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Reducing The Emergency Room Revolving Door Syndrome For The Poor, Uninsured And Chronically Ill Patient: Pilot Recommendations From A Process Improvement Evaluation

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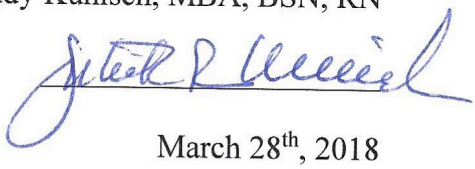

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Reducing the Emergency Room Revolving Door Syndrome for the Poor, Uninsured and Chronically Ill Patient: Recommendations from a Process Improvement Evaluation

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Abstract

Context: My Health LA (MHLA) is a Los Angeles County program that allows residents who are poor, without medical insurance (due to unaffordability and/or illegal immigration status) and without a primary care provider (un-empaneled) to enroll with an affiliated primary care clinic and receive free healthcare – related services.[1] Despite the launch of this initiative in October 2014, 35 percent of MHLA enrollees did not follow-up with a primary care clinic and 15 percent of their emergency department (ED) visits were considered avoidable in fiscal year 2015-2016.[2] **Objective:** In light of these findings**,** the MHLA enrollment pathway was evaluated at select agencies for the delineation of pilot improvement models. **Design, Settings & Participants:** Five sites were selected for the program evaluation, including a large urban medical center's emergency and urgent care departments, and three primary care clinic sites adjacent to the medical center. Data inquiry, interagency observations and patient and workforce interviews were conducted. **Main Outcome Measures:** The structure, process and outcomes of the program were evaluated. Findings were compared with other evidence-based interventions for similar populations for the delineation of process improvement models. **Results:** Identified successes within the enrollment pathway included free primary care services, use of a navigator in the ED and improved chronic illness management. Identified challenges included flawed program perceptions, patient communication gaps and current program limitations. **Conclusions:** A five-fold pilot process improvement model was proposed: short-term enhancement of communication surrounding the patient, short-term enhancement of communication to the patient at enrollment, medium-term enhancement of patient care coordination, medium to long-

term initiation of financial incentives for clinics with satisfactory MHLA enrollee primary care engagement and long – term expansion of service coverage.

KEY WORDS: My Health LA; primary care; chronic medical illness; medically uninsured; emergency services, hospital.

Background

Twenty-four million individuals remain uninsured after the passage of the Affordable Care Act (ACA) in 2010.[3] The incidence of chronic illness continues to rise in our nation, with roughly 117 million adult Americans affected.[4] Furthermore, around $1.3 trillion are drained yearly from our economy by chronic illness, threatening to hit 6 trillion dollars by 2050.[5] Many uninsured individuals with chronic illness report difficulties in gaining access to primary care, as well as access to medications and medical supplies.[6] This often drives use of emergency rooms as a substitute for primary care,[7,8] leads to higher rates of hospitalization[9] and contributes to higher co-morbidity and mortality rates.[8,10] These inappropriate usages of healthcare have contributed to increased health care costs, emergency department overcrowding and poor population health and patient experience due to fragmented care.

In October 2014, in part to address these issues, the county of Los Angeles, California created My Health LA (MHLA), a program for uninsured, adult residents (due to unaffordability and/or illegal immigration status) who do not have a primary care provider.[1] The program allows eligible individuals to enroll with partner clinics for a range of free primary, emergency, and specialty care services at participating hospitals. Enrollees also have access to prescription drugs (recent pharmacy benefits redesign in January 2018), as well as substance abuse and mental health treatment referrals (A. Luftig-Viste, personal communication, March 28, 2018).[1,11] The program's funding was $61 million in 2014-2015 ($56 million for primary care and $6 million for dental care) from county controlled funds designated for indigent programs (mix of federal, state and local resources).[12] Enrollment is renewable annually if the participant is still eligible.

