



## **Section J**

## **Appendix**

**Key Stakeholders, Community Leaders and Community Clinic Administrators Interviewed  
for the System of Care Needs Assessment Project**

KEY STAKEHOLDERS

Bruce Vancil  
Director, Cancer Control  
**American Cancer Society**

Mary Dewane  
Chief Executive Officer  
Peter Nakahata  
Director of Strategic Development  
Hilary Frazer, Project Manager  
**CalOptima**

Sid Gardner  
Director  
Center for Collaboration for Children  
**CSU Fullerton**

Mike Ruane  
Executive Director  
Alyce Mastrianni  
Director of Research & Evaluation  
**Children and Families First  
Commission**

Teresa Conk, VP Business Dev.  
Maria Miñon, MD  
Medical Director  
**Children's Hospital of Orange  
County/Children's Hospital at  
Mission (CHOC)**

Susan Zepeda  
Executive Director  
**Health Care Foundation for O.C.**

Gwyn Parry, MD  
Director Community Medicine  
**Hoag Memorial Hospital  
Presbyterian**

Edward Kacic  
President  
**Irvine Health Foundation**

Pamela Pimentel, RN  
Executive Director  
**M.O.M.S.**

Cynthia Coad, Chairman  
Theresa Arzate, Executive Assistant  
**O.C. Board of Supervisors**

Corey Timpson  
Director  
**OCCCCO**  
(Orange County Congregation  
Community Organization)

Larry Leaman, Director  
Patsy Calvert  
Director, Adult Services & Assistance  
Programs  
**O.C. Department of Social Services**

Mark Horton, MD, MSPH  
Director of Public Health  
**Orange County Health Care Agency**

Juliette Poulson, RN, MN  
Director  
Herbert Rosenzweig  
Deputy Agency Director  
**Orange County Health Care Agency**

Marika Bonner  
Executive Director/CEO  
Michele Revelle  
Director of Public Affairs &  
Communications  
**Orange County Medical  
Society/Association**

Bill Wood  
Vice President of Community Affairs  
**PacifiCare**

Senator Joseph Dunn  
Norma Cobb, District Director  
**Senate Representative**

David Mauss  
Director Business Development  
**Tenet Health System**

Stephanie McElheney  
Senior Vice President  
**United Way Community Services**

**Key Stakeholders, Community Leaders and Community Clinic Administrators Interviewed  
for the System of Care Needs Assessment Project**

COMMUNITY LEADERS

Diane Masseth-Jones, MS  
Executive Director  
Rebecca Pimentel  
Program Director  
**American Lung Association**

Carmela Castellano, CEO  
**California Primary Care Association**

Bernice Olivas, MS  
Program Director  
**Catholic Charities**

Bishop Jaime Soto  
**Diocese of Orange**

Lida Allbright  
Executive Director  
**Families Costa Mesa**

Jon Gilwee,  
VP, Orange County Office  
**HealthCare Association of Southern  
California**

Felix Schwarz, MA, MPH  
Executive Director  
Kenneth Scott  
Director, Healthy Families  
**Health Care Council of O.C.**

Janice Head, FACHE  
VP & Service Area Manager  
**Kaiser Foundation Hospital, O.C.**

America Bracho, MPH, CDE  
Chief Executive Officer/President  
**Latino Health Access**

Brian Wells, Director  
**Lutheran Social Services**

Karen Brooks  
Director of Homeless Programs  
**Mental Health Association of O.C.**

Sister Maura Judge, CSJ  
Manager, Healthy Ministry Partnership  
Carole Kartunen, RN, BSN  
Parish Nurse Coordinator  
Cathy Kang, RN, Staff Nurse  
**Mission Hospital  
Parish Nurse Program**

Pamela Mokler, MS  
Executive Director  
Mary Paul, MSG, Principal  
The Paul Company  
**Orange County Office on Aging**

John Webb  
FACT Program Manager  
**O.C. Department of Social Services**

Davine Abbott  
Director.  
Quality Management & Planning  
**Orange County Health Care Agency**

Amy Dale, MPH  
Division Manager  
Health Promotion & Prevention  
**Orange County Health Care Agency**

Kathleen Parris, RN, MSN  
Director, Public Health Nursing  
**Orange County Health Care Agency**

Penny Weismuller, RN, DrPH  
Division Manager  
**Orange County Health Care Agency**

Stanley Pappelbaum, MD  
Searle Turner, MD  
**Pappelbaum, Turner & Associates**

Maya Dunne  
Asst. VP & Community Outreach  
Sister Mary Therese Sweeney  
**St. Joseph Health System**

Ronald Di Luigi  
VP, Advocacy & Comm. Benefits  
**St. Joseph Health System  
Hospital Campus**

**Key Stakeholders, Community Leaders and Community Clinic Administrators Interviewed  
for the System of Care Needs Assessment Project**

COMMUNITY LEADERS (continued)

Gayle McLean, RN, MSN  
**Santa Ana Unified School  
District**

Ralph Cygan, MD  
Clinical Professor of Medicine  
Director  
Cindy Winner  
Director Ambulatory Services  
**UCI Medical Center**

Mai Cong, MA, LMFC  
President & CEO  
**Vietnamese Community of Orange  
County, Inc.**

Daniel Brothman, CEO  
Russ English  
Director, Managed Care  
**Western Medcial Center**

