

EVALUATING THE

# Vida Project

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**FINAL REPORT**



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*The Division of*  
**COMMUNITY  
HEALTH**

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UNIVERSITY OF SOUTHERN CALIFORNIA

# About the USC Division of Community Health

The Division of Community Health (The Division) is a multi-disciplinary team based in the Keck School of Medicine, Department of Family Medicine at the University of Southern California. The Division is devoted to promoting the health and well-being of communities, particularly underserved populations, and evaluating the impact of community interventions. The Division pools the extensive expertise of USC faculty and researchers with backgrounds in evaluation, health education, public policy, health services administration, survey research, epidemiology, international health, and bio-statistics. The Division also contributes to the education and training of future researchers by providing opportunities to undergraduate and graduate students.

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# Vida Project

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**FINAL REPORT**

Prepared by  
The Division of Community Health  
University of Southern California

*Michael R. Cousineau, Dr.PH*  
*Lori M. Nascimento, MPH*  
*Cindy Benitez, BA, BS*

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# Executive Summary

## BACKGROUND AND INTRODUCTION

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People without health insurance represent one of our nation's most pressing social problems. Nationally, over 45 million people in the US are without health coverage, including over 6 million in California and 1.6 million in Los Angeles County. Lack of health insurance is a particularly serious problem among Latinos who, as a group, have the highest percentage uninsured compared to every other ethnic group. People without health coverage are less likely to have a regular source of care, to have visited a doctor or other health provider in the past year, to have had important health screening tests, and they are more likely to delay or forgo needed health services.

Funded by The California Endowment, *the Vida project* began in 1999 as a community-based pilot project to improve access to health care for uninsured, low-income families living in the northeast San Fernando Valley. This unique project was developed to link access to care with community advocacy by enrolling uninsured, low-income families into a program that would provide them with case-management style assistance to enroll into health coverage, or county indigent programs, in addition to no-cost access to local providers who agree to participate in the program. The project also provided them with opportunities to get more involved in their communities.

The Vida Project evolved from three distinct issues:

1. the access barriers faced by low income immigrant families without health insurance,
2. the complex financial, political and organizational problems facing health care safety net providers, and
3. the capacity of communities to organize efforts to address and solve critical public health problems on their own.

The objectives of the program included recruiting and enrolling 1,200 families into Vida, screening and enrolling eligible Vida members into Medi-Cal, Healthy Families, or County indigent programs, increasing access to primary and preventive health care by providing case management services, removing programmatic and policy barriers to care, and developing active and empowered community leaders through leadership development and consumer education to advocate for systemic change in health care.

## **VIDA EVALUATION STUDY**

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This report focuses on our final evaluation study and answers the following two questions:

- Did Vida improve access to care and what was Vida’s role in this effort?
- Did Vida foster leadership and advocacy among its members and in the community in which Vida took place?

The evaluation design merged qualitative and quantitative methods to assess the experiences of Vida members, health care providers and staff involved in the pilot project. The evaluation team gathered data from various sources through observation, document review, participant surveys, and secondary data analysis to provide useful feedback to program staff and the funding agency.

## **FINDINGS FROM FINAL STUDY**

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A stratified sample of 430 Vida families was derived from membership rosters, representing 32% of all Vida families. Each family had a designated head of household to contact so we could ask him/her about their immediate family members. We completed 163 telephone surveys, 98% of which were conducted in Spanish.

The average age of survey respondents is 47 years, 84% are female, low-income, 100% are Latino and 98% were born outside of the United States.

Key findings include the following:

- Self-reported health status of Vida members is not as good as similar populations, with a large percentage of respondents having at least one chronic disease;
- Since joining Vida, access to care has improved, such as obtaining coverage and establishing a medical home (i.e. having a regular provider);
- Many Vida members still face difficulty in obtaining care;
- Vida members are satisfied with the medical services they received from providers overall, and have found referrals given to them by the Vida project very useful;
- Services provided by Vida appear to be helpful and important to respondents in their effort to receive needed health care services;
- Participation at Vida events was low; and
- Vida leadership activities were scarce and poorly documented, demonstrating limited success in this component of the project.

## DISCUSSION AND RECOMMENDATIONS

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The Vida project has been a five-year effort to connect individuals with health care providers and health insurance programs, build community leadership and participate in efforts to save and expand the safety net. Vida did improve access to care by linking individuals and family members to health insurance programs, by referring individuals to safety net clinics and specific providers, and by establishing a medical home, especially for those with a chronic illness. But Vida was less effective as a grass-roots advocacy and leadership development strategy. From the beginning, the project was promoted with the message that participants would obtain better access to care, and that appears to be the main motivation for Vida members.

This final evaluation report recommends the following:

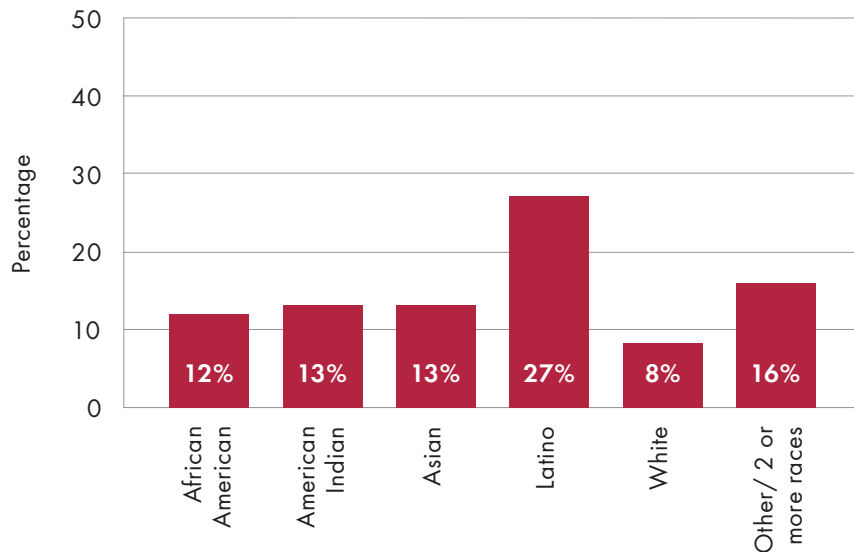
- ***Continue family-centered programs.*** The Vida project could build on its success in working with families, not just individuals, for modified and new health programs, outreach and advocacy.
- ***Engage the Vida population using effective communication by Vida members.*** Active members from the existing network of Vida families could become an effective community-based advocacy group to receive and distribute information on important community health issues.
- ***Continue eligibility work, and examine Healthy Kids as a new option for Vida members.*** We recommend that the L.A. Health Consumer Center continue to contact Vida families to assess and reassess their eligibility for programs, focusing their efforts on families with children.
- ***Improve communication among Vida health care providers.*** We believe that having better communication between providers and Vida staff regarding policy changes, Vida membership and their use of services would help providers to be more responsive and supportive of the Vida project.
- ***Rethink and redesign the leadership component.*** We recommend a modification of this strategy in which community members, leaders and providers develop a specific plan for identifying, motivating and supporting individuals who want to become community health leaders and clearly specify a set of measurable objectives.

# Introduction and Background

## Statement of the problem

People without health insurance represent one of our nation’s most pressing social problems. Nationally, over 45 million people in the US are without health coverage, including over 6 million in California, and 1.6 million in Los Angeles County [2]. Lack of health insurance is a particularly serious problem among Latinos who, as a group, have the highest percentage who are uninsured compared to every other ethnic group. In Los Angeles County, among all age groups, 27% of Latinos are uninsured, more than 10 percentage points higher than other racial and ethnic group (See Figure 1). Immigration status also plays a role in insurance coverage rates. Immigrants account for more than one-quarter of all uninsured individuals [1]. California has the largest number (3.2 million) and percentage (27%) of uninsured immigrants in the nation. Immigrants are disproportionately employed in low-wage jobs including service sector or self-employed businesses that are less likely to offer health insurance. [1], Moreover, immigrants face more obstacles to enrolling in public programs. In Los Angeles County, nearly half of the county’s uninsured population consists of immigrants [2].

**FIGURE 1. Percentage of Uninsured by Race/Ethnicity in Los Angeles County**



Source: CHIS 2003 Data (N=1,644,000)

***Consequences of being uninsured.*** There are several consequences of not having health insurance for both adults and children. People without health coverage are less likely to have a regular source of care, to have visited a doctor or other health provider in the past year, to have had important health screening tests, and they are more likely to have delayed or forgone needed health services [3]. The uninsured are less likely to report being in good health, and being uninsured is associated with increased mortality rates by 10-15% [4] [5]. Among families, research shows that children with uninsured parents are less likely to obtain needed health care, and are thus less likely to receive important health assessments and treatments, causing them to miss school more often and perform at lower cognitive levels [5] [6].

***The health care safety net.*** Without health insurance, low income and uninsured families and individuals rely on public and private clinics, charity care from hospitals and physicians, or hospital emergency rooms, often termed *The Safety Net*. The clinics and hospitals of the Los Angeles County Department of Health Services is a key component of the safety net. Yet the County has struggled over the years with a series of financial crises, which has threatened the stability of the entire health care system. The 1995 crisis nearly resulted in a system wide melt down but was averted by a five year \$1 billion Medicaid demonstration project (also known as the 1115 waiver) which included a plan to reorganize care away from costly inpatient care by expanding outpatient services. Some of the funds supported the development of the Public Private Partnership (PPP) program, whereby LA County contracts with private clinics, health centers and private physicians to provide primary care to the County's eligible uninsured population. As the end of the County's 1115 waiver approaches, the system is currently facing another potentially devastating financial crisis triggered by projected multi-million dollar budget deficits by the fiscal year 2008-2009 [7].

## Purpose of the Vida Project

The Vida Project was developed based upon three distinct but highly connected issues: 1) the access barriers faced by those without health insurance, 2) the complex financial, political and organizational problems facing health care safety net providers, and 3) the capacity of communities to organize efforts to address and solve critical public health problems on their own.

The overall goal of Vida is to improve access to health care for families in the northeast San Fernando Valley. Specifically, this community-based pilot project was designed to address the three distinct issues described above — consequences of being uninsured, the health care safety net and the 1115 waiver. This was done by first enrolling families in the Vida program which in turn assisted them to apply for

formal health coverage programs (Medi-Cal or Healthy Families), county indigent programs, or gain access to local providers who had agreed to participate in this pilot program. In addition, the project planned to identify and train Vida enrollees (referred to as *Vida members* throughout this paper) to be active community leaders. These leaders would then organize others to address the difficult health issues surrounding the uninsured and the safety net in Los Angeles.