Los Angeles County + USC (LAC + USC) is a large urban medical center that participates in the program. MHLA eligible patients who are treated at LAC + USC's emergency department and urgent care center are often referred to The Wellness Center (TWC) located on its campus, which assists the patient with enrollment. Once enrolled, the patient is referred to their clinic of choice for primary care follow-up. Despite this initiative, approximately 35 percent of MHLA newly enrolled patients did not engage with primary care in fiscal year 2015-2016,[1] and 16 percent of MHLA enrollees' ED visits were considered avoidable.[12] We evaluated the structure, process and outcomes of the MHLA enrollment pathways at select agencies and compared our findings with other evidence-based interventions for the delineation of pilot improvement recommendations. The recommendations were proposed to MHLA for the goals of enhancement of the current MHLA enrollment model, increased primary care engagement and decreased avoidable emergency department visits by the target population.

Methods and Approach

The evaluation was built on the classic framework of Avedis Donabedian, which identified structure, process and outcomes as essential elements when evaluating quality of care.[13] Five sites were selected for the project: LAC + USC emergency and urgent care departments, TWC at The Historic General Hospital, St John's Well Child and Family Center (Reverend Warner Traynham), Clinica Msr. Oscar A. Romero Pico Union and Clinica Msr. Oscar A. Romero Boyle Heights. These sites were selected due to their location in service planning areas 4 and 6, which have the highest MHLA enrollment rates (Figure 1).

Evaluation of the MHLA structure involved a review of the select agencies' profiles and their communities' profiles through the U.S. Census Bureau and communication with the select agencies' leadership. Evaluation of the process included observations of the MHLA enrollment at the select sites and conduction of twenty-two (22) interagency workforce and fifteen (15) interagency patient semi – structured interviews. Through the interviews, the workforce's knowledge of the program, interagency relationships, referral and enrollment challenges, potential areas of improvement and outcomes were evaluated (Table 2). Outcomes are related to health recovery including functional restoration and patient attitudes and satisfaction.[14] In addition, outcomes were also assessed through data analysis reflecting primary care and preventative health engagement. Leaders at the agencies were instrumental in assessing the agency profile and facilitating interviewee recruitment. Two Internal Review Board (IRB) exemptions were obtained from Yale University prior to interviews.

Finally, we conducted a literature review of evidence-based interventions for similar populations for comparison with our findings. Public data from the Los Angeles County Department of Public Health, the Commonwealth Fund, the Henry J. Kaiser Family Foundation and the U.S. Census Bureau yielded additional information.

Evaluation Findings

The Structure: Communities & Interagency Profiles

In the target communities, the population is predominantly Latino, with lower high school education and medical insurance rates, as well as higher federal poverty level rates in comparison to the national demographic profile (Table 1).

LAC + USC ED is open 24/7, with peak hours between 11 a.m. and 7 p.m. (B. Daniel, personal communication, January 7, 2018) while the urgent care is open Mondays through Fridays between 08:00 am and 08:00 p.m. with similar peak hours (R. Trotzky – Sirr, personal communication, February 23, 2018). At TWC, several agencies are housed and offer a wide array of programs including CalFresh, Maternal and Child Health Access, Covered California and Neighborhood Legal Services, cooking and exercise classes. TWC is open Monday through Friday from 08: 30 a.m. to 05:00 p.m. and Saturdays from 09:00 a.m. to 12:00 p.m.

Clinica Msr. Oscar A. Romero (O.A.R.) and St John's Family and Health Center are federally qualified health centers that provide comprehensive primary care - driven services to underserved Los Angeles residents. Both organizations' clinics are open Monday through Friday, with extended clinic hours throughout the week.

The Process: Referral and Enrollment Elements

At LAC+USC's emergency department, disease chronicity risk stratification is applied prior to the referral of MHLA eligible patients to community partner clinics. MHLA eligible ED patients with two or more chronic illnesses or medical conditions demanding urgent attention are forwarded to the Department of Health Services (DHS) Appointment Service Center (ASC) for consideration of empanelment to a DHS clinic (R. Trotzky, personal communication, March 29, 2017) versus an "open" MHLA clinic (still accepting patients) via the New Empanelment Request Form (NERF). In this process, DHS will provide background patient information to the clinic and attempt to connect the patient to the clinic via phone whenever possible and if requested by the community partner clinic.[15]

MHLA eligible patients deemed clinically stable at discharge in the ED are likely to be referred to TWC, where enrollment specialists will assist them in applying and enrolling into MHLA (R. Trotzky, personal communication, March 29, 2017). Recently, the process of having a wellness center navigator in the emergency department was initiated. The enrollment involves the patient's choice of one MHLA partner clinic, with the option of switching to another clinic within a three-month window post enrollment. If enrolled at TWC, patients self – navigate, with resources provided at TWC to make an initial appointment at their chosen clinic (R. Trotzky, personal communication, March 29, 2017). MHLA enrolled patients who return to the LAC+USC emergency department or urgent care center are identified and highlighted with a "MHLA" icon in the electronic medical records system dashboard to alert medical providers of the need for primary care follow-up counseling.

