts in the Antelope Valley is likely due to fact that this SPA is the largest in terms of square miles and the sole contractor working in this region focuses much of its efforts on reaching children and families in this expansive geographic area. SPAs 4 (Metro) and 7 (East LA) similarly have high rates of outreach contacts per 1,000 uninsured (1,342 and 1,336 respectively). SPA 2 (San Fernando) on the other hand has the lowest ratio of outreach contacts per 1,000 uninsured children in the county with 545 outreach contacts per 1,000 uninsured.

Exhibit 4 also shows variation in outreach contacts per 1,000 uninsured across health districts. The ratios range from over 2,700 contacts per 1,000 uninsured children in the East LA district to a low of 73 contacts per 1,000 uninsured children in the Torrance district.

Variations within SPAs. While multiple contractors serve SPA 8, the largest is the Long Beach Department of Public Health, which may explain why outreach in this SPA is primarily seen in the Long Beach district. Within SPA 2 (San Fernando), the highest ratio is found in the Glendale district with roughly 1,400 contacts per 1,000 uninsured children, nearly 10 times greater than the ratio seen in the San Fernando district with 148 contacts per 1,000 uninsured children. Stark differences among health districts within SPA 2 may also be explained by the location of a hospital-based contractor situated in the Glendale region and the smaller number of outreach contacts needed at provider sites to generate an application and subsequent enrollment.

Considerable variations can also be seen in SPA 3 (San Gabriel) with two health districts having over 2,000 outreach contacts per 1,000 uninsured and two health districts with approximately 450 outreach contacts per 1,000 uninsured. The variability in this SPA, particularly with respect to the focus of outreach in the El Monte and Foothill health districts is likely the result of one contractor in this area that employs a grassroots, door-to-door “promotora” approach, using volunteers from the community, to reach uninsured children and families.

4. Applications Completed

During the July 2003 to June 2005 period, the contractors completed over 43,000 applications, with approximately 17,600 applications to Medi-Cal, 13,400 to Healthy Families and 12,000 to the local Healthy Kids program (see Exhibit 1). Total applications completed ranged from a low of approximately 1,300 in SPAs 1 (Antelope Valley) and 5 (West) to almost 10,000 applications in SPA 6 (South), where the largest number of uninsured children reside (see Exhibit 1). SPAs 3 (San Gabriel), 4 (Central), 7 (East) and 8 (South Bay) had over 6,500 applications completed.

In analyzing applications completed per 1,000 uninsured, we similarly note considerable variations across SPAs and health districts. County-wide, 160 applications were completed per 1,000 uninsured children. Ratios across SPAs ranged from a low of 70 in SPA 2 (San Fernando) to 193 applications completed per 1,000 uninsured in SPA 6 (South) (see Exhibit 4).

Variations within SPAs. Across health districts, rates varied from a low total of 50 applications completed per 1,000 uninsured children in the Torrance district to over six times that ratio in the Foothill district with 323 applications per 1,000 uninsured children (see Exhibit 4). In SPA 3 (San Gabriel), the El Monte and Foothill districts had over 300 applications completed per 1,000 uninsured children, nearly three times the ratio seen in the Pomona district

with 103 applications completed per 1,000 uninsured children (see Exhibit 4). The high rate of applications completed in the El Monte and Foothill districts may be due to the unique form of outreach provided in this area noted above. Similarly, large variations are seen in SPA 8 (South Bay) with the highest ratios found in the Long Beach and Inglewood districts (205 and 240 applications completed per 1,000 uninsured respectively), four to five times higher than the ratio seen in the Torrance district of 50 applications per 1,000 uninsured children (see Exhibit 4). These variations within SPA 8 are likely due to the efforts of the location and focus of one contractor in SPA 8, namely the Long Beach Public Health Department.