COMMUNITY CLINICS

Jacqueline Tran  
Clinic Administrator  
**Asian Health Center (VNCOC)**

Debra Drew, MA  
Executive Director  
**Camino Health Center**

Patricia Dutriz, RN, MN  
Executive Director  
**Casa De Salud Family Health Center**

Kathy Kolodge, RN  
Director of Ambulatory Services  
Rosa Kelson  
Marilyn Mills  
**CHOC Clinic  
Clinica CHOC Para Ninos**

Marty Earlabough-Gordon  
Executive Director  
**COCCC**

Nancy Rushton  
Executive Director  
**Friends of Children Health Center**

Martha Lester  
Executive Director  
**The Gary Center**

Jackie Cherewick  
Chief Executive Officer  
**Huntington Beach Community Clinic**

Cathy Teschke, RN  
Clinic Director  
**La Amistad**

Ericka Waidley  
Executive Director  
**Laguna Beach Community Clinic**

Rosalie Corless  
Executive Director  
**Lestonnac Free Clinic**

Christine Ta  
Executive Director  
**Nhan Hoa Comprehensive Health  
Center**

Jefferson Hendrix, MD  
Director  
**O.C. Rescue Mission Mobile Van**

Jon Dunn, MSW, MBA  
President/Chief Executive Officer  
**Planned Parenthood**

Rocio Nuñez-Magdaleno  
Director of Community Benefit  
Fund Development  
**Puente a La Salud Mobile Clinic**

**Key Stakeholders, Community Leaders and Community Clinic Administrators Interviewed  
for the System of Care Needs Assessment Project**

COMMUNITY CLINICS (continued)

Barry Ross  
Vice President, Healthy Communities  
**St Jude Medical Center Mobile  
Health Center**

Mary Moyer, RN, BSN, PHN  
Clinic Nurse Manager  
**Share Our Selves Free Clinic**

Rosilee Gamboa  
Executive Director  
**Sierra Health Center**

Terry Fowler  
Director, Ambulatory Care  
**UCI Medical Center, Orange**

Laura Mansilla, RN  
Nurse Administrator  
**UCI Family Health Center, Anaheim**

Nancy Downey-Hurtado, RN  
Administrator  
**UCI Family Health Center, Santa Ana**

**Completed Interviews Reflected in Summary Appearing in Pages J5 through J33**

## **SUMMARY OF KEY STAKEHOLDERS' AND COMMUNITY LEADERS' INTERVIEWS**

*pmpm*<sup>®</sup> consultants interviewed more than sixty members of the community identified by the Coalition Task Force as being key stakeholders and community leaders whose perceptions and input are considered vital to the development of a system of care to serve the Target Population. The results of these interviews are presented below. Some perceptions are presented verbatim, some have been paraphrased, and whenever there were conflicting opinions on a topic, all views have been represented in this summary. The opinions and perceptions of these thought-leaders were captured as presented. Our team did not challenge these opinions and perceptions even when other evidence would produce a contrary conclusion. A disconnect between a perception and reality is in itself an identification of a gap requiring action. These interview results have been drawn on substantially in the identification of service needs, barriers to access and availability, and the environmental and political factors that must be considered and confronted in the pursuit of a system of care.

*ISSUE: Lack of health care coverage for younger residents (18-34) and their children as identified in 2000 Health Needs Assessment*

Cultural Barriers

- Cultural issues to access—particularly for the Hispanic/Latino population
- Undocumented residents fearful to seek services
- Issue of pride with some—do not want to be perceived as receiving welfare
- Must bring healthcare to this population—not the other way around (more direct involvement in churches and other places where residents are involved)

Economic Barriers

- Economic gap for those who are above poverty level but do not earn enough to maintain standard of living in Orange County—sacrifice health coverage to pay for other daily essentials
- Not poor enough for public programs; do not earn enough to afford private coverage
- Co-payments in most plans are too high for this income level
- Twenty percent of MOMS (Maternity Outreach Management System) client base now English speaking; average age is 24 in households where adults are working three jobs at minimum wage
- Many in this age group are very mobile and change jobs often
- Bridges database suggests coverage may be episodic—people get coverage only when they need it
- Believe many in this age range are undocumented—assistance to this population is inconsistent with political views of the County

System Barriers

- Lack of employer-based coverage for many
- Lack of coverage for student population
- Issue of lack of knowledge and understanding of what programs are available to them
- Population cannot navigate the complex assistance programs available to them—need funding for case management and outreach to assist in the enrollment process

Not Viewed as a Priority

- No advocacy group for this population
- Lack of perception of this as an issue—thus, it is not a priority for funding
- With emphasis on coverage for children, those younger than 18 qualify for coverage, but their parents do not
- This age population does not see health insurance as a priority

*ISSUE: What can be done to provide better health care access to the 18 to 34 age group?*

Outreach, Improvement of Existing Programs

- Considerable outreach to enroll population in Healthy Families and CalOPTIMA
- Broaden access to Healthy Families coverage
- Encourage employers to support enrollment in Healthy Families
- Continue efforts to simplify application processes
- Efforts to simplify eligibility/application process not well received at the State level—increasing the number of eligibles increases the program costs to the State
- Need “lock-in” features that keep clients in programs once enrolled
- Confirmation that medical data will not affect immigration status
- One-stop eligibility for all programs