Literature Review

A Review of the literature on successful care coordination programs for similar populations was completed. Enrollment in free clinics results in lower ED visits in uninsured individuals.[16,17] Patient centered medical homes also help decrease emergency room visits for chronically ill patients[18] and patients with a usual source of care.[19] Furthermore, the use of care coordination for uninsured chronically ill individuals is associated with decreased emergency room use and decreased hospital admissions,[10,20] increased primary care use and lower associated acute care visits and costs.[10]

Block et al[20] evaluated the Access Partnership Program or TAP, a comprehensive case management program between primary and specialty care clinicians at East Baltimore Medical Center that used a navigator to schedule specialty care appointments,

arrange transportation, provide appointment reminders and arrange timely primary care follow-up for uninsured or underinsured chronically ill patients. The program statistically decreased emergency room utilization for the patient population.

Glendenning-Napoli et al[10] also examined the effects of an intensive community-based case management program that involved the use of a nurse case manager to conduct home visits, assess the community and home barriers and assist with primary care visits follow – up for uninsured patients with one or more chronic diseases. The effects of the intervention were significant towards decreased acute outpatient encounters and hospital admissions, decreased aggregate costs for acute care patient encounters and admissions and increased primary care use.[10]

Successes

Evidence – Based Identified Successes

MHLA has partnered with many patient-centered medical homes and provided free access to primary care and ancillary services, which have been proven to lower emergency department visits for chronically ill patients, uninsured patients, and uninsured patients with a chronic illness.[16,17,18,20] In addition, involvement of a Wellness Center navigator is in alignment with the use of care coordination for this population, as highlighted by Block et al.[20]

Workforce Identified Successes.

Process. Patients who enroll at the clinic sites are often able to obtain same day appointments (Table 3).

Outcomes. The workforce identified that patients reported general health benefits from clinic visits, improved chronic illness management and various health-related classes at the clinics and TWC (Table 3).

Patient Identified Successes.

Process. Most patients who followed-up with their clinic reported no difficulty in making the first or subsequent clinic appointments or in getting to clinic for their appointment. Within the interpersonal aspect of the process, most patients identified having good relationships with all workers and providers they have encountered on their path to enrollment and no difficulty in renewing their enrollment (Table 3).

Outcomes. Patients who connected with their assigned clinics overwhelmingly identified successes related to a better sense of understanding, management and control of their chronic condition. Patients receiving regular care at a partner clinic reported 0 to 1 ED visit in the past year; for those who reported going to the ED more than once in the past year, these visits were related to serious medical circumstances. All patients reported being satisfied with the program (Table 3).

Data – Identified Outcome Successes.

Outcomes. Engaging in primary care because of MHLA enrollment yielded high engagement with health prevention modalities, such as cancer screenings. Most of Clinica Msr. Oscar A. Romero's 2016 MHLA enrollees with hypertension, hyperlipidemia and diabetes had breast cancer screening, colon cancer screening, diabetic foot exams and tobacco cessation counseling (Table 3).

Gaps, Challenges & Interviewees' Recommendations

Evidence – Based Identified Gaps.

In comparison to the care coordination as described by Block et al[20] and Glendenning-Napoli et al,[10] the enrollment pathway does not have a continuous care coordination program within the select agencies that follows the patient from initial Wellness Center enrollment to the first clinic visit. The NERF process appears to have a more coordinated process by which, after the eligible patients are enrolled, DHS sends a list of MHLA empaneled patients to their respective clinics, but also provides background patient information to the clinic and attempts to connect the patient to the clinic if possible and/or requested by the clinic.[15]

Data – Identified Challenges.