5. Healthy Kids Enrollment

Enrollment data for this analysis was limited to the Healthy Kids program although many children were enrolled in Medi-Cal and Healthy Families as a result of the Healthy Kids-based outreach activities. The majority of enrollees, approximately 20 percent, come from SPA 2 (San Fernando) where over 9,000 children are enrolled, followed by SPAs 4 (Metro) and 6 (South), each with over 7,000 Healthy Kids enrollees (see Exhibits 3 and 5). Across health districts total enrollees ranged from a low of approximately 600 enrollees in the Harbor district to over 4,000 in the West Valley district. Seven districts had over 2,000 Healthy Kids enrollees. In SPA 2 (San Fernando) nearly 4,000 children were enrolled in Healthy Kids from the West Valley district but fewer than 800 enrollees were from the Glendale district.

Comparative distributions. While SPA 2 (San Fernando) received a smaller allocation of total funds (10 percent) relative to its share of the uninsured (18 percent), it generated 21 percent of the Healthy Kids enrollments (see Exhibit 3). SPA 8 (South Bay) generated 14 percent of the Healthy Kids enrollees, about proportionate to its share of the uninsured (15 percent), although it receives about 11 percent of total investments (see Exhibit 3). Smaller, but disproportionately

higher number of enrollments relative to share of uninsured also occurred in SPAs 3 (San Gabriel) and 4 (Metro). The percentage of total enrollments in SPAs 3 (San Gabriel Valley) (15 percent) and SPA 4 (Metro) (17 Percent) were higher than their relative share of uninsured (each 14 percent). Conversely, SPA 6 (South) had about 17 percent of total Healthy Kids enrollments, even though the SPA has 19 percent of the uninsured and receives 19 percent of the funding. Similarly, SPA 7 has 14 percent of the uninsured and receives 17 percent of the funding, but generated about 13 percent of the Healthy Kids enrollments (see Exhibit 3).

Rate of enrollment per 1,000 uninsured. County-wide, 157 children were enrolled in Healthy Kids per 1,000 uninsured children (see Exhibit 5). Variations in this rate across SPAs range from 76 enrollees per 1,000 uninsured children in SPA 1 (Antelope Valley) to a high of 193 enrollees per 1,000 uninsured children in SPA 4 (Metro). Fifteen health districts surpassed the county-wide rate of 157 Healthy Kids enrollees per 1,000 uninsured children. The lowest rates were found in the Torrance, Southwest, Alhambra and Antelope Valley districts, each with fewer than 100 Healthy Kids enrollees per 1,000 uninsured children. The highest rates were found in the Bellflower (SPA 7), Pasadena and Foothill (SPA 3) health districts, where there were approximately 270 enrollees per 1,000 uninsured children (see Exhibit 5).

CONCLUSIONS and POLICY DISCUSSION

This study, using a variety of data sources, provides an empirical approach to looking at the allocation of outreach and enrollment dollars relative to need. As future funding for the local Healthy Kids program may be forthcoming, and the limited dollars available for older children ages 6-18 remains, the need to effectively deploy limited resources is critical to the sustainability of the program until such funding is secured.

Data from this study shows that at the SPA level, funds have been relatively well allocated in proportion to the distribution of uninsured children. Differences within SPAs, particularly with respect to outreach contacts and applications completed, were more noticeable. It is probable that these differences are due to the location of contractors and the types of activities being conducted. For example, differences in rates of outreach contacts per 1,000 uninsured children were particularly noticeable in SPA 3 (San Gabriel). Both the El Monte and Foothill districts had more than two outreach contacts made per uninsured child which may in part be due to the “promotora” outreach approach used by the contractor in this region and its status as a hospital.

When data are examined across health districts, there appear to be some discrepancies between funding relative to need. The Central, El Monte and South districts receive nearly 30 percent of the outreach and enrollment dollars invested county-wide, but do not have the highest rates of uninsured children in the county. In fact, three health districts, namely San Antonio, West Valley, and Compton have a demonstrably larger share of the uninsured but receive a disproportionately smaller share of total funds. San Antonio for example has eight percent of the county’s uninsured but receives less than three percent of total outreach and enrollment dollars. Despite the efforts of four contractors in SPA 7 (East LA), only two agencies focus any efforts in the San Antonio district which may be in part be due to the location of these contractors, both of which are outside the San Antonio district. Meanwhile, the district of Bellflower receives the largest proportion of outreach and enrollment dollars in this SPA, approximately 32 percent, but has only about eight percent of the SPA’s uninsured.