New Program Development

- Develop low cost health insurance options specifically to help with cost of services provided through Emergency Departments
- Only answer to these issues is universal health insurance
- CalOPTIMA working on small business benefit package for employers who currently offer no health care coverage—target date 2003/2004
- Treat family as a unit with a full array of benefits—break down existing walls between sectors/bureaucracy
- Improved State and Federal funding

Collaboration

- Need to work with business—develop a business roundtable
- Initiate and maintain ongoing dialogue and collaboration between the Orange County Health Care Agency and the Coalition of Orange County Community Clinics regarding programs directed at communicable disease screening, immunization, treatment
- Work more with the advocacy groups (Latino Health Access, Families Costa Mesa, Vietnamese Community of Orange County, Inc., OCAPICA, Legal Aid) and develop neighborhood peer counseling regarding accessing health care services
- Intensify marketing and educational efforts to reach this age group
- Fully utilize the family support agencies—Family Resource Centers

Priorities

- Improve access to primary care services before health is in a state of crisis
- Morbidity with this age group is low; focus must be on health education and preventive care
- Need public policy that more effectively addresses leading causes of death in this age group: drugs, violence, accidents
- Minority groups have different needs—target language and education regarding health and prevention

**ISSUE:** *Disparity amongst regions in the percentage of population accessing Medi-Cal/CalOPTIMA (Community Needs Assessment reported greater utilization in North Region)*

North Region Demographics

- Believes cost of living is lowest in the North Region—higher density housing, more rentals available
- More stable population in the North Region—as opposed to the Central or South where undocumented populations are greater
- More recruiting efforts in the North—South Region not as active

Demographics of Other Regions

- There are areas of need in each Region—need to distinguish between communities and within communities using demographic data
- There are unaddressed populations in San Clemente and San Juan Capistrano, also Laguna
- Would expect highest Cal Optima enrollment in Santa Ana and Garden Grove
- Believe the highest percentage of uninsured and undocumented residents are in the South Region—also the Region with the highest Hispanic/Latino population (Santa Ana in particular)
- There are unaddressed populations in Brea, La Habra, Dana Point, Orange
- Not enough access to Community Clinics in most areas

Outreach

- CalOPTIMA and Clinics sponsor health fairs in all Regions
- If a police car is visible at a health fair, immigrants will not attend

Barriers

- Socio-economic factors contribute to access problems for Vietnamese and Latinos—Garden Grove, Anaheim and Buena Park have high numbers of uninsured
- Fear of being reported to Immigration Service is a barrier to access these programs.
- Navigating the eligibility/enrollment process for Healthy Families and MSI is too difficult
- Mixed eligibility for programs in the same household is confusing—enrollment and continuing eligibility processes are too complex and cumbersome

Other Comments

- The County MSI (Medical Services to the Indigent) is serving fewer people each year—eligibility criteria is onerous

*ISSUE: Transportation as a barrier to accessing health care services (particularly in the North Region as cited in the Community Needs Assessment)*

Convenience

- County does not have a good transportation system, and the North Region is the busiest area
- OCTA ridership is up
- Layout of bus schedules are likely part of the problem—too many transfers and off hours availability very poor
- Bus transportation is not convenient for mothers with a large number of children
- OCTA not doing much—not an integrated system
- In a series of focus groups held by HCA in the Central and North Regions transportation kept coming up as an issue—particularly for Seniors
- Accessing Clinics requires traveling long distances on surface streets once off of the freeways
- Public transportation is a problem—scheduling is not geared to low income people
- Public transportation is geared to issues of the disabled—not the indigent

Cost

- High cost of transportation per capita makes it difficult to offer at rate affordable to all
- Cost of transportation is significant to this population—although modest by most standards

Regional Differences

- North Region residents may have to travel further for services due to the scarcity of Clinics in that region
- Transportation is a much greater problem in the South Region—in Santa Ana particularly—not as much of an issue in the North Region

Improvements/Options

- Health Care Agency is linking with the Orange County Transit Authority (OCTA) to look at transportation issues and options
- Provide transportation coupons to enrollees in the various State and County sponsored health programs—provide lunch or some other incentive to encourage returning for care
- American Cancer Society provides transportation for medical appointments—a fleet of mini vans and a core of volunteer drivers; will also pay family members to drive patients to appointments
- Mobile vans providing health care services only stop at some of the churches—need to expand these local relationships with the Community Clinics

**ISSUE:** *Perceptions regarding the need for Community Clinic services in the South Region  
(Community Needs Assessment cites residents in this Region less likely to take their children  
to a Community Clinic)*

#### Demographics

- South Region is geographically much larger with higher per capita incomes
- Large immigrant population who fear deportation
- Perceive limited demand as population is more affluent
- Cost of housing barrier to low income population residing in this Region
- Perception of affluence that is not reality in many communities (San Juan Capistrano, Laguna, Dana Point, San Clemente)

#### Perceived Need In South Region

- Believe there are some vastly underserved areas within the South Region—El Toro, Lake Forest, San Clemente, San Juan Capistrano
- Perceive “pockets of need” in Newport, Costa Mesa, perhaps Laguna
- Many families are “on the edge” and one change will push them over

#### Community Clinic Barriers

- Many Community Clinics do not see children
- Community Clinics cannot ignore the need to engage the population
- Scarcity of Community Clinics in this Region—very spread out