MHLA Primary care engagement at the select clinics showed that in fiscal year 2015-2016, 27 to 36 percent of enrollees did not follow-up at the clinic (Table 4). Overall, 33 percent of MHLA enrollees and 38 percent of MHLA enrollees did not have a primary care visit respectively in service planning areas 4 and 6 during fiscal year 2015-2016 (Table 4).

Workforce – Identified Challenges.

Process. Most workforce interviewees felt there was minimal to no collaboration and/or communication between the emergency department, TWC and the local MHLA partner clinic. Several themes emerged during workforce interviews regarding gaps in the referral process from ED to TWC. Within the technical aspect of the referral process, emerging themes included: challenges in accessibility and frustration related to long ED wait. Within the pathway from TWC MHLA enrollment to making and going to the first clinic appointment, the following themes emerged: negative program perceptions; transportation costs; environmental barriers; low Health Literacy

leading and provider gender preference not accommodated for desired visit date (Table 4). Other challenges toward making subsequent follow – up appointments were mentioned: short provider change window and lack of specialty care coverage.

Patient – Identified Challenges.

Patients identified delayed appointments, perception of lack of specialty referral coverage, limited medication coverage and low provider satisfaction as challenges (Table 3).

Workforce and Patients Initial Recommendations.

Workforce Recommendations. Initial workforce recommendations towards improving first clinic appointment completion post MHLA enrollment included: addition of MHLA clinic partnerships; increase in communication & collaboration among all agencies; provision of patient – centered assistance; and provision of standardized, thorough and consistent MHLA instructions when "sending off" all new enrollees (Table 3). Workforce recommendations towards improving subsequent follow-up visit adherence were similar to first visit recommendations, with the addition of: extension of the change of provider change window; providing of clear post enrollment instructions regarding items not covered by MHLA; provision of alternative options when items are not covered; and provision of extended clinic hours at all MHLA clinics.

Patients Recommendations. Patient recommendations corroborated the workforce's recommendations, including minimizing clinic appointment delays, increasing MHLA medication coverage and providing the opportunity to change MHLA providers during the year.

Process Improvement Pilot Recommendations

Our vulnerable patient population has certainly had many successes within the program, such as prompt follow-up with local primary clinics, lower emergency department use, improved sense of health knowledge and improved health after enrollment. Enhancing the program structure and process would ensure the continued improvement and sustainability of these favorable health outcomes for our population. The final short-term (six months to one year), medium-term (one to three years) and long-term (three to five years) recommendations are five-fold (Figure 2):

- short-term initiation of enhanced communication around the patient
- short-term initiation of enhanced communication to the patient at enrollment
- medium-term enhancement of patient care coordination
- medium to long-term initiation of financial incentives for clinics with high MHLA enrollee primary care engagement
- long-term expansion of MHLA service coverage

Enhanced Communication Surrounding the Patient

Recurrent themes within the interpersonal aspect of the referral process included the lack of interagency collaboration leading to miscommunication occurrences with patients. Enhancing the communication between MHLA, LAC + USC ED and urgent care, TWC and major local MHLA clinic partners would be beneficial towards providing unified and consistent messaging to patients within the referral and enrollment pathway. An annual workforce training lead by MHLA and key player organizations and agencies in each SPA could be beneficial towards this end. Such an annual training would be a

platform for consistent and dynamic discussions on strategic planning, program updates as well as ongoing challenges and action plan.

Enhanced Communication to the Patient

The workforce and patients repeatedly underlined items that seemingly prevented patients from going to clinic after enrollment in MHLA. The repetition of several of these items highlighted the need for patients to be given a standardized discharge checklist guide for use across all MHLA enrollment sites. This checklist would be used as a guide by the enroller for verbal discussion of crucial information after enrollment, including:

- highlight of the provider/clinic change criteria;
- reassurance that their personal information will remain confidential and will only be shared in case of endangerment of self or others;
- discussion of items not covered by MHLA including specialty care referral;
- existing option for walk – in visits; and
- existing option for proof of visit