After a planning phase in the mid-1990's, the Vida project was launched as a three-year pilot project funded by The California Endowment. It was extended through 2005 with additional grants and an amended scope of work. The objectives of the Vida program included the following:

- Recruiting and enrolling 1,200 families into Vida,
- Prescreening Vida members for County programs including PPP and the County's Ability to Pay Plan (ATP), and (later included) screening for the outpatient reduced-cost simplified application plan known as ORSA,
- Enrolling eligible Vida members into Medi-Cal and Healthy Families,
- Increasing access to primary and preventive health care by providing case management services, and removing programmatic and policy barriers to care,
- Developing active and empowered community leaders through leadership development and consumer education to advocate for systemic change in health care, and
- Expanding the Vida model to other areas, particularly the San Gabriel Valley.

## Structure and operation of Vida

*Where the Vida project took place.* Vida was organized in the San Fernando Valley which is a part of Los Angeles County's Service Planning Area (SPA) 2.<sup>1</sup> SPA 2 includes the San Fernando and Santa Clarita Valleys and covers 700 square miles, 36 cities and sixty-five zip codes. Forty percent of the SPA 2 population is Latino. Among adults in SPA 2, 24.5% were uninsured in 2003, and 8.3% of children were uninsured. Furthermore, 18.7% of adults and 4.9% of children did not have a regular source of care [8]. The majority of Vida participants live in Pacoima, Van Nuys, North Hollywood, Panorama City and San Fernando, all communities within SPA2. A community needs assessment has shown that more than half of the residents in three communities in SPA 2 (Panorama City, Pacoima and North

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<sup>1</sup> Los Angeles County is divided into eight service planning areas (SPAs) for the purpose of health care planning and needs based on data collection.

Hollywood) are living below the federal poverty level. The report concludes that these communities are among the most under-served and their populations among the most vulnerable in the San Fernando Valley, areas with high numbers of Latino residents, immigrants, and uninsured adults and children [9].

***Recruitment and enrollment.*** Prior to Vida enrollment, an organized outreach and recruitment effort was implemented to identify and enroll a specific number of families from various sites in the San Fernando Valley. Recruitment was led by Neighborhood Legal Services' (NLS) partner in the project, Los Angeles Metro Industrial Areas Foundation (IAF), and initially involved visits to churches with large congregations located in lower-income areas of the Valley. Churches were chosen because IAF had already started working with congregation members on community leadership, and some members had formed groups, assessed member needs and determined that health insurance and access to care were among their top priorities. Through a natural process of networking and sharing ideas, IAF, community members and NLS attorneys worked jointly to identify potential project partners, mostly through the churches. If a particular church director determined that their congregation would be interested and could benefit from participation in the project, Vida enrollment meetings were scheduled at the churches where priests promoted Vida at Sunday masses. Over time, new and different types of sites were added. By the end of the project, enrollment sites included eight churches, two schools, one housing project and the NLS office. These sites were located in the following San Fernando Valley neighborhoods: San Fernando, Pacoima, Van Nuys, Canoga Park, Reseda, and North Hollywood.

Enrolling in the project began with attendance at an "enrollment event", where participants were given an overview of the Vida project and how to obtain health services. At the enrollment event, new Vida members received a binder with information about the program and participating health care providers, met with an eligibility specialist for an assessment of how they may qualify and apply for available public health programs, and they signed forms, including a voluntary evaluation consent form. Most enrollment events took place in the evening and children were welcome. The enrollment period for the program lasted just under three and a half years, beginning in January 1999 and ending in May 2002.

Following each enrollment event, data from the signed forms were entered into newly created Vida database, which managed information about member families such as names, birthdates, health insurance history and income level. The Vida database was housed at NLS and maintained by Vida Project staff. Counselors from the Los Angeles Health Consumer Center (HCC) also entered data into their HCC database to track and update the insurance status of Vida members.

***Screening for health insurance and other programs.*** Part of Vida enrollment consisted of being screened for eligibility for a public coverage program, such as Medi-Cal or the county indigent program. Only people who were uninsured at the time of enrollment were eligible for Vida. Then, families were assisted by Vida and County staff to identify programs that they may be eligible for, such as the County program.

***Participating health providers.*** During the development of the project, numerous community and county clinics and hospitals were approached with the support of the Los Angeles County Department of Health Services (DHS), to provide no-cost health care services to Vida participants. Under the 1999 ordinance, 24 clinics were committed to providing care to Vida participants during the pilot period. These providers included community and county clinics and hospitals located throughout the San Fernando Valley, about two-thirds of which are PPP providers. These providers were part of the Valley Care Community Consortium, and participants in this group were committed supporters for improving access to care for the Vida member population. In sum, enrolling in the Vida project meant automatic access to these participating providers, eliminating the need for additional screening form applications.

***Using services.*** Since Vida members were already pre-screened and the participating providers had already agreed to provide access to Vida members without additional screening, Vida members were able to use services at these providers by simply showing his/her Vida card to the front desk. Vida members were eligible for office visits, preventive care, optometry, and some specialty care at the designated Vida provider sites. Dental extractions were also covered under Vida, and were performed at the County Mid-Valley clinic. Vida staff and the partnering providers gave referrals to low-cost clinics for additional services.

From the time of enrollment and many times thereafter, Vida staff members reminded Vida members that “Vida is not health insurance” and that they should continue to seek health coverage if they have the opportunity. Often, the participating providers would try to enroll eligible family members into Medi-Cal and Healthy Families, or seek reimbursement under the County’s Ability to Pay (ATP) plan or Public Private Partnership (PPP) program, later called the outpatient reduced-cost simplified application plan (ORSA). Linking Vida participants to public programs was an important objective of the program as it became clear that Vida would not provide access indefinitely to participants, and having regular health insurance would provide them with more benefits.

***Building community leadership and advocacy.*** Another component of Vida was to identify and train community health leaders. The purpose of this strategy was to provide educational and advocacy opportunities to the Vida participants over time, and observe who emerged as community leaders. Vida members were contacted about educational events, leadership training and participation in local advocacy efforts, such as immigrant rights. Those who emerged as leaders would receive additional training and education to work on issues that they identified as important in their respective communities.

### **SUPPORT AND PARTICIPATING ORGANIZATIONS.**

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The Vida project was funded by several grants from The California Endowment (TCE). The first was awarded in 1999, following the County Board of Supervisor's approval in June 1999 of an ordinance that stated county and public-private partnership (PPP) clinics would provide services to Vida participants at no cost. The first TCE award launched the three year pilot project. In 2002, TCE provided another award to expand and continue the Vida project for another three years. Funding of approximately \$2.3 million was allocated to enable the Vida project to continue providing services and examine the value and feasibility of this program to improve access to health care for low-income, minority, immigrant populations residing in Los Angeles County.

***Participating organizations.*** The Vida project was designed as a partnership or collaborative involving five major partners. Each had a specific role in the overall project, some of which changed over time. They include the following:

**NEIGHBORHOOD LEGAL SERVICES OF LOS ANGELES COUNTY (NLS)** is the *Lead agency*, responsible for enrolling Vida members, maintaining contact with members by providing education, outreach, and referrals, responding to participant inquiries, reporting to TCE, and working with the evaluation team.

**HEALTH CONSUMER CENTER OF LOS ANGELES COUNTY (HCC)** is housed at NLS. The HCC is responsible for contacting Vida members to determine eligibility for health insurance and/or county health programs, assisting members to enroll in health programs, being available to help resolve eligibility and/or service problems regarding access to health care issues, and advocating for health care rights and services on behalf of participants.

**LOS ANGELES METRO INDUSTRIAL AREAS FOUNDATION (IAF)** is responsible for outreach and recruitment of Vida members through building relationships with community churches and organizations. IAF is the lead agency for the identification of "leaders" within the Vida member population; and advocacy and leadership training with Vida members.

**VALLEY CARE COMMUNITY CONSORTIUM** is a community-based health planning collaborative in the San Fernando Valley. A group of providers and stakeholders from this consortium was instrumental in advocating for Vida members to receive health care at the PPP clinics without additional screening or payments, and to facilitate clients' use of both PPP and county clinics.

**UNIVERSITY OF SOUTHERN CALIFORNIA, DIVISION OF COMMUNITY HEALTH (USC)** is responsible for evaluating the Vida project, collecting data, data analysis and dissemination of findings to determine project successes and areas for improvement.

## Evaluation of the Vida Project

### **APPROACH AND RESEARCH QUESTIONS**

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The evaluation design merged qualitative and quantitative methods to assess the experiences of Vida members, health care providers and staff involved in the pilot project. The evaluation team used a multi-method, multi-level approach to gather data from various sources and provide useful feedback to program staff and the funding agency. When possible, we used standardized data collection instruments and questions, and collected data in English and Spanish, according to the preferences of the study respondents. Because this was a pilot project, the evaluation study was designed to assess the formation of Vida and the process and outcomes associated with efforts to reach its goals. Six annual progress reports and evaluation study reports were written pertaining to the Vida project, and these included findings derived from activity reports, leadership logs, utilization data, provider feedback and surveys.

The evaluation team provided real-time feedback to facilitate program improvements, particularly during the enrollment period. As the project developed and changed, the evaluation plan was also modified. For example, after the Vida project stopped enrolling new members, we could no longer conduct baseline surveys at enrollment so we developed and implemented a cross-sectional survey of Vida members at different points in time, and we conducted a survey with the Vida providers regarding the members' use of services.

This report provides our final assessment of the Vida project and focuses on answering the following two questions:

- Did Vida improve access to care and what was Vida's role in this effort?
- Did Vida foster leadership and advocacy among its members and in the community in which Vida took place?

## METHODS

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From the project's inception in 1999, the evaluation team used the following data collection methods to understand the effectiveness of Vida project activities:

***Participant observation.*** Evaluators attended enrollment events, leadership training sessions, outreach activities, educational workshops and other events to observe Vida activities. We examined the operational structure, processes and level of member participation at these events. We also observed how Vida activities are documented, including use of the Vida database and the educational and tracking materials used for the project.

***Document review.*** Throughout the evaluation study, we reviewed documents developed for Vida members and those used by Vida staff and project management. These documents included activity reports, leadership logs, and utilization profiles of the Vida members. We reviewed both hard copies and electronic documents periodically, depending on the frequency and type of activities in progress. We also reviewed materials developed by the Health Consumer Center (HCC) and Vida staff to provide education and information to Vida members regarding important health care access issues.

***Participant surveys.*** We developed several surveys using standardized questions when possible to measure Vida members' self-reported change in access to care issues and health indicators among Vida members, in addition to program satisfaction questions. We also created and implemented a survey specifically for Vida health care providers.

***Secondary data analysis.*** In the first few years of the study, we looked at data from the Los Angeles County Department of Health Services to examine enrollment and utilization of services by Vida members. This effort was halted when it became clear that the data could not be effectively matched with Vida participant information to provide accurate and reliable information. When available, we also looked at data stored in NLS's Vida project database.

The following table provides an overview of the Vida project goals with brief results for the five year project.