#### Other Comments

- Some residents may be traveling to Santa Ana for care—some to Mexico
- Transportation is a big issue
- Some seniors with diabetes have been redirected to the South Region for Clinic services where appointments are more readily available
- Network in the south is not as strong—may not know about existing clinics in Laguna Beach and San Juan Capistrano
- Community Clinics need to form strategic relationships with Family Resource Centers

**ISSUE:** *Perceptions regarding access to health care coverage and services in the Central Region (the Region where residents are less likely to report having health care coverage as cited in the Needs Assessment)*

Cultural Barriers

- Santa Ana is the number one Spanish speaking city in the United States (percent of population) and Anaheim is ranked number four. Population appears to have a higher percentage of the population that are less educated and have lower incomes than other areas of the county. This affects their ability to access health care.
- Larger undocumented immigrant population—fear of deportation
- More health care services acquired through “non-mainstream” “underground” providers—readily available in neighborhoods
- People accessing services feel they are not treated with respect
- Language barriers to accessing care
- While children often qualify for coverage, because the parents do not, the children are not enrolled in coverage programs
- Cultural indifference to health care coverage—not valued—lack of importance placed on preventive care
- Need to respect cultural traditions while building bridges to current/modern health care

Other Barriers

- Economically most disadvantaged of the Regions
- Employers less likely to offer health care coverage
- Higher percentage of unemployment in this region
- Transportation is a barrier to accessing care
- Do not enroll because of the amount of paperwork required—view it as a nuisance and a hassle
- Outreach to elderly is minimal at best

Other Comments

- There continues to be a huge need for services in Santa Ana
- Tenet Corporation now working with Health Net and other plans in a joint effort to get small employers to enroll eligible children in Healthy Families

*ISSUE: Current efforts to improve access to health care coverage for residents of the Central Region  
(applicable to other regions as well)*

Current Outreach

- UCI is helping to promote enrollment in Healthy Families
- Healthy Families is undertaking outreach to businesses
- Latino Health Access and Family Resource Centers (Families Costa Mesa) are working on outreach and coordination—special 92701 ZIP Code project
- Prop 10 has funded outreach programs
- Using places of employment for outreach to enroll in various programs is not well coordinated—Healthy Families Task Force has coordination assignment, but this is not perceived as their major job
- HCA has a Health Access Steering Committee working together with CalOPTIMA
- Western Medical Center getting grants to enroll eligibles
- School based outreach is active in Santa Ana and Anaheim

Suggested Outreach

- Need to have residential outreach to educate families about available program options
- Need to familiarize employers and employees with Medi-Cal program and other funding sources
- Need to add health access component to Community Clinics—community advocate to meet with families for follow-through
- Need education regarding eligibility and entitlement
- Many non-profit organizations and advocacy groups trying to improve enrollment—no effective centralized leadership effort that focuses on eligibility as a priority
- Need a broad, coordinated community effort
- Coalition is making inroads—but should not try to do this on their own—not strong enough yet
- Coordinated effort needs leadership from hospitals and HCA
- Need leadership with a keen interest to improve the quality of life
- Coordination is a “gap” that can be fixed

Additional Services

- Tobacco Settlement funds are going to Community Clinics to provide additional services
- Additional mobile clinics coming on line should help with access
- Diabetic program expansion efforts underway

Other Comments

- Hospitals need to do more
- Biggest issue is maintaining eligibility—if paperwork is involved, enrollment declines
- Money being spent on brochures rather than on an eligibility/enrollment program
- County is seen as a detriment—does not want a system that enables enrollment thereby increasing costs
- Santa Ana Chamber of Commerce looking at employee retention issues—a major one being availability of health care coverage
- Health Council sought grant from Empowerment Zone to help fund its current outreach project but did not receive funding

*ISSUE: Perception of reasons Central Region residents may not consistently access the same clinic for their care?*

Clinic Issues

- Differences in fee structures and hours
- Residents know what each Clinic can offer—not all offer the same services
- Not given respect—too impersonal—no bonding or trust established—residents talk with each other
- Too much pressure to pay
- Clinics are not all staffed with minority nurses—language issues
- Perception that quality of care at Clinics is not equal to the mainstream providers
- Perception that there is greater quality of care from “real doctors” versus Nurse Practitioners and Physician Assistants
- Clinic data system not integrated, so it is not possible to track patients—particularly those shopping for drugs
- Perception is that Clinics are only for the POOR—when people are better there is a stigma about going to the Clinics
- Need to improve the quality image of the Clinics—promote quality standards as condition of licensure
- Many private physician offices are not as good as the Clinics—but belief is that the Clinics are only for the poor
- Have Clinics that respond to current acute care need—reactive—not a “primary care system”
- Believe residents migrate to the Central Region—many think UCI is the County hospital
- Poor to fair availability and accessibility—many communities only get mobile clinics on infrequent schedule

Population Issues

- Cultural practices—may access for a particular reason, but do not return for test results or subsequent problems—not looking to establish a health home
- Population is very mobile—frequent changes in residences
- Hispanic population is used to getting care at the “corner drug store”
- Undocumented population may move from Clinic to Clinic to avoid being reported
- Need fast service with easy access—only seek health care when they are in dire need