Enhancement of Care Coordination

Care coordination, as supported by the literature, should be enhanced in the program. The emergency department has initiated the use of a Wellness Center navigator to meet prospective needs in the ED. However, there appears to be little to no communication among agencies within the patient's transition from the emergency room to The Wellness Center, and later from The Wellness Center to the community partner clinic. Similar to the NERF process, we propose that a batch list of prospective and recent enrollees be sent respectively from the emergency department to TWC, then from TWC to the partner clinic of enrollment, including the name and phone number of patients that

were either referred to the receiving agency or enrolled in MHLA (within a secure database). The receiving agency would proceed with one to two-week follow-up phone calls to ensure the patient has taken the appropriate steps towards advancing within the enrollment pathway. In these instances, TWC and clinic would arrange for follow-up appointments as needed by the patient. This process could be designed within each service planning area among its major key player health agencies.

Financial incentives for clinics with satisfactory MHLA enrollee primary care engagement

Many themes revolved around meeting patients' barriers with patient-centered interventions such as bus tokens, accommodating appointment requests, offering proof of visit and providing multi-lingual care. Currently, the Los Angeles County DHS reimburses partner clinics through capitated payments at a set rate per enrolled patient each month. Providing reimbursements to partner clinics for satisfactory annual primary engagement by MHLA enrollees, may further promote the implementation of such interventions to keep these patients engaged.

Expanding My Health LA's program services

It is clear that many MHLA services will eventually need to be expanded, including provider-change window and addition of partner clinics. The recent redesign of the program's pharmacy benefits may aid in this realm as well. As the uninsured and chronically ill patient population continues to grow, these services will need to expand to meet health needs.

Limitations

We did not have the ability to follow the same patients from their initial MHLA registration at TWC to their first and subsequent clinic appointments for a more reliable account of referral pathway challenges, due to the need for every interview to remain completely anonymous. Additional confounding factors included recruitment with an incentive that may have led to subject bias and recruitment assistance by the sites that may have led to selection bias. In addition, some interviewees voiced doubts on the future of the program in relation to the current anxiety-producing, uncertain immigration laws. The latter may have influenced the answers of our patient subjects.

Discussion

Uninsured individuals still represent a considerable portion of our population. Uninsured individuals with chronic illness are specifically at higher risk for poor health and inappropriate emergency services utilization, often using the emergency room as their source of primary care. The literature highlights emergency room care coordination as a successful intervention toward decreasing emergency room visits and hospitalizations while increasing primary care utilization for this population.[10,20] Some may argue that the possibility that patients may not engage in primary care follow-up should prevent funding care coordination initiatives. However, the evidence has also shown that an ER coordination program for socioeconomically challenged patients leads to a reduction in acute care patient encounter costs and a reduction in in-patient admission costs.[10]

To address similar challenges, MHLA was launched in October 2014.[1] We evaluated the program through patient and workforce interviews and a literature review. The program has achieved many successes according to the literature and interviews,

including the provision of free health care services and improved health for the patients. However, several gaps and challenges remain. We have proposed a set of recommendations for the program's enhancement including the implementation of vectors towards enhancing communication around the patient, communication to the patient and care coordination of the patient. Expansion of the program's services was also a long-term recommendation.

Implications for Policy and Practice

This evaluation and our proposed recommendations may:

- set the tone for implementation of these models in similar populations;
- guide future research towards evaluating the effects of these models on primary care engagement and emergency room visits rates;
- lead to continued improvement of population health through higher rates of primary engagement and lower avoidable emergency department visits;
- promote lower healthcare costs per capita; and
- better patient care experience and outcomes.