TABLE I. Summary of Vida Project Goals and Status

VIDA PROJECT GOAL	STATUS	NOTES
1. Recruitment and enrolling 1,200 families into Vida	Met	Exceeded goal, as 1,363 families were enrolled into Vida.
2. Increasing access to primary and preventive health care by providing case management services, and removing programmatic and policy barriers to care	Met	Several indicators suggest that Vida was helpful and important in improving respondents' access to care, although significant barriers still exist.
3. Developing active and empowered community leaders through leadership development and consumer education to advocate for systemic change in health care	Not Met	The number and level of participation of the Vida plaintiff group, FAITH, is unclear, and does not appear to include active community leaders. If community leaders did emerge from this project, they were few in numbers.
4. Enrolling eligible Vida members into Medi-Cal and Healthy Families	Met	Findings reveal that 29% of respondents have full coverage, and 19% have limited coverage, and 52% of respondents' family members have full coverage, and an additional 5% have limited coverage. It is important to note that at enrollment, 100% of Vida participants were uninsured.
5. Expanding the Vida model to other areas, particularly the San Gabriel Valley	Not Met	While efforts were made, including meetings, trainings and participation in events, a Vida-like model was never implemented in the San Gabriel Valley.
6. Prescreening others for County programs including PPP and the County's Ability to Pay Plan (ATP), and (later included) screening for the outpatient reduced-cost simplified application plan known as ORSA	Met	Vida members were screened at enrollment and then again annually to determine their eligibility for County programs (if they were deemed ineligible for State programs, such as Medi-Cal).

## Summary of previous Vida evaluation studies and progress reports

***Vida interim evaluation report (April 2000).*** This report provided evaluation findings for the first year of the Vida project (January through December of 1999), with a focus on project recruitment and enrollment, leadership development and changes in members' access to care. Data were collected by examining Vida project activity reports, reviewing leadership logs, analyzing utilization data provided by ValleyCare providers, and by administering a Vida Participant Survey with a sample of 40 Vida families.

This report included the following key findings: 350 families were enrolled in Vida during the project's first year, and about 22% of those who enrolled used health services through Vida. About 20% of participants applied for Medi-Cal since their enrollment, while others mistakenly considered Vida as coverage. Three-fourths of participants attended at least one Vida meeting. After joining Vida, Participants reported that they were more likely to have a regular source of care, receive preventive services, and have a need for dental and/or vision care.

***Vida longitudinal cross-sectional survey (July 2001).*** This survey was conducted as a longitudinal study in which a cohort of Vida members was interviewed at the time of their enrollment between January 1, 2000 and March, 31, 2000 and then again six months later. Of the 532 people who enrolled in Vida during the study period, we completed baseline interview with 454 members, representing an 85% response rate. Among those, 343 follow-up interviews were completed at the six-month period. The 343 participants who completed both baseline and follow-up surveys represents nearly two-thirds (64%) of those who were eligible to participate in this survey.

The study findings showed an improvement in self-reported health status (i.e. "fair" changed to "good") for almost one-third of the respondents from baseline to the six-month follow-up. It also appeared that over the six month period, more survey respondents had a usual source of care, reported having a regular provider, and frequented clinics for medical care. Almost one-third of survey respondents reported greater ease in obtaining medical care after being in Vida for six months. Ninety percent of respondents who made health care appointments were able to keep their appointment, which suggested interest on the part of participants to seek out health care, as well as a capability and willingness on the providers' side to serve this population. On the other hand, a higher proportion reported not being able to get medical care when needed, and the main reasons cited included high costs and barriers within provider organizations. The proportion of uninsured participants dropped from baseline, but remained very high as almost one-fifth of respondents reported not being eligible for public insurance programs.

Recommendations and lessons learned from this study included policy suggestions around the program itself (how joining Vida helps linkage efforts), family coverage and access to care (e.g. evidence that family coverage improve health outcomes), reducing barriers to care (e.g. helping members find a medical home), the role of Vida providers and health improvement. There were also numerous findings illustrating the short-term effects of the project on Vida members' access to and use of health care services which were further studied in subsequent reports.

***Vida II evaluation progress report (July 2002) based on a participant baseline survey at enrollment.*** We conducted a cross-sectional survey to obtain baseline data on all Vida participants who were newly enrolled in the project in the month of May, 2002 regarding their access to care and utilization of health services prior to receiving any services associated with Vida enrollment. During the enrollment events that took place in May of 2002, bilingual evaluators conducted in-person interviews with adult members of newly enrolled families, and gathered information about all other enrolled family members (their children). Our response rate for this survey was close to 100% due to our on-site, in-person, pre-planned data collection strategy collaborating with NLS.

This baseline survey included 28 families, consisting of 69 individuals, 36% of whom were children. Among survey respondents, 96% reported their ethnicity as Latino, 70% were female and 70% were under the age of 50. Just over one-third (36%) of adult respondents were employed, mostly in the occupations of housekeeping (30%), landscaping (20%) and food services (20%). Ninety-two percent of respondents reported being uninsured.

Findings from this study illustrated that nearly 90% of the adult respondents and 32% of the children of these respondents reported having no usual source of care, and 85% of respondents said it was *hard* or *very hard* to get medical care. However, the reported rate of preventive care was relatively good. Eighty-three percent of respondents said their child(ren) had a well check-up in the past 12 months, all adult females reported having had a pap smear test, all adult males over 40 had been screened for prostate cancer and all females over 40 reported having had a mammogram exam. Still, 26% of respondents reported having visited the emergency room in the past 12 months.

This study provided a more in-depth profile of Vida participants as they enrolled in the project, particularly in terms of their occupations, which showed that most adults worked in the fields of housekeeping and day labor and landscaping, often self-employed and usually without benefits such as health insurance.

***Vida II evaluation progress report (June 2003).*** This progress report provided updates on the Vida grant objectives and data analysis efforts. We reported our difficulty in obtaining accurate utilization data from the County, discussed the

development of small business focus groups, an effort to create a Vida-like project in the San Gabriel Valley, and the development of a Vida Leadership Survey.

***Leadership report and study.*** The purpose of the leadership study was to evaluate the leadership component of the Vida project in terms of recruitment, retention and the work conducted by community leaders. In the first year of the Vida project, IAF helped to form and guide a group called VOICE (valley organized in community efforts) mostly by working with local churches, to create a network of resources and volunteers within the San Fernando Valley community serviced by Vida. Their premise was to develop community leaders from within existing networks, and their activities included meetings and trainings. However, there was very little documentation of these activities, and thus it was difficult to understand their work and conduct an evaluation. Our evaluation report recommended the development and use of a VOICE volunteer database to track the number and types of leaders to better identify the numbers and activities of leaders. Other recommendations included: create a mentorship program, expand outreach activities to reach more target populations, and examine a more collaborated and organized effort of enrollment and community empowerment by creating a Vida/VOICE newsletter.

In the summer of 2003, we conducted a leadership evaluation study by interviewing Vida participants who were identified as leaders by Vida and IAF staff, and had attended three Vida Leadership Training Sessions in July – August 2003. The study was conducted using a leadership survey that was based on a community health leader instrument developed for a study of the retention and productivity of health leaders in Long Beach and in the San Gabriel Valley. The survey included questions about the leader's level of satisfaction as community leaders, their intentions to work as leaders, their support and social networks, empowerment and their attitudes as leaders.

To evaluate the leadership training, we attended the three training sessions, completed Evaluator Observation Forms, reviewed materials, and conducted a leadership survey with the 12 participants. Evaluators found that the Vida participants identified as leaders consisted largely of a group of Vida members that were also part of an organizational plaintiff group named FAITH (Families Aimed at Improving Their Healthcare). Due to infrequent meetings and schedule conflicts, a follow-up leadership survey was not conducted and thus data from the leadership study do not include long-term findings.

Our limited findings from this study suggest that in general, the participants felt the workshops were effective and helpful, and they were better prepared to share the information they learned with friends and neighbors. However, participants also felt that more workshops were needed and that they need more unity within their communities to improve communications and to utilize what they had learned.

Participants also mentioned the need for better logistics at workshops (e.g. available child care) to improve participation rates.

*Provider study, findings from guided interviews with ValleyCare executive and administrative staff (June 2004).* Our process evaluation of the Vida project included an examination of the role of participating health care providers in the Vida project. We conducted a qualitative study of executive and administrative staff from ValleyCare’s county health centers and PPP clinics that provided services for Vida participants. We conducted 13 interviews by telephone from March through April of 2004, representing about half of the Vida provider sites. The interviews covered three main areas: clinic/health center participation in the Vida project, interactions with Vida patients, and communications with Vida staff.

One strategy of the Vida project was to conduct a financial screening of participants at the time of their enrollment to determine their eligibility for various health programs. Technically, only people without insurance could join Vida, and then they were screened for county indigent health programs. Given that the screening process took place at the time of enrollment, Vida providers were asked to accept Vida participants, upon demonstration of their Vida card, without additional financial screening. However, this was usually not the case, which caused frustration among both the patients and providers. Interviews with participating providers found that high staff turnover at the Vida office and at the participating clinics led to a lack of information and communication to follow through with the original plan.

Results from the provider interviews revealed that the lack of communication between Vida project staff and providers resulted in further confusion, such as not knowing whether the Vida project was still active. Many of the providers did not feel they benefited from Vida, as some of their patients would have been their patients regardless of their involvement with Vida. However, providers did state that one possible benefit of the project was to improve access to care by providing education and information about preventive services. Some providers stated that perhaps Vida participants would not have sought care, particularly in regard to preventive screenings, had it not been for their involvement in the project. Finally, the results from this provider study showed that there was variation between community clinic staff members and county health center staff, in which the county staff had a clearer understanding of the financial screening procedures and were more likely to accept the Vida card.

# Final Evaluation Study

We designed a final evaluation study to obtain a summative account of the Vida project emphasizing participants' change in access to care, perception of Vida, and leadership and advocacy. We also measured outcome data on health care indicators from Vida participants who have been enrolled in the project for at least two and a half years.

## Methods

The data collection instrument for the final Vida evaluation survey was developed using questions from our previous Vida assessment surveys and from other standardized instruments. The data collection instrument consisted of approximately 50 items, including both open and closed-ended questions. The questions covered participant involvement and satisfaction with the Vida project, access to care issues, self-reported health status, use of health services, health insurance status and general demographics. The instrument also allowed for participants to share their concerns and suggestions regarding community issues and the Vida project in general.