Environmental Issues

- Lack of appropriate public transportation

**ISSUE:**     *Perceptions regarding adequacy of current health care services provided to uninsured and underinsured*

Economic Barriers

- Hospitals are not providing services—most require \$1200 to \$1500 deposit for services; UCI and Western are also reducing availability
- Need to reimburse better for mammograms
- Affordability of services is a major problem—some cannot afford co-pays and prescriptions
- UCI fees are much too high; CHOC and St. Joseph's more willing to find funding
- Grant limitations sometimes restrict accessibility of care; expanded hours an issue
- Affordability of care is good through use of the sliding scale concept; however, infrastructure limitations affects ability to take dollars from some funding sources
- Rates are high—but many clients do not pay all of the bill
- Affordability is a major barrier once patient gets beyond Clinic level
- Population will not spend money on health care at the expense of other essentials
- There needs to be a separate funding source to support Clinic administration so that more of Clinic's funds can go into direct patient care—higher salaries for providers will attract qualified staff
- If Clinics are to be principal/only source of services, need to triple capacity—no services in some areas (i.e., Brea), and not enough capacity in current locations
- Consider creating “specialty clinics” to serve as focal point for treatment of chronic diseases and related conditions—serve broad area of county
- Those who come to this country as refugees can access Medi-Cal; undocumented immigrants cannot
- Only two free clinics left in the county
- Current funding requests are principally to strengthen existing programs—not for adding new/innovative programs

Service Needs

- Gaps in primary care services; also need more attention to smoking cessation and cancer screening
- Primary care services are adequate
- Emergency and urgent care is very good
- Timeliness of access to specialty care is lacking
- Need more clinics—have 33 cities and only 19 clinics—need dozens more like Casa de Salud
- Lack of dental services is an issue

### Service Needs (continued)

- Primary care needs are adequately met, but specialty care is not—others should try to develop specialist services program like Camino's
- Has a positive perception of the availability of services—particularly through programs such as Healthy Families and California Kids
- Need more clinics or expanded hours—what we have is not enough
- Need organized approach to specialty care
- Lack of preventive care is a major issue
- Neither primary care nor specialty care are available, accessible or affordable
- Primary care is generally good, specialty care has its limitations in many areas (dental, orthopedics, diabetes management related to specialties)
- Current system has abandoned men—priority is focused on children, women and elderly
- Hours need to be extended to evenings and weekends
- Need collaboration with the Arthritis Foundation—number one chronic disease of the elderly
- Need greater utilization of telemedicine for ophthalmologic exams
- Challenge is to balance health education needs versus medical care needs
- Mental health and behavioral health are both lacking—but same is true for insured populations

### Geographic Issues

- Geographic coverage is good with the exception of the North and South Regions
- Not enough services where people live
- More mobile clinics—take services to the population (services after church on Sunday)
- Should have a Community Clinic within every five mile radius of every pocket of poverty

### Operational Issues

- Lack of appointment systems and expanded hours are problems
- Culturally competent staff is key component, and not all Clinics have such staff available
- Clinic locations are convenient and residents are probably made to feel welcome—but follow-up is limited
- Hours are an issue—many cannot come in during the work day as they have no paid leave
- Hours are not consistent and are limited
- Need more bilingual, culturally competent staff—need Farsi and Korean speaking staff; also growing Rumanian population
- UCI is too confusing—hard to navigate
- Target populations need a guide/map of available services and ways to access

### Quality of Services

- Concerns about quality—differences between clinics need to be resolved
- Quality concerns extend to medical community as well
- Population is not made welcome at health systems/hospitals
- Quality of services is extremely variable—many offer episodically staffed volunteer physicians
- Caring staff, but variable quality—not standardized
- Excellent quality of care at Clinics—problem is with referrals to specialists
- Not able to uniformly measure and compare outcomes—some Clinics are more willing than others to set measurable standards
- Has not heard anything negative about quality of care
- Issue with some individual providers who appear as rough or not nice
- Quality of care is good, but need expanded professional staff (i.e., more physicians)
- Generally appropriateness of care is poor as there is not the required coordination and follow-up
- Quality is good at the Clinic level for the most part given their capabilities
- Specialty care quality is good—accessibility is the issue
- In some instances quality is an issue—not up to date with clinical protocols, using donated medications and supplies, variability in staff capability, clinicians not up to date on current disease management with some questionable cross-disease treatment
- Needs to be a definition of the adequacy of care relevant to services via a physician versus a nurse practitioner
- Different levels of care provided—particularly true of lab and radiology—cutting too many corners
- Do not believe that quality of care is limited to the physician-driven model, but there needs to be standard quality measures and documented results

### Other Comments

- Image of some Clinics is that they are there to serve the “homeless”
- Quality of care is good, but perception is that Clinics are not as good as “mainstream” providers—need data to prove quality of care
- Need more residents to establish “health homes”—ongoing relationship with a primary care physician
- Needs to be coordination between Health Systems (Hospitals), HMOs and Clinics to provide consistency and connectedness of primary care, specialty, and other services—high level collaboration needed
- Innovative use of mobile services may be more effective for reaching this population rather than fixed care
- There is public apathy/acknowledgement about the depth and breadth of the problem in Orange County

**ISSUE:** *Perception of language as a barrier to service (cited as an issue for 15% of the Central Region respondents in the Community Needs Assessment)*