Disproportionate funding allocations have not led to proportionate numbers of enrollments. For example, while SPA 2 (San Fernando) has a smaller allocation of spending (10 percent) relative to its share of the uninsured (18 percent), it generated 21 percent of all Healthy Kids

enrollments. SPA 8 (South Bay) generated 14 percent of the total Healthy Kids enrollees, about proportionate to its share of the uninsured, although it receives about 11 percent of the resources.

Implications. These discrepancies in funding, as identified by these analyses, suggest the need for a reassessment of investments and possibly some redistribution of funds. The need to refocus outreach and enrollment efforts to address areas of greatest need is critical for maximizing enrollment until more funds are secured. This is especially relevant in communities where larger proportions of uninsured and Healthy Kids–eligible children reside, and in districts with large and significant differences in the rate of investments relative to need.

These data suggest that DHS has the capacity to use its available data systems for a more empirical approach to the distribution of funding for outreach and enrollment in the next annual contract cycle. This is particularly important as other funders consolidate their funding for outreach and enrollment activities with DHS and more agencies begin using the CHOI Database. One approach for DHS could be to ask contractors to remain active in their current geographic areas, but fund the contractors at different amounts (increasing some and decreasing others) based on uninsured rates. Alternately, DHS may fund the existing contractors in amounts that are similar to the current funding period, but encourage agencies to reorganize their outreach and enrollment strategies to address areas with the greatest need.

Both of these approaches have pros and cons. The first is clearly responsive to changes in local needs for outreach enrollment. But it also has the potential to either punish or reward agencies based on their prior level of success. The second approach is more responsive to changing uninsured rates across health districts, but would require more coordination work with the contractors. This approach requires the reallocation of existing agencies across various districts, and would work best among those contractors that are mobile and can reallocate their

own activities. The level of DHS involvement to reduce contractor overlap and fill gaps in outreach activity, however, is potentially a major barrier to the adoption of this funding strategy.

Either approach provides a more empirical way of allocating funding to outreach and enrollment activities across health districts. While this may provide a foundation on which to base these decisions, it also raises other questions about whether all agencies receiving funding are performing equally. For example, while some of the contractors may be carrying out many outreach activities; the yield in terms of applications and actual enrollments may be very different based on the strategies employed and demographic profile of target community. DHS could make more informed decisions about funding if data were available on the actual success rates of the various activities used by the contractors. Comparing LACHS data on uninsured children by health district between 2003 and 2005 may be one approach to answering these questions.

FUTURE STUDIES

The data in this study shed some light on the geographic areas where funds are disproportionately allocated relative to need. However, additional studies are suggested to better understand these differences across health districts. More specifically, future studies could examine the effectiveness of different types of outreach strategies, productivity of different contractors, as well as differences in the demographic profile of populations (and their perceived barriers to access to care) in a health district to understanding differences across health districts in actual enrollment. Future studies could also examine the impact on retention and use of services particularly prevention.

Exhibit 1. Total Numbers and Percents of Uninsured Children Ages 0–17, Total Funding, Outreach Contacts, and Applications Completed with the Assistance of DHS Contractors by Health District, Fiscal Years 2003–2005