**Sample.** The sampling frame consisted of all families who enrolled in the Vida project. In December, 2004, after enrollment had been closed to new Vida members for some time, the Vida Project database housed at NLS showed 1,363 families enrolled in the Vida Project. We sought to interview a minimum of 10% of all Vida families, so we drew a 20% sample, assuming that we would not reach at least half of the families to due wrong numbers or lack of interest. We used a stratified sampling technique by enrollment date (i.e. the first  $n$  families enrolled on each enrollment date), between January 1999 through May 2002. Due to difficulty in contacting Vida participants, we received another 12% sample using the same stratified sampling technique in an effort to reach and interview 10% of all Vida families. In total, we received contact sheets for 430 families (six duplicates were excluded from the sample) representing 32% of all Vida families. Each family had a designated head of household to contact so we could ask him/her about their immediate family members. Vida project staff had informed participants prior to data collection that they may be contacted by the Vida evaluation team to participate in a survey.

**Data collection and data analysis.** Data collection took place from December 16, 2004 through January 27, 2005. All surveys were conducted by telephone from the Division of Community Health offices at the University of Southern California (USC). Bi-lingual (English and Spanish) students from USC were trained in data

collection, survey content and in using the QDS data collection program. Each survey took approximately 15 minutes to administer. Ninety-eight percent of the surveys were conducted in Spanish.

A database was created directly from our data collection instrument using the QDS, CAPI program. Following each day of data collection, the Project Manager would transfer all new records from the computers that were used into a centralized QDS survey warehouse. Due to the nature of this program, there was very little data cleaning to perform before we transferred the data to STATA for analysis. Cross-sectional data analysis was conducted using chi square analysis with a significant p-value of less than .05.

## Findings

This section will provide findings from this Final Evaluation Study of the Vida project and answers our two major evaluation questions. The first question is, *Did Vida improve access to care and what was Vida’s role in this effort?*

This will be answered in the following sections:

- Profile of Vida Respondents
- Health status of Vida members
- Access to care
- Vida’s impact on health care and the usefulness of Vida services and materials

## PROFILE OF VIDA RESPONDENTS

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We completed 163 interviews with Vida family heads of households, which represented 63% of the families in our sample, and approximately 12% of all Vida families (see Table 2). Non-respondents include 77 participants who we were unable to contact after multiple attempts and 18 who refused or said they were not interested in participating. The respondents we interviewed were considered to be the heads of household at the time of enrollment and/or the individual in their immediate family most responsible and knowledgeable for their families’ health care. While this survey did ask some questions about family members, most of the information collected focuses on the head of household (referred to as respondent) him/herself.

TABLE 2. Evaluation Study Response Rate

CATEGORY	TOTAL # OF CONTACTS
<b>Total Number of Vida Families</b>	1363
<b>Total Number of Contacts Received for Sample</b> (32% of Vida Families, with 6 duplicate contact sheets)	430
<b>Unreachable Contacts</b>	173
- wrong number (153)	
- no answer (10)	
- no number (5)	
- out of country (4)	
- deceased (1)	
<b>Reachable Contacts</b>	258
- 163 completed surveys	
- 77 unable to contact	
- 18 refused or not interested	
<b>Percentage of Respondents among total Vida family population (163/1363)</b>	12%
<b>Response Rate (163/258)</b>	<b>63%</b>
<b>Response rate from original sample frame (163/430)</b>	38%

Included in our study sample are those respondents who reported that they are no longer Vida members. Despite our records confirming Vida membership of our entire study sample, 23 of the respondents (16% of our total study population) reported that they were not a member of Vida. The reasons given by these respondents include: obtained other form of health insurance or Medi-Cal (57%), problems with using Vida providers such as having been refused treatment at a clinic as a Vida member (39%), or no longer interested (4%). We interpret this finding to mean that these respondents viewed Vida as a service or program similar to a health coverage plan, and when it did not work for them or when they received coverage from another source, they no longer needed Vida.

***Comparing Vida to other population groups.*** The average age of respondents is 47 years (ranging from 23 to 74 years), including eight over age 65. The majority are female (84%), 100% are Latino and 98% were born outside of the United States. The average number of years living in California among respondents is 20 years, (ranging from 4 to 71 years). Vida respondents, like all Vida participants, resided in the San Fernando Valley at the time of the survey. Based on Vida program eligibility at the time of enrollment, all respondents have low-incomes, although income was not assessed at

the time of the interview. In Table 2 we compare the demographics of the respondents to other populations including Los Angeles County residents, SPA 2 residents, and the population closest to the Vida respondents, SPA2 Latinos whose incomes fall below 200% of the federal poverty level (FPL). Our chart shows that Vida respondents are much more likely to have been born outside of the United States, consider themselves “Latino/Hispanic”, and indicate Spanish as their primary language.

TABLE 3. Demographic Characteristics of Vida Participants Compared to Other Sources

CHARACTERISTICS	% LA COUNTY	% SPA 2	% LOW-INCOME LATINOS (<199% FPL) IN SPA 2	% OF VIDA RESPONDENTS
<b>Gender</b>				
Female	50.4	50.3	53.8	84.1
Male	49.6	49.7	46.2	15.9
<b>Age</b>				
Under 18	27.9	28.9	43.3	0
18-64	61.6	59.8	52.4	99.5
Over 65	10.5	11.3	4.2	0.5
<b>Race/ Ethnicity</b>				
Latino	39.2	32.8	100	99.4
American Indian	0.7	0.4	—	—
Asian	11	8.8	—	0
African American	9.9	5	—	0
White	35.8	50.6	—	0
Other	3.4	2.4	—	0.6
<b>Place of birth</b>				
California	—	—	—	1.9
(Another U.S. State)	—	—	—	.6
In the U.S	67	68.3	45.3	—
Outside the U.S.	33	31.7	54.7	97.5
<b>Language used for this Interview*</b>				
English	—	—	—	1.7
Spanish	—	—	—	98.3
<b>Primary Language **</b>				
English	44.3	50.5	2.4****	—
Spanish	11.9	9.3	35.1	—
Other***	43.8	40.2	62.5	—

\* The interviews were conducted in the language respondents’ were most comfortable using, which we compare with “primary language” for the other data sources for the purpose of this study.

\*\* Language spoken at home

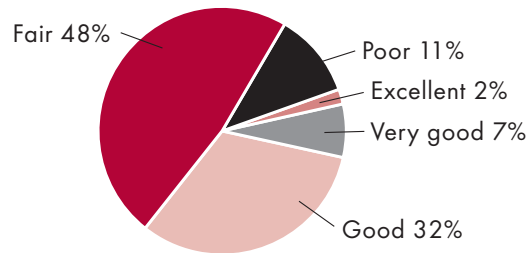
\*\*\* “Other” includes two or more languages spoken at home

\*\*\*\* Reported as statistically unstable by CHIS

## HEALTH STATUS OF VIDA MEMBERS

**Self-reported health status.** Figure 2 illustrates self-reported health status among Vida respondents. Our findings suggest that Vida members may not be as healthy as other similar populations. For example, only two percent of respondents reported their health as excellent, compared to 16% among a comparable population of Latinos in SPA2 [2]. Furthermore, 59% report their health status as fair or poor, compared to only 22% among adults in Los Angeles County, and 31% among Latino adults in SPA2 with incomes less than 199% of the Federal Poverty Level, a population similar to the Vida participant population [8].

FIGURE 2 . Self-Reported Health Status among Vida Respondents



Source: Vida QDS database.

**Prevalence of chronic illnesses.** One reason why Vida members may be less healthy is due to their prevalence of chronic health conditions. More than half of our study respondents (57%) report having been told by a doctor or other health care professional that they have a chronic disease. Table 3 compares the prevalence of chronic conditions among Vida members with data obtained from the California Health Insurance Survey (CHIS) and the Los Angeles County Health Survey. Vida members have higher rates of depression, diabetes, and hypertension compared to the populations reported by other data sources, but lower rates of asthma and cancer.

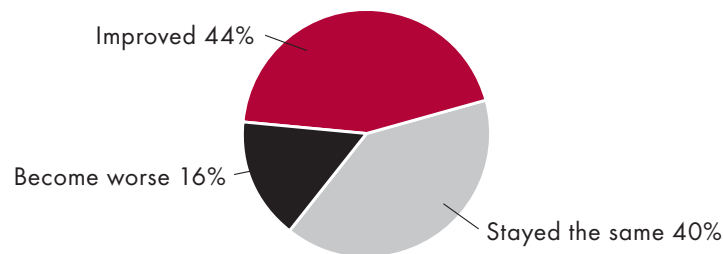
TABLE 4. Comparison of Vida Respondents with Other Populations Regarding Self-Reported Prevalence of Selected Chronic Diseases

	VIDA FINAL SURVEY	CHIS -ALL RACES -ALL FPL	CHIS -LATINOS -FPL 0-299%	L.A. HEALTH SURVEY -ENTIRE L.A. POPULATION	L.A. HEALTH SURVEY -LATINOS
Arthritis	16.7%	18.2%	11.8%	—	—
Asthma	4.9%	11.1%	6.2%	6.1%***	4%***
Cancer	0	7.3%	2.2%	—	—
Depression	17.9%	—	—	9%*	7%*
Diabetes	16.7%	6.6%	7.4%	7.9%**	11.8%**
Heart Problem	5.6%	6.9%	5%	—	—
Hypertension	24.7%	23.5%	18%	19%*	15%*

\* 1999-2000 L.A. Health Survey  
 \*\* 2002-2003 L.A. Health Survey  
 \*\*\* 2002-2003 Key Indicators of Health

**Self-reported improvement in health.** While Vida members may be less healthy than others, many respondents report that their health has improved since joining Vida. When asked about these changes in their health status, 44% of respondents claimed their health had improved, 40% reported it stayed the same, and 16% stated that their health became worse (See Figure 3)

FIGURE 3. Self-Reported Health Status Change after Becoming a Vida Member



Source: Vida QDS database.

## ACCESS TO CARE

We looked at the following six indicators of access to care among Vida respondents:

- Changes in health insurance status
- Having a medical home or regular provider
- Perceived ease or difficulty in getting care when needed
- Use of services
- Specialty care utilization
- Emergency room (ER) utilization

***Changes in health insurance status.*** At their initial enrollment, all Vida members were uninsured, and then after enrolling in the program, our previous reports showed that about a quarter of Vida members had obtained health insurance. In this survey, about two years after the last study was conducted, we found that 48% of respondents reported having some type of coverage, including 13% who had full Medi-Cal coverage, 19% with emergency or restricted Medi-Cal benefits, 9% with employment-based coverage, 4% with Medicare and 3% with private coverage (see Table 5). Still, slightly more than half (52%) of all Vida respondents remain uninsured.