Specific Language Issues

- Definite barrier—language is an issue with Spanish and Vietnamese patients
- Chinese are very underserved—have health coverage but cannot find provider to understand them (Mandarin)
- Korean, Arabic and Muslim patients are presenting new language and cultural issues
- Language is not a barrier to health care service—Council of Churches has not heard that this is a barrier
- Language as a barrier is growing—influx of residents with different languages but no corresponding capability to deal with them
- Language is not a major problem—Clinics and hospitals have interpreters
- Language becomes a greater problem outside of the Clinics in the health care system
- Cultural differences effectively increase language barriers—must understand the impact culture has on effectiveness of care
- Labeling medication appropriately for uneducated/language-challenged populations is a major delivery issue
- Need to expand bilingual staffing at higher level health positions

Possible Remedies

- Prop 10 funds needed to support outreach through churches
- Key to removing language barriers is to succeed with children 0 to 5
- Must work with communities to teach English as a second language—especially to second and third generation immigrants
- Orange County Health Needs Assessment responses underestimated language as a barrier—need a proactive effort to attract bilingual nurses, physicians, and staff
- Clinics need to do more outreach
- Educate community members to serve as interpreters—family advocate model to train volunteers
- Need to train more minority nurses
- Assist health professionals that have degrees from their native countries gain U.S. degrees in the health field
- Have successful health care providers mentor immigrant health care providers

Other Comments

- Residents of Central region are less sophisticated—less access to Internet—less ability to ask informed questions
- Internet health access very important—starting to work with California Endowment for grant to facilitate health education access
- Not only is language a barrier, but health education and awareness efforts must be culturally sensitive (i.e., crickets in Asian society)

**ISSUE:**     *Perceptions regarding appropriateness of sex education outside the home*

Barriers

- Sex education is a very sensitive subject that is not discussed openly in the community
- Santa Ana School Board is very conservative and sets the tone on this subject
- Both Asian and Latino cultures have taboos about this subject
- Religious objections influence this subject

Who Should Have A Role

- In some cultures, parents do not feel comfortable talking with children about sex
- All indications are that parents want schools and providers to provide some level of sex education in addition to what is provided at home
- Public education should include sex education with a provision for parents to opt out
- Health care providers are delinquent in their duties if they do not provide such education
- Public Health has a responsibility to educate children about sex
- Kids have petitioned Santa Ana School District for such education
- Perhaps a Family Resource Center would be a better sponsor of such education
- Community Clinics are a good place to get responsible and accurate information about mechanics of body functions
- Only someone you respect can place sex in the proper context—the message must be culturally appropriate

What Should Be Done

- There should be a “health education” requirement for graduation that addresses anatomy
- Need to establish forums to make sex education easier for children to accept
- Need to demonstrate that sex education in schools is a standard
- Medical community must demonstrate that sexuality is an important health issue
- Need more forums for open dialogue on this subject
- Best to teach parents too—not just children; avoid another generation gap
- Start by providing immigrant parents with education regarding the American culture—eventually sex would be the topic and parents could be advised how to discuss this topic with their children

What Is Being Done

- Nurse Family Partnership is a good program—not in the schools, but rather one on one
- Dr. Olds program very successful
- Some students, acting as peer counselors, are providing information in an unofficial and quiet way
- Health Fairs get written material out, but must be conservative
- Programs other than “just say no” are needed

*ISSUE: Perception of the key stakeholders regarding the level of collaboration amongst entities that provide care to the uninsured and underinsured*

#### Progress Made

- Collaboration is better than it once was—but still poor overall
- Provider community has done a good job of collaborating
- Positive perception of collaborative efforts
- UCI and CHOC working together under the Prop 10 Commission—Children’s Health Access is not working collaboratively
- Collaboration is getting better—there is more sharing of data
- COCCC has started doing a better job of collaborating

#### Funding Barriers

- Services to the medically indigent are substantially underfunded—health care is not a priority in Orange County
- County spends less per capita on health care than most other counties
- Incentive money needed to improve collaboration
- Collaboration can often breakdown because funding sources expire—without a plan for sustainability facilities close
- The Tobacco Tax money acted as a magnet for collaboration—since passage it has resulted in some divisiveness
- Competition for dollars complicates collaboration
- Everyone is looking for funding—there is no coordination
- Always a fight for the money—rather than fighting for quality services
- Believe that HCA has misled Community Clinics into believing that providing more access is needed to qualify for Tobacco funding—this is not so

#### Organizational Barriers

- No forums or groups for coming together
- Hospitals, physicians and clinics form a “Bermuda Triangle”—alignment of objectives may be an obstacle
- There is a lack of integration and communication—Measure H Advisory Board asked the County to formalize relationship with OCMA, COCCC and HASC as provider leadership group
- Move away from schools/health care provider silos—school-based health center concept has proven significant opportunity to improve mental and physical condition of this population
- There is a lack of care management in terms of feedback to the clinics from referral specialists
- Coordination is a “gap” that can be fixed

### Hospital Barriers

- Hospitals need to be more collaborative in funding programs for this population—they are making sizeable profits
- University and Tenet could be more collaborative—St. Joseph's and Hoag do very well

### What is Needed

- Identify and engage leadership
- Board of Supervisors should lead the charge for greater collaboration
- Need one unified vision—Needs Assessment Document has not been used for prioritization
- While there are a number of collaborative efforts there is NOT an overarching strategy nor a data-centered approach
- Mental Health, Community Clinics and HCA need stronger linkages
- HCA needs to talk about community health—not just public health
- HCA wants to build more collaboration with Needy Meds Program
- Collaboration has been “funding” driven—needs to be by subject area
- OCMA, COCCC, and HASC should be inclusive rather than competitive
- Legislative officials are not interested in community organizations—need to dispel beliefs that Orange County is a “rich” county
- Willingness to trust—not let competitive factors influence
- Need to understand what collaboration really means—then focus on common goals of providing quality services
- Need leadership with a keen interest to improve the quality of life