SPA	Health District	Uninsured (Ages 0-17)		Outreach Contacts	Funding	No. of Applications Completed with the Assistance of DHS Contractors			
		No.	%			Medi-Cal	Healthy Families	Healthy Kids	Total
1	Antelope Valley	9,000	8.3 (5.2 - 11.3)	12,476	\$304,496	386	707	253	1,346
2	Glendale	5,000	*6.7 (2.4 - 11.1)	6,807	\$233,357	310	265	373	948
	East Valley	15,000	12.5 (8.2 - 16.8)	6,823	\$163,718	374	255	373	1,002
	West Valley	22,000	10.1 (7.3 - 13.0)	12,023	\$156,718	381	272	403	1,056
	San Fernando	7,000	*5.5 (2.7 - 8.2)	1,037	\$293,964	128	127	157	412
	SPA 2 Total	49,000	9.1% (7.4 - 10.9)	26,690	\$847,757	1,193	919	1,306	3,418
3	Alhambra	7,000	*5.8 (2.2 - 9.4)	3,153	\$171,851	375	310	187	872
	El Monte	11,000	10.9 (7.1 - 14.8)	22,193	\$920,661	1,592	1,028	763	3,383
	Foothill	3,000	*4.4 (1.1 - 7.7)	7,098	\$2,000	378	306	286	970
	Pasadena	3,000	*10.5 (4.2 - 16.8)	2,600	\$87,000	48	273	172	493
	Pomona	14,000	9.2 (6.0 - 12.5)	6,449	\$181,442	655	489	294	1,438
	SPA 3 Total	39,000	8.1% (6.3 - 9.8)	41,493	\$1,362,954	3,048	2,406	1,702	7,156
4	Central	12,000	15.7 (10.2 - 21.1)	22,337	\$783,225	802	287	676	1,765
	Hollywood-Wilshire	13,000	10.6 (6.2 - 15.0)	19,269	\$431,193	1,190	558	1,428	3,176
	Northeast	12,000	15.7 (10.5 - 20.9)	8,047	\$575,425	589	451	658	1,698
	SPA 4 Total	37,000	13.4% (10.5 - 16.2)	49,653	\$1,789,843	2,581	1,296	2,762	6,639
5	West	7,000	*6.3% (3.0 - 9.6)	8,541	\$332,265	582	341	464	1,387
6	Compton	12,000	11.9 (7.4 - 16.5)	14,378	\$156,457	959	799	585	2,343
	South	11,000	17.5 (10.6 - 24.4)	5,811	\$732,488	1,019	619	487	2,125
	Southeast	10,000	*17.2 (10.1 - 24.3)	5,184	\$440,771	1,229	566	561	2,356
	Southwest	17,000	16.0 (10.9 - 21.1)	19,711	\$297,385	1,563	927	538	3,028
	SPA 6 Total	51,000	15.2% (12.4 - 18.1)	45,084	\$1,627,101	4,770	2,911	2,171	9,852
7	Bellflower	3,000	*3.5 (1.2 - 5.9)	4,346	\$475,659	317	286	248	851
	East LA	6,000	*7.4 (2.6 - 12.1)	16,414	\$450,273	451	503	367	1,321
	San Antonio	22,000	15.6 (11.3 - 19.8)	26,749	\$221,591	1,592	1,222	958	3,772
	Whittier	6,000	*7.0 (3.4 - 10.6)	3,245	\$341,939	222	467	242	931
	SPA 7 Total	38,000	9.3% (7.2 - 11.3)	50,754	\$1,489,462	2,582	2,478	1,815	6,875
8	Harbor	5,000	*8.7 (3.8 - 13.5)	2,130	\$103,532	253	211	85	549
	Inglewood	9,000	7.0 (3.9 - 10.2)	11,286	\$388,192	1,038	601	522	2,161
	Long Beach	16,000	11.5 (7.4 - 15.7)	22,686	\$297,471	936	1,398	947	3,281
	Torrance	11,000	11.0 (6.7 - 15.3)	800	\$162,206	198	166	191	555
	SPA 8 Total	41,000	9.7% (7.6 - 11.7)	36,902	\$951,401	2,425	2,376	1,745	6,546
Grand Total		270,000	10.1 (9.3 - 10.9)	271,593	\$8,705,278	17,567	13,434	12,218	43,219