TABLE 5. Insurance Status of Vida Respondents

INSURANCE TYPE	# OF RESPONDENTS	% OF TOTAL	COVERAGE STATUS
None	84	52%	No Coverage 52%
Emergency/ Restricted Medi-cal	31	19%	Limited Coverage 19%
Medi-Cal Blue Cross (3) General (5) Don't Know (8) Care One Molina Universal Plan Other (2)	21	13%	Full Coverage 29%
Medi-Care	6	4%	
Offered through work	15	9%	
Private Blue Cross CA Benefits Dental Plan Kaiser (3)	5	3%	
<b>TOTAL:</b>	<b>162</b>	<b>100%</b>	

Source: Vida evaluation QDS database

Only 16% (n=28) of respondents indicated that their work or spouse's work offered health insurance and 54% of those were enrolled in that insurance. Among those who do not receive coverage through work, more than 50% stated that health coverage was not offered to some or all employees, 12% reported that they (or their spouse) were self-employed and unable to provide coverage for themselves, and seven percent cited high cost of premiums as the main reason for being uninsured, while others referred to legal status and job instability.

Among spouses of the Vida respondents, we see even higher rates of uninsured, with 63% uninsured, 5% with limited coverage and just less than one-third who have full-coverage (see Table 6). Not surprisingly, children were more likely than spouses to have some form of coverage, which is expected given that children in Vida families should be eligible for at least one of the public coverage programs. Table 7 illustrates the type and rates of coverage among children of Vida respondents. About three-fourths have full-coverage, five percent have limited coverage and just over one-quarter have no coverage.

TABLE 6. Insurance Status of Spouses of Vida Respondents

INSURANCE TYPE	# OF RESPONDENTS	% OF TOTAL	COVERAGE STATUS
None	66	63%	No Coverage 63%
Indigent:	2	2%	Limited Coverage 5%
Emergency/ Restricted Medi-cal:	3	3%	
Medi-Cal	16	15%	Full Coverage 32%
Medi-Care	4	4%	
Offered through work	6	6%	
Private Blue Cross CA Benefits Dental Plan Kaiser (3)	7	7%	
<b>TOTAL:</b>	<b>104</b>	<b>100%</b>	

Source: Vida evaluation QDS database

TABLE 7. Insurance Status of Children of Vida Respondents

INSURANCE TYPE	# OF RESPONDENTS	% OF TOTAL	COVERAGE STATUS
None*	40	28%	No Coverage 28%
Indigent:	2	1%	Limited Coverage 5%
Emergency/ Restricted Medi-cal:	6	4%	
Medi-cal	54	38%	Full Coverage 67%
Healthy Kids	2	1%	
Healthy Families	19	13%	
Private (through work-4)**	21	15%	
<b>TOTAL:</b>	<b>144</b>	<b>100%</b>	

\* Total # of "None" responses include those who answered Vida for "other" type of insurance.

\*\* When tabulating these results, children were classified as those individuals who were reported as the son or daughter of the head of household or respondent at enrollment and were not necessarily under the age of 18, thus some may have insurance coverage offered to them through their job.

**Having a medical home or regular provider.** Previous Vida evaluation reports showed that between 29 – 34% of surveyed Vida members had a regular provider. This final survey shows 82% of respondents reporting that they have a regular health care provider. This suggests that, even in its later stages, Vida has been successful in connecting its members to a regular source to obtain health care services, an important indicator of access to quality care and outcomes. Among those respondents who said they have a regular provider, El Proyecto del Barrio, was most commonly mentioned followed by the county's ValleyCare clinic and Olive View Medical Center (see Table 8). Related to this finding is that the majority (72%) of those with chronic illnesses report that they are currently under a physician's care for their condition, and these respondents are more likely to report having a regular health care provider compared to those who are not under treatment.

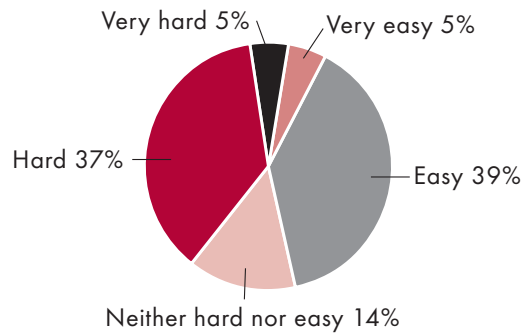
TABLE 8. Name of Regular Provider Reported by Respondents

FACILITY (NUMBER OF RESPONDENTS)	%
<b>El Proyecto del Barrio (32)</b>	26
<b>ValleyCare (27)</b> Mid Valley (7) San Fernando Clinic (7)	19
<b>Olive View (14)</b>	11
<b>Northeast Valley Health Corp. (11)</b>	9
<b>Other (43)</b>	35
No name (9)	
San Fernando Clinic (7)	
Kaiser (3)	
North Hollywood Health Center (3)	
Sierra Medical Center (2)	
San Miguel Clinic (2)	
Medicina Familiar (2)	
Mission City Community Clinic (2)	
Partinia Clinic (2)	
Only 1 response (14)	
- Burman Clinics	
- Clinica Medica General	
- LA County Hospital	
- LA Free Clinic	
- Samuel Ditsson Clinic	
- San Antonio	
- San Juda's Clinic	
- Santo Nino Clinic	
- Sylmar Medical Center	
- Tärzana Treatment Center	
- Victoria Medical Clinic	
- Women's Clinic	
- Molina	
<b>TOTAL</b>	<b>100%</b>

Source: Vida QDS database (N=129)

***Ease or difficulty in getting care.*** In assessing how easy or difficult it is to obtain needed medical care, we note a split distribution of responses: 42% claimed it was “hard” or “very hard” to obtain needed care, while 44% said it was “easy” or “very easy” (Figure 4).

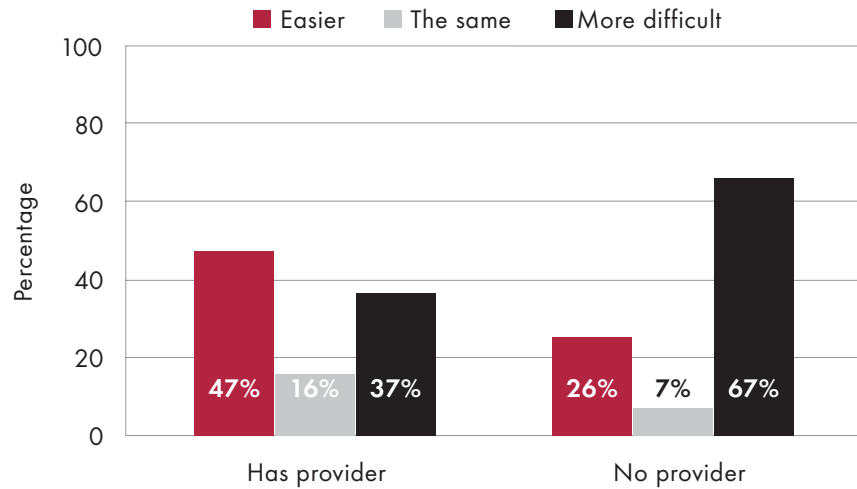
FIGURE 4. **Reported Ease or Difficulty of Obtaining Medical Care When Needed**



Source: Vida QDS database.

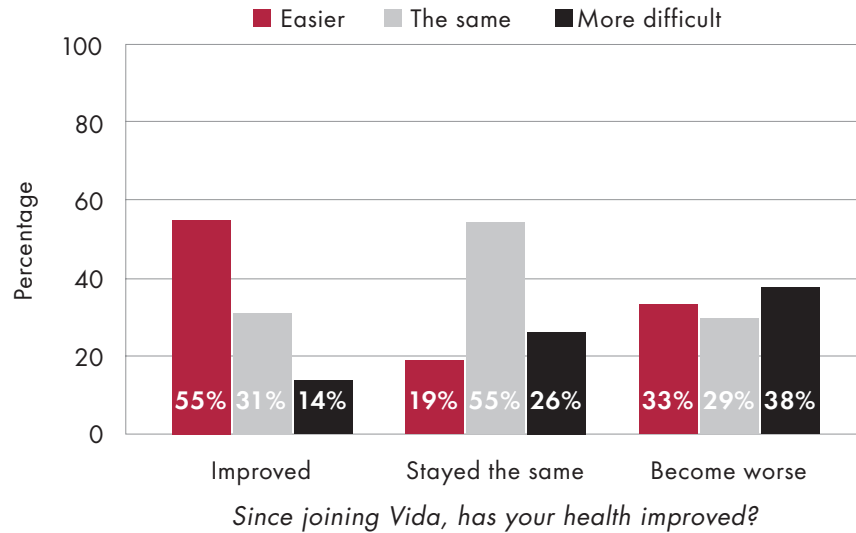
In order to understand what factors contribute to respondents' reported ease or difficulty in obtaining care, we examined the relationship between having a regular provider and their ability to obtain care. Figure 5 illustrates that those with a regular provider are more likely to report ease in obtaining care (47%) compared to those without a regular provider (26%) ( $p = .05$ ). This confirms other studies that show the benefit of a regular provider in overcoming many of the non-financial barriers to care especially those with on-going health problems. It is notable that we did not find such a significant relationship when we compared having a regular provider and ease of getting care prior to respondent's having joined Vida ( $p = .93$ ).

**FIGURE 5. Relationship Between Having a Regular Provider and Ease or Difficulty in Obtaining Needed Health Care Among Respondents**



There is also a statistically significant relationship among those who report that their health status had improved and those who say it is easy to get care ( $p=.0$ ) suggesting that as access to needed services improves health status also improves (Figure 6). For example, 55% of those who say that it is easier to obtain care after joining Vida also state that their health status had improved, compared to only 14% of those who said that it was more difficult to obtain needed care.

**FIGURE 6. Relationship Between Improved Health Status and Ease or Difficulty in Obtaining Needed Health Care Among Respondents**



Most respondents report that Vida has had a favorable impact on their health, including two-thirds who said that Vida is very important for their health.

**Use of services.** While we did not obtain and analyze utilization data as part of this study, we did look at the role of Vida in providing medical referrals and the use of those referrals, a significant factor in utilization given the number of referrals provided. In fact, 83% of respondents report receiving a referral from either Vida or from the HCC to a health provider (Table 9). These providers included (in order by percentage of referrals given) El Proyecto del Barrio (22%), Olive View Medical Center (17%), Valley Care (12%), San Fernando Clinic (5%), Northeast Valley Health Corporation (4%), Medicina Familiar (4%) and Mission City Community Clinic (3%). Nineteen percent of respondents found their provider through information available in binders they had received during their Vida enrollment event.

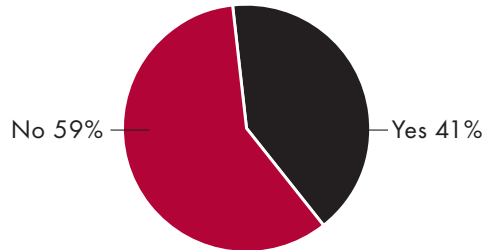
TABLE 9. Names of Providers given by Vida/HCA as Referrals

FACILITY	%
El Proyecto del Barrio	22
<i>Vida Binder</i> (list of Vida providers)	19
Olive View	17
Other	14
Valley Care	12
San Fernando Clinic	5
Northeast Valley Health Corp.	4
Medicina Familiar	4
Mission City Community Clinic	3
TOTAL	100%

The majority of Vida respondents (88%) who had been given a referral tried to use the provider. Among the small number who did not try to use services (n = 16), the reasons included: they did not need medical attention (38%), clinic hours were inconvenient, they preferred another location, Vida was not accepted, fear of additional charges, proximity, and they did not know the location of the clinic that was referred to them. Despite these important barriers, we clearly found that the majority of those who needed care did receive services and Vida appeared to be instrumental in facilitating successful referrals.