### Other Comments

- Geographical considerations make collaboration difficult
- Professional prejudices may inhibit progress
- Philosophical differences amongst participants

### Comments Specific to Role of COCCC

- Could coordinate service providers (a pool of physicians who would accept referrals)
- Could play a role in central purchasing of supplies pharmaceuticals, health education materials—take on collaborative tasks and build unity
- Focus should not be on individual clinic's choice but rather there should be a uniform business plan to guide operations
- Needs to develop system of clinics—more infrastructure to help manage
- Help upgrade clinics through development of standards, quality improvement/measurement, contract negotiation
- Needs to be more involved in planning—where do they need more and different types of clinics

Comments Specific to Role of COCCC (continued)

- Little joint planning—critical of COCCC for not involving others in planning process
- COCCC has learned through process for DHS funding that they need to collaborate first and then jointly apply for funding
- Pursuit of third-party payment is NOT on their agenda and it should be—have stopped patients from paying
- Need a broad, coordinated community effort to develop a system of care—Coalition does not have the prestige to make this happen
- Coalition is making inroads—but should not try to do this on their own—not strong enough yet

*ISSUE: Perception of availability of a pool of physician providers who will accept referrals on a fixed-fee schedule to serve this target population*

Barriers

- Business mind-set of physicians and hospitals is detrimental to the service level to this population
- Many physicians will accept some new patients but there must be a control on the number of referrals
- Such a pool will be available only if another source subsidizes so that physicians can afford to participate at a reasonable level of compensation
- As a whole, the medical community is NOT willing to participate in a formal network setting

What is Needed

- Need a legal mandate that both PCPs and Specialists assume some responsibility—perhaps a County bill
- There needs to be a training program so that PCPs can provided an expanded scope of service
- If paperwork is not too cumbersome and compensation is adequate, physicians will participate—since State increased Medi-Cal rates many more physicians see these patients
- A program that is equitable for all who participate

Models That Work

- California Kids can serve as model program—identified a group of physicians willing to be part of a community effort
- CalOptima works this way, and is working well—has increased access for Orange County residents tremendously

Other Comments

- Refusal to participate ultimately costs the system more because diagnosis and treatment is not timely
- OCMA has made promises—but only 25% of community physicians belong to this organization
- Delivery site is not a barrier—some would prefer patients to come to their office, others to go to clinics

**ISSUE:**     *Perception of the most important health care issues for the Latino/Hispanic population*

Service Needs

- Basic health education
- Weight control—nutrition and exercise
- Early prenatal care
- Chronic disease management and treatment
- Children’s services need to focus on diabetes, obesity and asthma—asthma is a huge problem
- Elderly services need to focus on nutrition, hypertension and diabetes
- Access to specialty services
- Use of alcohol is an issue—substance abuse
- Diabetes

Knowledge Needs

- Knowledge of what services are available and how to access them—need repetitive message
- Understanding of the value of preventive health education
- Better understanding of value of health insurance—especially for children
- Importance of establishing a “health home”
- Overcome distrust of medical professionals, government, and external organizations

Environmental Needs

- Universal health insurance
- Higher minimum wage
- Reasonably priced housing—get people out of disease-ridden house
- Create healthier environments—less crowding, more recreation

Delivery System Deficiencies

- Emergency Response personnel cannot speak Spanish
- Transportation issue needs to be addressed to improve access
- Coordination of resources to more effectively serve the population
- Solutions to the language barrier
- Funding is a limitation for the uninsured
- Diversify care solutions to meet all needs of the family unit—comprehensive solutions
- Without insurance you cannot get mental health services in Orange County

**ISSUE:**     *Perception of the most important health care issues for the Asian population*

Service Needs

- Tobacco cessation—heavy smokers—second-hand smoke affects children
- Early developmental assessments
- Early prenatal care
- Specialist services (though some believe Asians have better access to specialty care than Latino population)
- Nutrition education
- Breast care
- Preventive health education

Knowledge Needs

- Importance of establishing a “health home”

Environmental Needs

- Universal health insurance

Delivery System Deficiencies

- Do not get pap smears, thus high incidence of cervical cancer—do not want male MDs—Nhan Hoa Nurse Practitioners better received
- Incidence of undetected disease for Asian women very high
- Language barrier is even more challenging than for Latino population
- Need more Asian health care professionals—a more diverse work force

Other Comments

- Great potential for overuse of drugs—believe all physician visits should result in prescription for medications (send unused drugs to family in Vietnam)
- Reliance on alternative treatment methods before utilizing traditional medical interventions

**ISSUE:**     *Perception regarding specific health care needs of adolescent population*

Service Needs

- Need continuous educational effort regarding tobacco control, nutritional habits, exercise—pick a day when you eat right—“April Food Day”
- Integration into well care
- Dental services
- Immunizations
- Nutrition—obesity avoidance
- Sex education

Delivery System Suggestions

- Need encouragement to access care— sometimes give-aways or event-based options are effective
- Need places where they feel comfortable getting answers
- Need to understand the importance of establishing a “health home”
- Encourage peer counseling—teenage promotores
- Need to reach their parents
- Increase advertising/communication through youth groups
- Clinics should work through churches and YMCA/YWCA