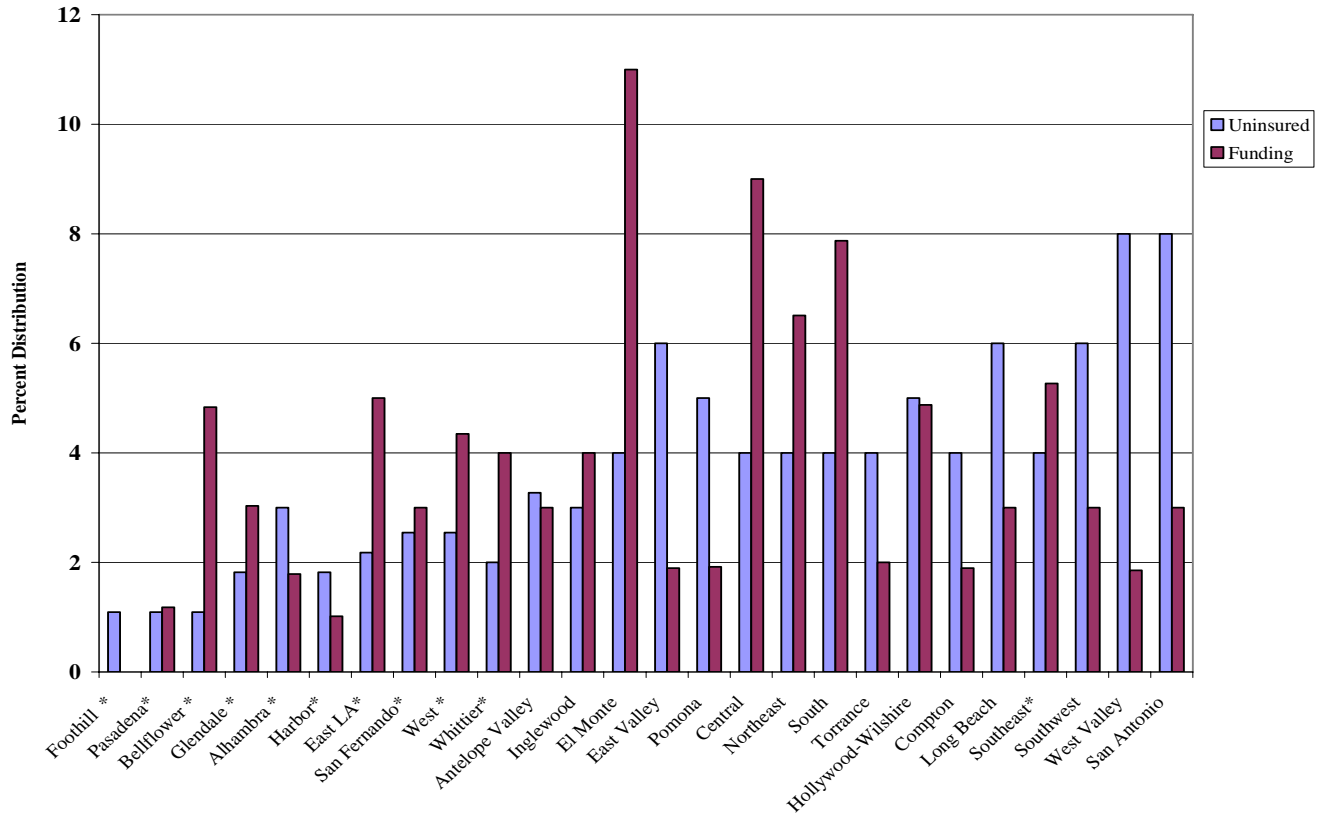
Source: LACHS 2002–2003, LA DHS CHOI Database, July 2003 to June 2005, and DHS and TCE (limited to funding for agencies also funded by DHS) administrative data, 2003–2005.

Notes: LACHS 2002–2003 data estimates may differ from prior estimates as new weights were utilized beginning March 20, 2006. Due to rounding, SPA and health district totals do not sum 270,000, which is the LACHS 2002–2003 estimate of uninsured children ages 0–17.

The information presented from LACHS 2003 is based on self-reported data from a randomly-selected, representative sample of 5,995 Los Angeles County parents/guardians. The percentages and numbers are the best estimates of the actual prevalence of each described characteristic in the population. The 95 percent confidence intervals (CI) represent the margin of error that occurs with statistical sampling, and means that the actual prevalence in the population, 95 out of 100 times sampled, would fall within the range provided. Methods for collecting these data have changed in recent years. A study by the U.S. Bureau of the Census in the year 2000 found that the total number of uninsured Americans dropped by 8 percent (or approximately 3 percentage points) when a “verification” question was added for those who initially responded that they were without coverage. Initial LA County Health Surveys (1997 and 1999–2000) did not include this verification and therefore may have overestimated the population of uninsured. The 2002–2003 and 2005 estimates are lower than prior years’ estimates, reflecting both real changes in coverage levels, particularly for children, and better methods for assessing health insurance coverage.