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Tables

COMMUNITIES [ZIP CODE], POPULATION	NATIONAL RATES	BOYLE HEIGTHS [90033], 48,852 (CLINICA O.A.R.)	PICO UNION [90057], 44,998 (CLINICA O.A.R.)	SOUTH PARK [90007], 43,426 (ST JOHN'S WARNER TRAYNHAM)
AGE	15 – 19 years : 7.1% 45 - 49 years: 7.4% 50 - 54 years: 9.9%	Under 5 yo: 8.7% 10 – 14 years : 8.5% 15-19 years: 10.2%	15 – 19 years : 9.9% 20-24 years: 11.2% 25-29 years: 9.9%	15 – 19 years : 9.9% 20-24 years: 28.9% 25-29 years: 10.1%
GENDER	Female 50.8% v. male 49.2%	Female 50.0% v. male 50.0%	Female 46.0% v. male 54.0%	Female 48.9% v. male 51.1%
EDUCATION & UNEMPLOYMENT (16 years & over)	H.S. Graduate: 87.0% Bachelor Graduate: 30.3% Unemployed 7.4%	H.S. Graduate: 45.2% Bachelor Graduate: 9.2% Unemployed 9.6%	H.S. Graduate: 54.3% Bachelor Graduate: 18.2% Unemployed 9.8%	H.S. Graduate: 64.5% Bachelor Graduate: 25.2% Unemployed 13.0%
RACIAL MAKE UP	Hispanic or Latino: 16.3% Not Hispanic or Latino: 83.7% White: 63.7% Asian : 4.7% Black : 12.2%	Hispanic or Latino: 91.5% Not Hispanic or Latino: 8.5% White: 2.2% Asian : 4.2% Black : 1.4%	Hispanic or Latino: 69.2% Not Hispanic or Latino: 30.8% White: 5.4% Asian : 19.8% Black : 4.2%	Hispanic or Latino: 54.2% Not Hispanic or Latino: 45.8% White: 17.2% Asian : 15.3% Black : 10.9%
FAMILIES WITH INCOME BELOW FEDERAL POVERTY LEVEL	11.0%	34.4%	33.5%	34.4%
MEAN HOUSEHOLD INCOME	$77,866	$40,123	$38,511	$33, 802
HOUSING	Owner-occupied units: 65.9% Rented units: 34.1%	Owner-occupied units: 18.3% Rented units: 81.7%	Owner-occupied units: 3.9% Rented units: 96.1%	Owner-occupied units: 10.8% Rented units: 89.2%
FQHCS/HPSAS/PCP PER 1,000				
HEALTH INSURANCE STATUS (18 years & over)	Insured: 88.3% Uninsured: 11.7%	Insured: 76.1% Uninsured: 23.9%	Insured: 61.2%% Uninsured: 38.8%	Insured: 84.4% Uninsured: 15.6%
TRAVELING DISTANCE FROM THE WELLNESS CENTER/ LAC+USC ED/UCC	-	Walking distance from ED of 5 mins	From ED: Bus route: ~36 mins via 487/489, 910/950 & 14/37 to 42 mins via 70/71 and 16/17/316 Driving: 16 to 19 mins depending on route	From ED: Bus route: ~32 mins via 910/950 OR 70/71 followed by 4X OR Silver streak then 4X Driiving: 17 – 19 mins depnding on route

Table 1. Communities Profiles [22]

WORKFORCE INTERVIEWEES PROFILE	N=22
Physician/Advanced Practice Provider	n=4
Registered Nurse	n=1
Medical Assistant	n=1
Eligibility Or Benefits Counselor/Enroller	n=7
Outreach Worker	n=1
Client Navigator/Registration Clerk/Patient Resource Worker	n=7
Referral Specialist	n=1

PATIENT INTERVIEWEES PROFILE	N=15
Age	
Range	32 to 66 years old
Median	47 years old
Average	47.8 years old
Gender	
Male	20%
Female	80%
Race	
Hispanic	100%
Chronic Illness	
Hyperlipidemia	67%
Hypertension	46%
Diabetes Mellitus type II	46%
Arthritis	8%
Coronary Artery Disease	8%
Location Where Learned about MHLA	
Partner clinic/self-referral	33%
Community outreach	33%
Acquaintance/Friend	20%
LAC + USC ED	7%
TWC	7%

Table 2. Workforce & Interviewee Profile

	Structure	Process	Outcomes
Workforce	N/A	10% Patient enrolling at clinic sites often obtain same-day appointments	5% General Benefit from referral 18% Improved chronic illness management
Patient	N/A	93% No challenge in making initial appointment Same day appointment Appointment date reasonable 100% No challenge in getting to clinic Short distance between clinic and home Bus route to clinic easily accessible 87% Good relationship with interagency workers	93% Better sense of health knowledge 93% Improved health Satisfaction with the program 53% 0 to 1 Emergency Department clinic visit per year 80% Preference of clinic over ED for medical evaluation Less waiting times in clinic More trust towards clinic providers Clinic inclusive of additional services
Evidence-Based	N/A	Free access to primary care and ancillary services Use of TWC Navigator in the emergency department	N/A
MHLA Preventative Health Engagement, Data Analysis (L. Morales, personal communication, March 2 2018)	N/A	N/A	MHLA enrollees with hypertension 89% breast cancer Screened 62% colon cancer Screened 72% diabetic foot examined 96% tobacco screening & cessation counseled MHLA enrollees with diabetes 88% breast cancer