Finally, we examined the impact of County health service reductions and clinic closures on use of services among Vida members. Nearly a quarter of respondents report that the closures made health services more difficult to obtain. Some of the specific issues mentioned included: their clinic had closed, had longer waits, poorer quality of care, they had not been able to receive needed care. Twenty-nine percent of respondents reported that their clinic no longer accepted Vida or they could not get appointments or needed medicine.

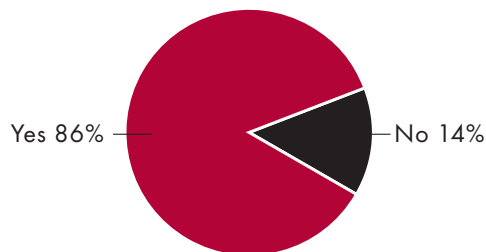
***Specialty care utilization.*** Specialty care is an important component of access, particularly with a population that includes a high number of people with chronic diseases. Among Vida respondents, 41% were referred to a specialist in the past 12 months (see Figure 7), and 84% were successful in seeing the referred specialist. Over 70% report that the clinic made the appointment for them, while 14% made the appointment themselves.

**FIGURE 7. Percentage of Respondents who were Referred to a Specialist**

Source: Vida QDS database.

Almost one-quarter of the respondents were able to see the specialist within one week of making the appointment, and another 23% were able to see the specialist between one and four weeks after their appointment was made. Less than 20% of respondents had to wait more than two months for an appointment with a specialist. After arriving at the specialist's office, half said they waited less than one hour, and the other half waited more than one hour to see the specialist; almost one-third were seen by the specialist within 30 minutes after arriving.

Not all respondents followed through with their referral for specialty care. Of the 11% who were referred to specialists but unable to make an appointment, the reasons cited most often were cost and not being able to find a specialist who accepted Medi-Cal. In terms of satisfaction with the care they received, 86% report satisfaction with specialist care (see Figure 8), consistent with the informal feedback Vida members have provided to Vida staff about their overall satisfaction with provider care.

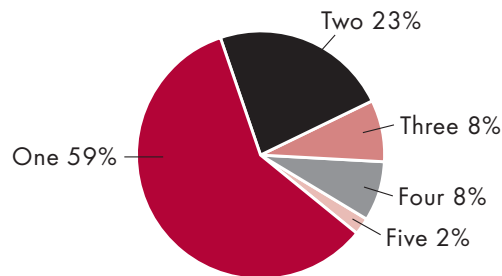
**FIGURE 8. Percentage of Respondents who were Satisfied with their Specialist**

Source: Vida QDS database.

**Emergency room (ER) utilization.** ER use has long been associated with individuals having barriers to accessing health care. People use the ER because they have an emergency or urgent health problem or because they have no primary care provider and use the ER for general ambulatory care. Often, those who face barriers to accessing basic health care delay preventive care or responding to a non-urgent health problem and then turn to the ER once the problem has escalated. Others use the emergency room because of convenience, such as being open at night and on weekends. We asked several questions about emergency room usage to better understand the practices of Vida respondents.

In previous studies, ER use among Vida participants ranged from 10% to 26%. In this study, 30% reported having visited a hospital emergency room either for themselves or for an immediate family member (such as their spouse or children) in the past 12 months. The majority used the ER for their own health problem, and 16% for that of a family member. Among ER users, 58% reported having visited the ER one time, 23% two times, and 8% had made three or more visits to the emergency room (Figure 9). The ER at Olive View Medical Center accounted for over 40% of all ER visits reported by respondents.

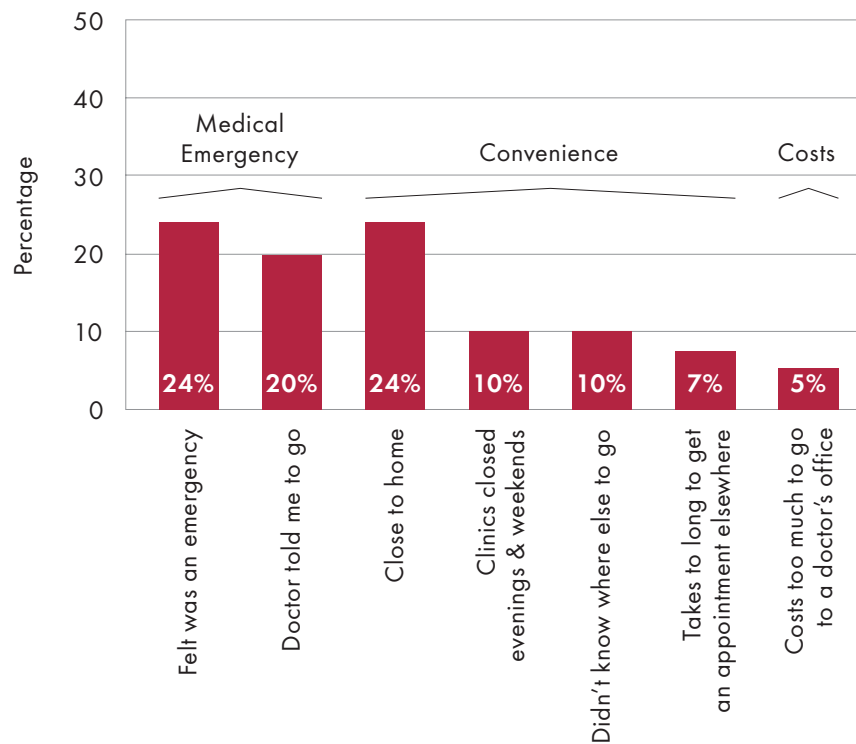
**FIGURE 9. Among Those who Visited an ER, Percentage of Times that Respondents Went to the ER for Themselves or an Immediate Family Member in the Last 12 Months**



We asked respondents why they visited an emergency room as opposed to a non-emergency health care facility. While all ER visits stemmed from the need to diagnose or treat a medical problem, our findings show that 44% visited an ER for a medical emergency, 51% reported reasons related to system and access barriers or convenience (e.g. close to home), and 5% specified cost concerns (see Figure 10). Among those considered as a *medical emergency*, we included respondent’s explanation (i.e. “felt it was an emergency”) and those who said that their doctors told them to go to the ER. The system and access reasons included 24% who specified that the ER was *close to their*

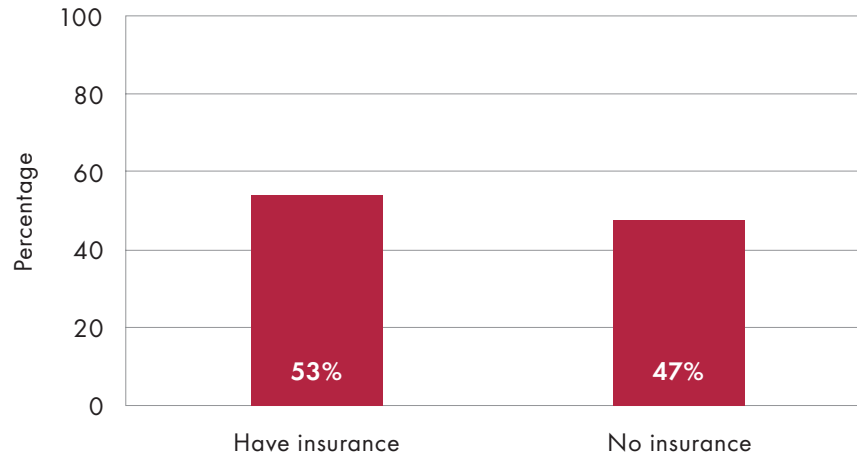
home, 10% who said that clinics were *closed evenings and weekends*, 10% who *didn't know where else to go* and 7% who said it *takes too long to get an appointment elsewhere*. In sum, the reasons given by respondents showed that just over half of the reported ER visits were not due to medical emergencies; rather, convenience and cost played a significant role in ER use.

**FIGURE 10. Reasons Given by Respondents as to Why They Visited the ER Instead of Somewhere Else**



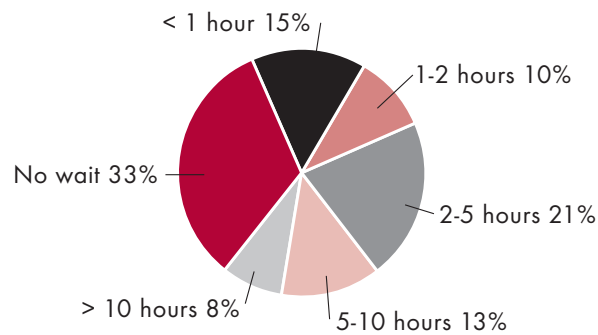
Our study did not find a significant relationship between having health insurance and ER use. Figure 11 shows that of the 48 respondents who went to the ER (either for themselves or for an immediate family member), just over half (53%) reported having some type of insurance while the remaining 47% reported having no insurance.

**FIGURE I I . Comparison of Reported ER Use by Insurance Status Among Respondents**



While ER waiting times are often cited as a frustration by consumers, our study did not show this to be the case for the majority of respondents. Figure 7 shows that one-third of the respondents reported no wait to receive care at the ER, 15% waited less than one hour and 10% waited between one and two hours for care. The remaining 42% reported having to wait more than two hours before seeing a provider, including 8% who waited more than 10 hours.

**FIGURE I 2 . Amount of Time Respondents Waited to Receive Care in the ER**



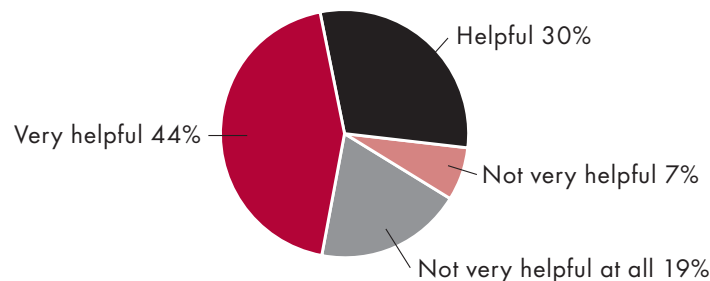
Source: Vida QDS database.