*Estimate is based on a cell size < 20, corresponding to a relative standard error > 23 percent of the point estimate, which may be statistically unstable.

Exhibit 2. A Comparison of the Distribution of Spending for Outreach and Enrollment by Health District with Distribution Estimates of Uninsured Children, Ages 0–17, 2003



Source: LACHS 2002–2003, DHS & TCE (limited to funding for agencies also funded by DHS) Administrative data July 2003 to June 2005.

Exhibit 3. A Comparison of the Distribution of Uninsured Children, Outreach and Enrollment Spending, and Healthy Kids Enrollments by SPA, 2003–2005

SPA	Uninsured Children ¹		OERU Spending ²		Enrollments ³	
	Number	Distribution (%)	Number	Distribution (%)	Number	Distribution (%)
1 Antelope Valley	9,000	3	\$304,496	3	684	2
2 San Fernando Valley	49,000	18	\$847,757	10	9,021	21
3 San Gabriel Valley	39,000	14	\$1,362,954	16	6,418	15
4 Metro	37,000	14	\$1,789,843	21	7,146	17
5 West	7,000	3	\$332,265	4	758	2
6 South	51,000	19	\$1,627,101	19	7,162	17
7 East	38,000	14	\$1,489,462	17	5,442	13
8 South Bay	41,000	15	\$951,401	11	5,782	14
Total	270,000 ^a	100	\$8,705,279	100	42,413	100

Sources: 1. LACHS 2002–2003; 2. DHS and TCE (limited to funding for agencies also funded by DHS) administrative data, 2003–2005; and 3. L.A. Care Health Plan, 2006.

Note: These percentages represent the distribution. For example, 3 percent of all uninsured children reside in SPA 1 (Antelope Valley).

^a Due to rounding, SPA totals do not sum 270,000 which is the LACHS 2002–2003 estimate of uninsured children ages 0–17.

Exhibit 4. Rates of Outreach Contacts per 1,000 Uninsured Children, Rates of Funding (DHS and TCE Dollars) per 1,000 Uninsured Children and Rates of Applications Completed with the Assistance of DHS Contractors per 1,000 Uninsured Children, by Health District, Fiscal Years 2003–2005

SPA	Health District	No. of Outreach Contacts per 1,000 Uninsured	Funding per 1,000 Uninsured	No. of Applications Completed per 1,000 Uninsured			
				Medi-Cal	Healthy Families	Healthy Kids	Total
1	Antelope Valley	1,386	\$33,833	43	79	28	150
2	Glendale	1,361	\$46,671	62	53	75	190
	East Valley	455	\$10,915	25	17	25	67
	West Valley	547	\$7,124	17	12	18	48
	San Fernando	148	\$41,995	18	18	22	59
	SPA 2 Total	545	\$17,301	24	19	27	70
3	Alhambra	450	\$24,550	54	44	27	125
	El Monte	2,018	\$83,696	145	93	69	308
	Foothill	2,366	\$667	126	102	95	323
	Pasadena	867	\$29,000	16	91	57	164
	Pomona	461	\$12,960	47	35	21	103
	SPA 3 Total	1,064	\$34,948	78	62	44	183
4	Central	1,861	\$65,269	67	24	56	147
	Hollywood-Wilshire	1,482	\$33,169	92	43	110	244
	Northeast	671	\$47,952	49	38	55	142
	SPA 4 Total	1,342	\$48,374	70	35	75	179
5	West	1,220	\$47,466	83	49	66	198
6	Compton	1,198	\$13,038	80	67	49	195
	South	528	\$66,590	93	56	44	193
	Southeast	518	\$44,077	123	57	56	236
	Southwest	1,159	\$17,493	92	55	32	178
	SPA 6 Total	884	\$31,904	94	57	43	193
7	Bellflower	1,449	\$158,553	106	95	83	284
	East LA	2,736	\$75,046	75	84	61	220
	San Antonio	1,216	\$10,072	72	56	44	171
	Whittier	541	\$56,990	37	78	40	155
	SPA 7 Total	1,336	\$39,196	68	65	48	181
8	Harbor	426	\$20,706	51	42	17	110
	Inglewood	1,254	\$43,132	115	67	58	240
	Long Beach	1,418	\$18,592	59	87	59	205
	Torrance	73	\$14,746	18	15	17	50
	SPA 8 Total	900	\$23,205	59	58	43	160
Total		1,006	\$32,242	65	73	44	160