			Screened 60% colon cancer Screened 71% diabetic foot examined 97% tobacco screening & cessation counseled MHLA enrollees with hyperlipidemia 89% breast cancer Screened 64% colon cancer Screened 73% diabetic foot examined 96% tobacco screening & cessation counseled

Table 3. Identified Successes

Interview groups	ED to The Wellness Center	Wellness Center to Partner Clinic Follow-up Post MHLA Enrollment	Workforce & Patient Recommendations
Workforce Process	Challenges in Accessibility The Wellness Center not easily accessible / locatable No days at TWC with extended hours Frustration Related to Long ED Wait	**Making & Going to First Clinic Appointment** Flawed program perceptions 32% Perception of clinic appointment and/or specialty care referral delay 23% Perception that personal identification information to be divulged to immigration services 14% Perception of language barrier 9% Perception of (high) cost to visit 5% Frustration secondary to belief TWC is clinic 5% Transportation financial challenges Environmental Barriers 14% Work hours conflict 18% Fear of losing employment if missed work days 5% Appointment visit given to further location for accommodation of desired date 5% Lack of childcare coverage Low Health Literacy 14% Lack of comprehension of MHLA enrollment implications and instructions 5% Lack of understanding of for need for health maintenance after emergency health condition was resolved in ED **Making & Going to Subsequent**	**ED to TWC** Increase campus signs of TWC location & services Outsource a Wellness Center Navigator/ station to the ED **Making & Going to First Appointment** MHLA clinic partnership expansion Increase in communication & collaboration among involved agencies Patient – centered assistance at all points of pathway Use of layman's terms on discharge forms in the emergency department and at TWC after MHLA enrollment Transportation assistance offered as needed in ED, at TWC and partner clinic Offer proof of visit at TWC and at clinic as needed Promotion of multi-lingual care MHLA promotion of limited appointment delays for recent ED visitors Clinic/TWC to ensure initial clinic follow-up complete Standardized, thorough MHLA instructions provided to patient through checklist mnemonic when "sending off" MHLA

		Clinic Appointment 27% Perception of lack of specialty care coverage 14% Appointment delays 9% Work schedule conflicts 9% Short provider-change window 5% Fear of personal information being divulged to the immigration services 5% Low patient satisfaction	patient Consistent Information given to patients about My Health LA at the time of enrollment including: Change of provider criteria Patient personal and personal Health Information will not be shared at TWC or clinic of enrollment Clinic prospective provision of proof of visit Clinics potential for walk-in visits **Making & Going to Subsequent Follow-up Visits** Extending the change of provider window / providing a back-up clinic at time of enrollment Providing clear post enrollment instructions regarding items not covered by MHLA Providing alternative options when items not covered such as ability to pay and alternate medication brands MHLA partner clinics with regular business hours to consider extended hours clinic days
Patients Process	N/A	20% Appointment delay 6% No specialty coverage 6% Limited medication coverage 6% Negative experience with provider	Clinic to minimize appointment delays Increased MHLA medication coverage Provision of opportunity to change providers during the year
Outcomes	N/A	20% Would rather seek medical attention in the emergency department rather than the clinic 33% had more than one (1)	Accommodate to patient's visit requests as much as possible

		emergency department visit in the past year	
MHLA Primary Care Engagement Data Analysis (A. Luftig-Viste, personal communication, Jan 2, 2018)			
Process	N/A	N/A	N/A
Outcomes	N/A	Enrollment and Primary Care Visits in FY 15-16 – 33% with 0 clinic visit count in SPA 4 Metro area 36% with 0 clinic visit count at Clinica Romero (Boyle Heights) 38% with 0 clinic count in SPA 6 South area 27% with 0 visit count at St John's well child clinic 30% with 0 clinic visit couth (Pico Union)	N/A