## IMPACT ON HEALTH CARE AND THE USEFULNESS OF VIDA SERVICES AND MATERIALS

Being a Vida member means that in addition to using Vida for direct health care services, members are welcome to call the Vida office with a variety of questions as needed, and Vida families are regularly contacted about community events, particularly relating to health, by project staff. Some of the services that Vida provides include giving referrals to members, and facilitating health insurance enrollment through information and contact with the L.A. HCC and applicant assisters. Vida members also receive educational materials developed and/or distributed by the project to inform, educate and empower members. This section will provide findings on the impact of Vida on health care and the usefulness of materials used throughout the project.

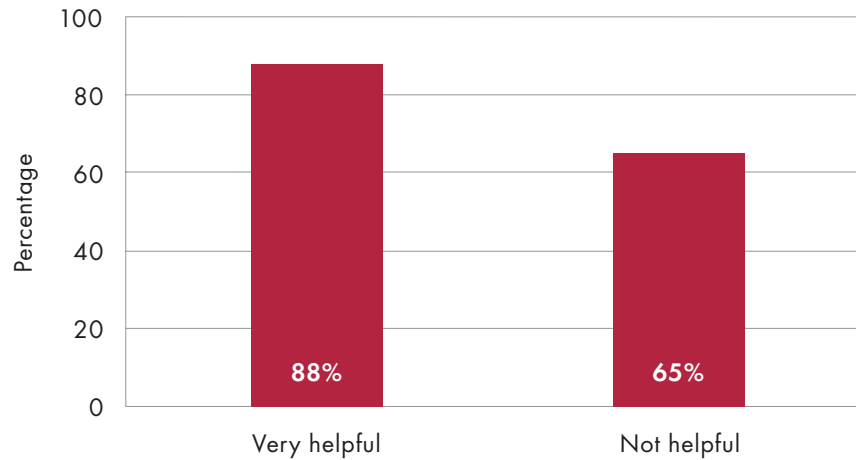
***Impact of Vida on health care.*** Almost three-fourths of respondents report that since joining Vida, there was a time in which they needed help in getting health care. Among these, 74% report that Vida was helpful in getting them the assistance they needed (see Figure 13).

FIGURE 13. Helpfulness of Vida in Getting Health Care Needed by Respondents



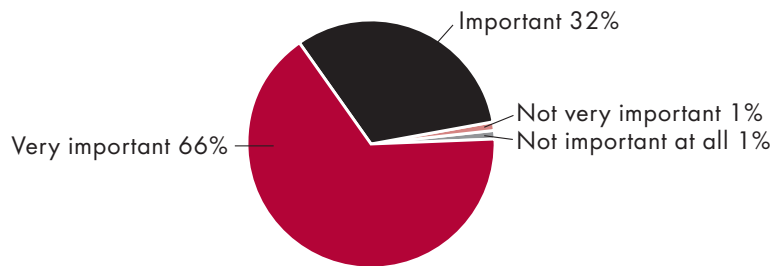
Respondents who reported Vida as helpful tended to be more likely to report their health status as improved, and were more likely to report having a regular provider compared to those who said that Vida was not helpful. For example, 41% of respondents who said Vida was helpful reported their health status as “excellent”, “very good”, or “good”, compared to only 19% of those who did not find Vida helpful. Furthermore, we found a statistically significant relationship ( $p=.004$ ) between those who rate Vida as helpful and having a regular health care provider. Among those who report Vida as being helpful, 88% say they have a regular provider, and among those who did not find Vida helpful, only 65% have a regular provider (Figure 14). Overall, it is clear that despite the level of assistance or specific task that the project may have done to provide help to Vida members, we see that higher reported levels of “helpfulness” correspond to better access to care among respondents.

FIGURE 14. **Rated *Helpfulness* of Vida by Respondents and Percentage of those who have a Regular Health Care Provider**



Furthermore, 98% say that Vida had an important or *very important* impact on their health care (Figure 15).

FIGURE 15. **Level of Importance of Vida on Respondent’s (and their family) Health**



Despite high satisfaction with Vida, members still report significant health care barriers. For example, when we asked respondents if they knew who to contact when having a problem with health insurance or needed health care, only 37% said they knew who to contact, and among those, half mentioned they would contact a clinic or provider, 33% said they would contact the Vida project (they usually specified a Vida staff member by name) or refer to the Vida binder, 10% mentioned their health plan and seven percent had other responses (See Table 10).

TABLE 10. **Summary Results of Who Respondents Would Call for Help Regarding a Problem with Health Insurance or Needing Health Care**

CONTACT	%
<b>Clinic/Provider</b>	50
Clinic	
Doctor's name	
Social Worker	
<b>Vida Project</b>	33
Isidro	
Binder/folder	
<b>Health Plan</b>	10
Blue Cross	
Medi-Cal	
Healthy Families	
<b>Other</b>	7
911	
Don't know/ remember	

Source: Vida QDS database (N=58)

**Usefulness of the materials.** At the time of enrollment, all Vida families were given a binder filled with information on obtaining health care, provider contact sheets, and relevant health and coverage information. The vast majority (81%) of respondents said the Vida binder was helpful or very helpful. Only nine percent did not find the binder helpful, and the others either did not remember or said they did not have the binder. The Vida binder proved useful in providing essential health care information, as we anecdotally learned that many of the participants continued to refer back to the binder, even those who no longer considered themselves active in the Vida project.

In sum, our findings to the first evaluation question, *Did Vida improve access to care and what was Vida's role in this effort?* Include the following observations:

- Self-reported health status is not as good as similar populations, with a large percentage of respondents having at least one chronic disease
- Since joining Vida, access to care has improved, such as obtaining coverage and establishing a medical home (i.e. having a regular provider)
- Many Vida members still face difficulty accessing care
- Overall, Vida members are satisfied with the medical services they received from providers, and have found referrals given to them by the Vida project to be very useful
- Services provided by Vida appear to be helpful and important to respondents in their effort to receive needed health care services

This next section will respond to our second evaluation question, which is:  
*Did Vida foster leadership and advocacy among its members and in the community in which Vida took place?*

This question will be examined by looking at Vida’s impact on community involvement and community leadership.

### **IMPACT ON COMMUNITY INVOLVEMENT AND COMMUNITY LEADERSHIP**

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Over the five year course of the project, Vida members were informed of various issues and community events, such as workers’ rights, immigration, health insurance and health programs, all available in both verbal and written Spanish and English. Vida activity logs, maintained by Vida staff, included the dates and event type for all Vida activities. Vida members were invited to these activities through written materials by mail and at times, by telephone calls.

*Did the Vida Project encourage community involvement?* Table 11 shows that in the 12 months prior to our final evaluation survey (March 2004 through June 2005), almost 20 Vida sponsored events took place. These events were aimed at recruiting, training and educating Vida members to become active and empowered in their respective communities.

Almost three-quarters of respondents (74%) said they had been asked to participate in a Vida event; two-thirds reported that the last time they were asked to participate in such an event was more than one year ago. Only eight percent of respondents had been asked to participate in an event in the six months prior to responding to the survey. Based on these responses, it appears that the majority of our study sample did not attend most of the events listed in Table 11.

One specific community event that Vida members were invited to participate in stemmed from the L.A. County closure of several county clinics and health centers. Thirty percent of Vida respondents reported that they had been asked to participate in efforts to slow down or stop the closure of these clinics.

**TABLE I I . Compilation of Vida Program Activities  
March 2004-June 2005**

	TOPICS			
	FAITH (VIDA LEADER GROUP)	HEALTHY KIDS	PUBLIC HEALTH	OTHER
<b>Events</b>	FAITH training, FAITH meeting	HK enrollment	IAF meeting, Valley Care Community Consortium meeting	Retreat in Santa Rosa, LA-Metro IAF follow-up
<b>Lead Agency</b>	NLS	—	IAF, Valley Care	NLS, IAF
<b>Date of Events</b>	Oct. 30, '04 Mar. 10, '05 May 4, 20, '05 Jun. 1, 3, 20, '05	Nov. 30, '04 Jan. 11, 25, '05 Feb. 22, '05	Jul. 18, '04 Jan. 13, '05 Apr. 25, '05 May 23, '05	Mar. 3, 21, 24, '05
<b>Specific Issues</b>	Leadership, county information, Public health issues	Screening and enrollment into the Healthy Kids Program	Public Health	Update on LAC lawsuit and plaintiff group prep, police involvement, other issues
<b>Materials</b>	—	Packets on HCC, workers' rights, self-help, immigration	HCC packets, other	NLS packets, other

### *Attendance for Vida events*

In terms of actual attendance at events, 66% of respondents reported that they attended between two and five Vida events, in addition to the initial enrollment into the Vida project. Seventeen percent said they had not attended any Vida events since enrolling in the program. In response to the clinic closure events, 17 respondents, representing 10% of respondents, participated in these efforts.

Even though we saw relatively low participation rates, our findings suggest that a higher level of participation in Vida activities is related to positive health access findings. For example, as Table 12 illustrates, we see a correlation between respondents' level of participation in activities and their self-reported change in health status. Specifically, among those respondents who reported attending six more Vida events, 86% reported that their health status had improved since joining Vida, while only 53% of respondents who did not attend any Vida events reported that their health status had improved. We also see a slight correlation between the number of Vida events attended and respondents' reported level of ease or difficulty in obtaining necessary medical care. For example, among those who attended six or more Vida events, 13% reported it to be "very easy" to obtain medical care, and no respondents reported that it was "very easy" among those who attended zero or only one Vida event. Perhaps those respondents who participate in more health and other community events are also taking a more active role in managing their personal health care.

TABLE 12. Level of Participation in Vida Events, Change in Health Status, and Access to Care

COMPARED TO WHEN YOU FIRST JOINED VIDA, HAS YOUR HEALTH...	HOW MANY VIDA EVENT HAVE YOU ATTENDED?			
	0	1	2-5	6+
Improved	53%	55%	49%	86%
Stayed the Same	41%	36%	39%	14%
Become worse	6%	9%	12%	0

TODAY, HOW EASY OR DIFFICULT IS IT FOR YOU TO OBTAIN MEDICAL CARE WHEN YOU NEED IT?	HOW MANY VIDA EVENTS HAVE YOU ATTENDED?			
	0	1	2-5	6+
Very easy	0	0	5%	13%
Easy	53%	38%	42%	29%
Neither hard nor easy	12%	8%	14%	29%
Hard	29%	46%	36%	29%
Very Hard	6%	8%	3%	0

Source: Vida evaluation QDS database

**Community leadership.** While the definition of a leader within the Vida project has not been specified, we consider a Vida Leader to be a participant who has expressed interest and became involved in educational and advocacy work in their community, has been identified by IAF or Vida staff as a leader, and has participated in leadership and other training sessions geared towards community advocacy and leadership. Among survey respondents, 10% said they had been asked to become a Vida Leader and 7% considered themselves a Vida Leader. According to Vida management, 12 Vida members were considered community leaders who took part in the plaintiff group called FAITH (Families Aimed at Improving the Healthcare). The self-identified leaders in our study do not, however, match the list of leaders identified by the Vida program. We conclude that different interpretations exist of the role and definition of a Vida Leader. Table 11, presented earlier, outlines some of the meetings that took place with the FAITH group, over the past year and a half. Still, it is difficult to assess their level of community involvement due to a lack of documentation and regular communication with these leaders and those who work directly with them.