Source: LACHS 2002–2003 and LA DHS CHOI Database, July 2003 to June 2005; DHS and TCE (limited to funding for agencies also funded by DHS) administrative data, 2003–2005.

Notes: LACHS 2002–2003 data estimates may differ from prior estimates as new weights were utilized beginning March 20, 2006.

The information presented from LACHS 2003 is based on self-reported data from a randomly-selected, representative sample of 5,995 Los Angeles County parents/guardians. The percentages and numbers are the best estimates of the actual prevalence of each described characteristic in the population. The 95 percent confidence intervals (CI) represent the margin of error that occurs with statistical sampling, and means that the actual prevalence in the population, 95 out of 100 times sampled, would fall within the range provided. Methods for collecting these data have changed in recent years. A study by the U.S. Bureau of the Census in the year 2000 found that the total number of uninsured Americans dropped by 8 percent (or approximately 3 percentage points) when a “verification” question was added for those who initially responded that they were without coverage. Initial LA County Health Surveys (1997 and 1999–2000) did not include this verification and therefore may have overestimated the population of uninsured. The 2002–2003 and 2005 estimates are lower than prior years’ estimates, reflecting both real changes in coverage levels, particularly for children, but also better methods for assessing health insurance coverage.

*Estimate is based on a cell size < 20, corresponding to a relative standard error > 23% of the point estimate, which may be statistically unstable.

EXHIBIT 5. Total Number of Children Enrolled in Healthy Kids and Rate of Healthy Kids Enrollment per 1,000 Uninsured Children, by Health District, Fiscal Years 2003–2005

SPA	Health District	Healthy Kids Enrollment	RATE of Enrollment (Number of Children Enrolled in Healthy Kids per 1,000 Uninsured Children)
1	Antelope Valley	684	76
2	Glendale	790	158
	East Valley	2,475	165
	West Valley	4,047	244
	San Fernando	1,709	184
	<i>SPA 2</i>	<i>9,021</i>	<i>184</i>
3	Alhambra	660	94
	El Monte	2,334	212
	Foothill	800	267
	Pasadena	816	272
	Pomona	1,808	129
	<i>SPA 3</i>	<i>6,418</i>	<i>165</i>
4	Central	1,508	126
	Hollywood-Wilshire	3,439	265
	Northeast	2,199	183
	<i>SPA 4</i>	<i>7,146</i>	<i>193</i>
5	West	758	108
6	Compton	2,003	167
	South	1,796	163
	Southeast	1,751	175
	Southwest	1,612	95
	<i>SPA 6</i>	<i>7,162</i>	<i>140</i>
7	Bellflower	817	272
	East LA	1,034	172
	San Antonio	2,941	134
	Whittier	650	108
	<i>SPA 7</i>	<i>5,442</i>	<i>143</i>
8	Harbor	606	121
	Inglewood	2,145	238
	Long Beach	2,320	145
	Torrance	711	65
	<i>SPA 8</i>	<i>5,782</i>	<i>141</i>
Total		42,413	157