Table 4. Interviewees & Data – Identified Challenges & Recommendations

Figures

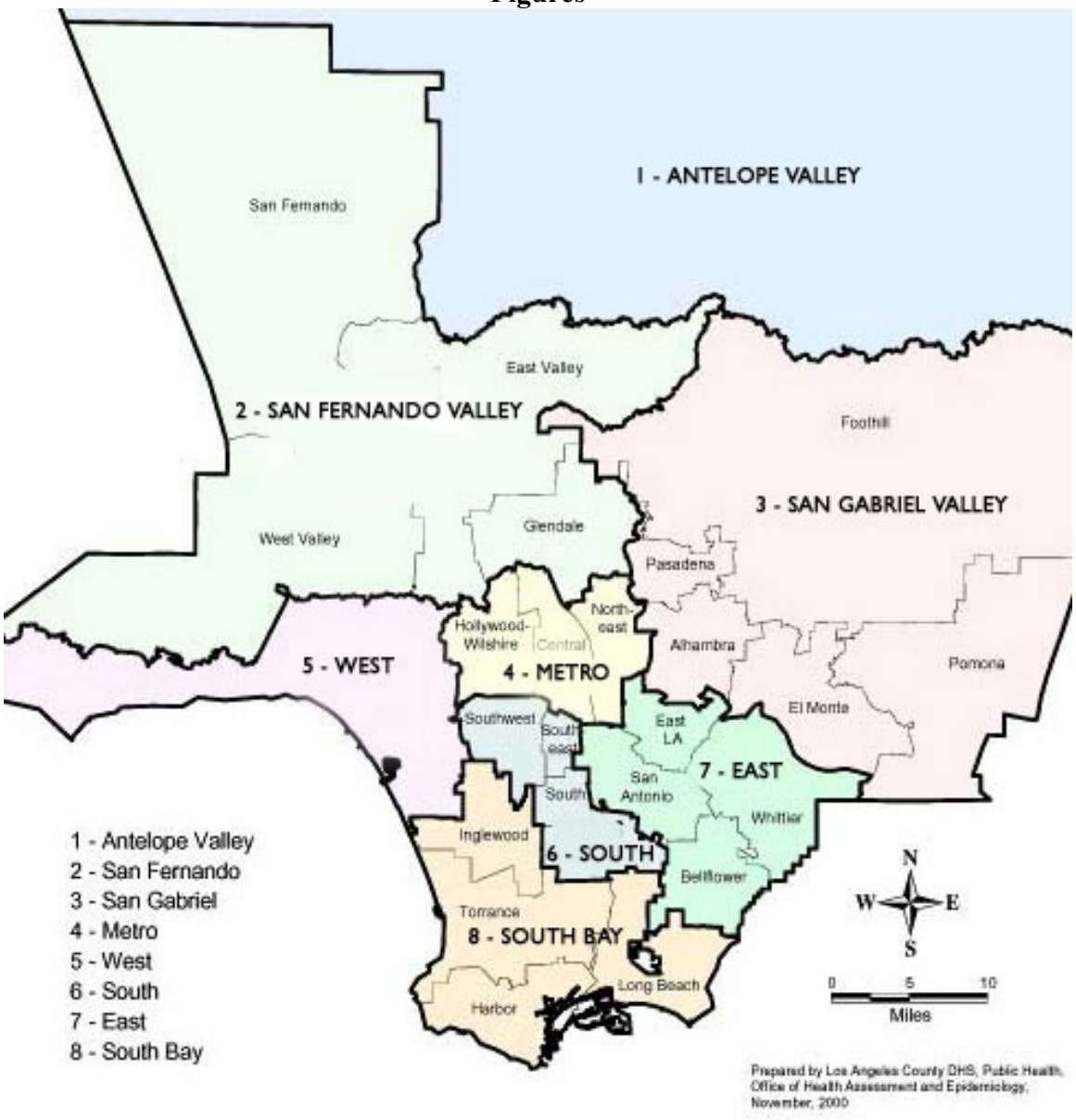

Figure 1. Los Angeles County Service Areas, From United Way of Greater Los Angeles[21]