*Community health concerns.* As mentioned earlier, in addition to improving access to care and identifying community leaders, the Vida project was also designed to encourage advocacy and participation in community issues among Vida participants. While this component of the project has been difficult to assess due to limited activities and documentation, we did ask respondents for their top community concerns regarding the health and safety of their neighborhoods. This was an open-ended question that yielded many different responses, and thus for the purposes of our evaluation we re-coded these responses into six categories according to the responses received (see Table 13). Slightly more than two-thirds of the responses referred to health care issues. In particular, 28% reported “health insurance and access” issues as their top community concern, followed by the need for more clinics (22%), and other general health issues (17%). General community concerns such as immigration issues and education accounted for 13% of respondent’s comments, 12% of the responses included crime and safety issues, and finally 8% of the responses listed environmental health concerns like trash and pollution.

TABLE 13. Respondent's Top Community Concerns

CONCERNS	%
<b>Health Insurance and Access Issues</b> <i>access/coverage/affordability</i>	28
Vida Program (28)	
- more info. about the program	
- more community outreach	
- Vida is no longer accepted	
- lack of information and awareness (5)	
- low cost (9)	
- lack of health insurance (18)	
- insurance for children (4)	
- emergency insurance (4)	
<b>Health Service Issues</b>	22
Clinic and hospital closure (24)	
Need for more clinics and hospitals (11)	
- nearby and access to	
Improved health care (12)	
- faster and better service	
Lack of health care (5)	
- don't know where to receive medical attn.	
- emergency care concerns	
<b>General Health Issues</b>	17
Family health (11)	
Community health (3)	
Personal health (13)	
Treatment for specific illnesses (13)	
<b>Other Response Categories</b>	13
General concerns within the community (5)	
- homelessness	
- discrimination	
Immigration issues (4)	
Education (4)	
Transportation (2)	
Childcare (1)	
Other (16)	
<b>Crime and Safety</b>	12
<b>Environmental Health Issues</b>	8
Neighborhood Cleanliness (8)	
Trash (6)	
Pollution (5)	
<b>TOTAL</b>	<b>100%</b>

Source: Vida QDS database (N=240)

In sum, our findings to the second evaluation question, *Did Vida foster leadership and advocacy among its members and in the community in which Vida took place?* include the following observations:

- Most Vida respondents have been invited to various community events, but less so in the past year.
- Participation at Vida events was low, including the important activities around clinic closures that directly affect many Vida members.
- Vida leadership activities were scarce and poorly documented, demonstrating limited success in this component of the project.
- Respondents clearly remain very concerned about health care issues, particularly access to care (i.e. obtaining coverage), in addition to health service, general health and environmental concerns.
- In brief, our findings suggest that Vida fostered little leadership and advocacy among its members.

## Discussion and Conclusions

The Vida project has been a five-year effort to connect individuals with health care providers and health insurance programs, build community leadership and participate in efforts to save and expand the safety net. We know that low income individuals face many administrative and bureaucratic obstacles to programs and services, and the Vida project helped connect people in need to those programs and services. Our evaluation findings show that Vida did improve access to care by linking individuals and family members to health insurance programs, by referring individuals to safety net clinics and specific providers, and by establishing a medical home, especially for those with a chronic illness.

Vida was predicated on a County and private partnership provider network, and an ordinance authorizing prescreening individuals into the health programs at these provider sites. The Vida project concept and operations were interrupted in part by recent cutbacks in indigent health care services and the termination of the LA County ordinance. Yet, while some members reported that these clinic closures did pose problems, our data do not reveal that these policy changes had much impact on access and utilization. Our previous study of Vida providers showed that many clinics had assumed that Vida was no longer in existence even before the ordinance terminated. Many stopped accepting the Vida card although they continued to provide care, especially for those already in their patient base. Thus, for many participants, the initial connection to these providers seemed sufficient for them to stay in the system and receive needed care.

The partnerships that were established early in the project were critical to the program's success in improving access, especially in linking Vida families to health insurance programs, and by providing referrals for care and assisting participants who experienced health care problems. While our findings suggest that low income individuals continue to have problems engaging the health care system, we note that the assistance offered by a program like Vida could make a positive difference in improving access to care. The use of the Health Consumer Center appears to be a particularly effective way to track, update information on Vida families, and to identify and assist family members with enrollment and utilization problems when necessary. The overall impact of case management-type assistance offered by Vida is not surprising given the findings of other programs that use primary care case management to augment managed care enrollment.

Our final evaluation study showed that almost half of Vida respondents obtained health coverage (including limited coverage) since joining the project, which

indicates success, considering the fact that health insurance enrollment limits enrollment to certain categories of individuals due to state policy guidelines. Many adult members of Vida are just not eligible for many of the state programs either because of age, immigration status or other restrictions. Some consistency found in the linkage of members to these programs since the beginning of the project suggests that all Vida members who are eligible for a program were identified and enrolled. The expansion of Healthy Kids to undocumented immigrant children may provide new opportunities for children of Vida members, but many adults would still remain ineligible for coverage.

For those with chronic illnesses, regardless of insurance coverage, Vida opened the door to the health care system and provided access to a broad range of services including primary care and specialty care. Moreover, our data suggest that Vida assisted individuals by linking members to appropriate primary care and away from more costly emergency services. The increase in clinic utilization may indicate an increasing awareness of the importance of seeing a provider early and making it relatively easy to do so. We also note that even among the uninsured, those with chronic illnesses were getting the care they need generally through the safety net clinics and hospitals. Many of these changes are noted and persisted even after significant changes in the organization and financing of safety net providers, and the rescinding of the LA County ordinance authorizing prescreening of Vida members.

While Vida did lead to improvement in access to care, it was less effective as a grass-roots advocacy and leadership development strategy. From the beginning, the project was promoted with the message that participants would obtain better access to care, and that appears to be the main motivation for Vida members. While community involvement and leadership opportunities were presented, few participated in organized efforts to address broader problems in their community including the cutbacks in county health services. Moreover, we saw little evidence that Vida members themselves organized activities rather than responding themselves to appeals from NLS or other partners.

One of the problems in Vida relates to its unclear mandate and program objectives. Vida remains an uncertain and confusing program for many of its participants. Throughout the project, evaluators observed that there was no clear understanding among members and providers about what Vida is and what it was trying to accomplish and how it differs from health coverage or other health programs. Despite numerous efforts by staff to clarify that the Vida project was not insurance, many Vida participants continue to view Vida as health insurance. For some this confusion led Vida members to dis-enroll in the project even though they were not enrolled in Medi-Cal or other health program, or because members felt that the Vida project was not working for them. Still, other members felt that the overall

experience with the Vida project enabled them to become more involved and aware of health insurance and other social services and issues, and new lines of communication were established to obtain needed information.

***Limitations of this study.*** The Vida members are a self selected sample and our data confirm that many of the individuals who joined the Vida project were those with chronic illnesses, individuals most likely to benefit from establishing a connection with the health care system. Due to staff changes and funding gaps, the Vida project activities and interventions fluctuated over the past six years. While the study sampling frame did not greatly vary, our evaluation included a series of studies with key informants and Vida participants that did change. Thus, in retrospect, we realize that our study would have been more revealing had we followed one group of Vida respondents throughout the entire study. Our approach to capture cross-sectional data was, however, effective in revealing important trends and experiences among a wider range of participants. Another limitation in our final study is that those Vida members we were able to contact and who agreed to participate in our survey may differ from those we could not reach. Finally, due to difficulties in obtaining the most recent Vida database, we cannot make definitive assumptions about the entire Vida population based upon our sample from this final survey. Despite various internal and external changes that had an impact on Vida, the project continued to focus its efforts on access to care for the original enrollees, and our evaluation results are reflective of this effort.

# Recommendations

We propose the following recommendations based on our overall evaluation findings of the Vida project.

***Continue family-centered programs.*** The Vida project could build on its success in working with families, not just individuals, for modified and new health programs, outreach and advocacy. A family centered pilot project could be launched from a Vida-like platform with augmentation dollars covering premiums for ineligible parents and older children.

***Engage the Vida population using effective communication by Vida members.*** Use of the Vida member population for outreach and educational announcements should continue in order to maintain contact with participants and provide them with opportunities to become more involved in local community activities. We recommend that NLS develop a strategic outline of methods and plans to communicate with the Vida population, and try to move the communication efforts from NLS to be administered by Vida volunteers themselves. Active members from the existing network of Vida families could become an effective community-based advocacy group to receive and distribute information on important community health issues.

***Continue eligibility work, and examine Healthy Kids as a new option for Vida members.*** Our data suggest that there are uninsured children in the Vida project who would be eligible to enroll in local coverage programs, such as Healthy Kids. We recommend that the L.A. Health Consumer Center continue to contact Vida families to assess and reassess for program eligibility, focusing their efforts on families with children. For example, starting in Fall of 2005, contact each Vida family with children under 18 years of age to assess eligibility among those children without coverage. Maintain records regarding applications and enrollment using the HCA database, as is currently being done, and eventually these families will be moved out of the Vida program with coverage and receive guidance from the qualified HCC counselors.

***Improve communication among Vida health care providers.*** A lack of information among providers about Vida acted as a barrier for some Vida members to access health care services. We believe that having better communication between providers and Vida staff regarding policy changes, Vida membership and their use of services would help providers to be more responsive and supportive of the Vida project. Providers should be invited to strategy meetings to continue efforts to reduce barriers for high need groups such as the Vida population. Efforts may include the development of new models of care and collaboration.

***Rethink and redesign the leadership component.*** The idea behind the leadership and advocacy component of Vida was exciting and promising; however, we saw very little success from this strategy. We recommend a modification of this component in which community members, leaders and providers develop a specific plan for identifying, motivating and supporting individuals who want to become community health leaders. We suggest a specific set of measurable objectives be established that clearly outlines who would be targeted, what skills they would develop and what they would actually do as community leaders. The operations and progress of this type of plan should be well-documented to apply findings for program improvements, and to seek funding to support the successful components of such a program. The development of a promotora model where individuals are trained in substantive health areas as well as leadership and advocacy should be explored, as this model has been shown to be effective and have some self sufficiency in other communities. Some of the issues leaders could address could stem from concerns expressed by Vida respondents that were revealed through our participant surveys. Lastly, the relationship between greater participation in Vida events and positive health access suggests that improving and expanding upon this component of the project to serve others may also improve health status of the participants.

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