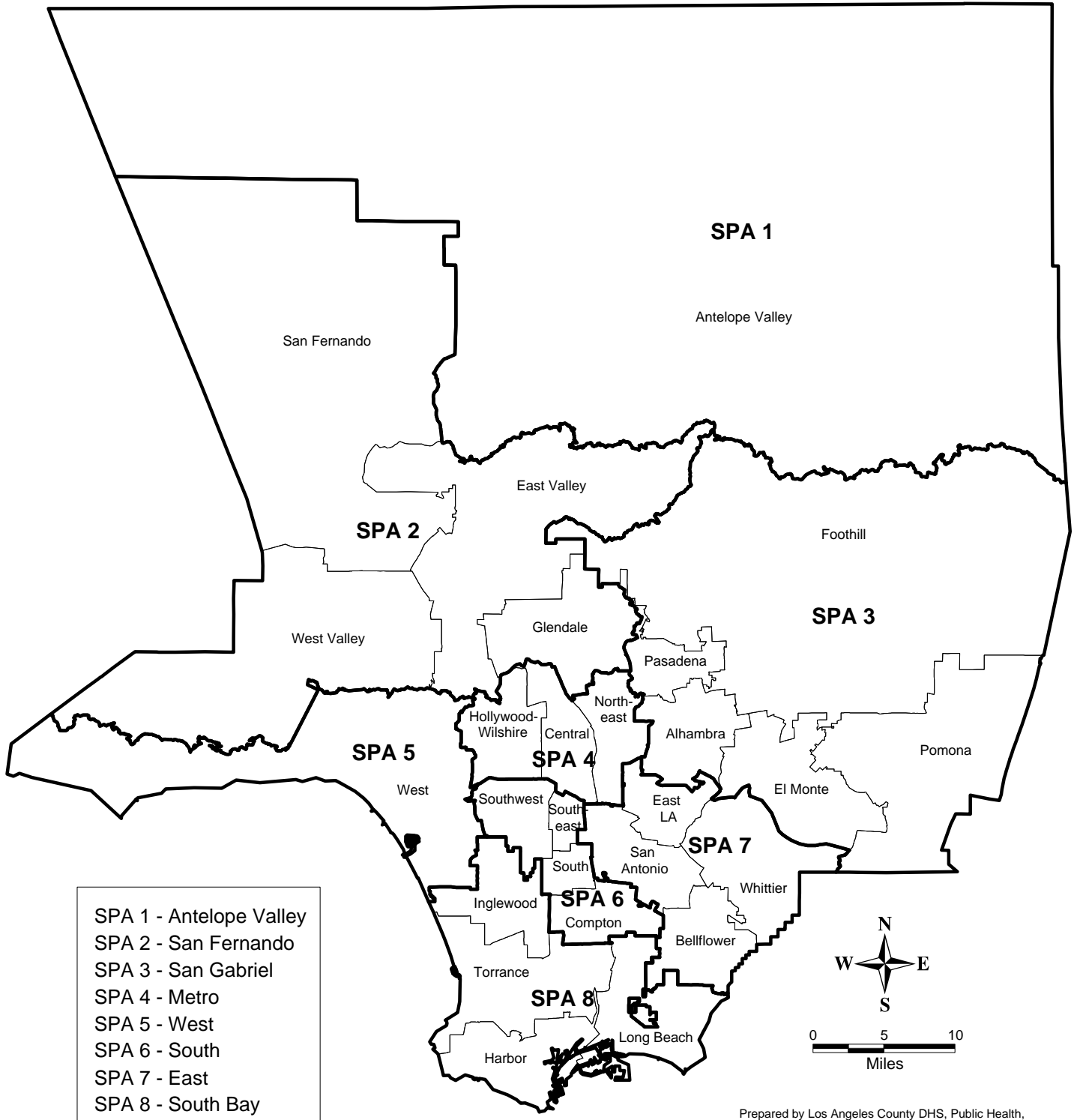
Source: L.A. Care Health Plan, May 2006 and LACHS 2002–2003.

APPENDIX 1. LOS ANGELES COUNTY SPA MAP

(See Attached PDF)

Los Angeles County

Service Planning Areas and Health Districts



Prepared by Los Angeles County DHS, Public Health,
Office of Health Assessment and Epidemiology,
November, 2000

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