Other Comments

- Need universal health insurance
- Youth need to develop their self esteem—when at Community Clinic express interest in them, ask about career interests
- Community Clinics could have posters that might attract/motivate youth to a better life

**ISSUE:**     *Perception regarding specific health care needs of elderly population*

Service Needs

- Adult day health care clinic options
- Senior meal programs—Public Health Nurses used to provide assessments
- Immunization clinics
- Medication education—do not report drug incompatibility—too embarrassed to ask questions
- Home health
- Oxygen
- Medications via public health nurse
- Nutritional education
- Quality of life issues
- Mental health needs
- Chronic disease management
- Exercise programs

Delivery System Suggestions

- Mobile services—bring care to them
- Go where they are—community centers, churches, shopping centers
- Need community input sessions—providers and an education committee
- Clinics have not focused on services to the elderly—need training on how to serve the elderly
- Need specialized outreach—elderly Latina women should be a particular target
- Geriatric knowledge is severely lacking

Environmental Needs

- Transportation system is woefully inadequate—most ride programs are City specific not Countywide
- Reimbursement is too low—provider pool is shrinking
- Need a hero on the Board of Supervisors

**ISSUE:** *Perceptions regarding the services most important to the uninsured and underinsured populations*

Primary Care, Specialty Care, and Ancillary/Allied Health Services ordered by frequency of identification by eighteen of the key stakeholders and community leaders interviewed as being one of the top ten most important services for the uninsured and underinsured.

Primary Care		Specialty Care		Ancillary and Allied Health Services	
Pediatrics	11	Ophthalmology	8	Dental	15
Internal Medicine	9	Endocrinology	8	Mental Health	13
Family Practice	9	Cardiology	7	Substance Abuse Counseling	9
OB –GYN	7	OB-GYN	7	Family Planning	5
Nurse Practitioner	5	Oncology	6	Physical Abuse Counseling – Children	4
		Podiatry	5	Home Health	3
		Allergy	5	Optical – Vision Checks	3
		Psychiatry	4	Radiology	2
		Urgent Care	4	Laboratory	2
		Urology	4	GeroPsych	2
		Surgery – General	4	Physical Abuse Counseling - Adult	2
		Surgery – Orthopedic	3	Suicide Prevention Services	2
		Gastroenterology	2	Alternative Medicine	1
		ENT	2	Elderly Abuse Counseling	1
		Pulmonary Medicine	2	Prenatal Care	1
		Geriatrics	1	Audiology	
		Nephrology	1	Physical Therapy	
		Rheumatology	1	Speech Therapy	
		Neurology	1		
		Dermatology			

Prevention/Disease Screening Programs and Health Education Programs ordered by frequency of identification by fifteen of the key stakeholders and community leaders interviewed as being one of the top ten most important services for the uninsured and underinsured.

Prevention/Disease Screening		Health Education	
Annual Physical Exams	15	Diabetes Education	10
Mammograms	12	General Nutrition	10
Immunizations	11	Culturally Directed Programs	8
Chronic Disease Checks	8	Sex Education	8
Flu Shots	6	Subjects Targeted to Teens	6
Blood Pressure Testing	6	Smoking Cessation	7
Family Planning	6	Healthy Aging	7
Sexually Transmitted Disease Checks	4	Pharmacy and Medication Use	8
Prostate Exams	4	Parenting	6
Foot Care	3	Oral Health	5
	3	Appropriate Use of Emergency Services	6
		Child Birth	4
		Weight Loss	3
		Aids Awareness	3
		Vision Care	2
		Physical Activity	2
		Sexually Transmitted Diseases	2
		CPR & First Aid	2
		Environmental Safety	2
		Injury Prevention	1
		Substance Abuse	2
		Domestic Violence	1
		Behavioral Classes	
		Body Mechanics	

**Comments:**

- Nurse Practitioner is viewed as being outside of primary care as NP and/or PA can be used as team members only
- Positive receptivity to Nurse Practitioners in Latino populations
- There is a disparity between what underserved population believes are important issues and what health care providers believe are important

### PROJECT DEFINITION OF “UNDERINSURED”

“Underinsured: Individual and family situations in which the health insurance policy or health benefits plan is less than complete and comprehensive. For example, the family may lack coverage for specific services, have a maximum benefits limit or cap on covered services, or have a high copayment or coinsurance.”<sup>1</sup>

“The term *underinsured* indicates individuals and families with government assisted health care coverage or only partial coverage (may include any or all of the following: no dental, vision or mental health coverage and/or not all family members are covered).<sup>2</sup>

“Underinsurance here refers to medical needs that either are not covered by health plans at all or are covered but with high copayments that force beneficiaries to forgo treatment.”<sup>3</sup>

The above definitions of “Underinsured”, and others used frequently to describe those individuals and families with less than full and comprehensive coverage for all of the health care services that might be required, are so broad as to include most population segments, even those with reasonably rich benefit packages. Use of these definitions for the purpose of this engagement, to identify the health care needs of the underserved populations, would result in an over-representation of those who are truly “Underinsured”.

We have therefore limited the definitional scope of “Underinsured” to mean those individuals and families who are receiving assistance in purchasing/obtaining government or private sponsored health coverage targeted to low income adults and children, and for whom the health care benefits are limited in scope of covered services or in the duration of coverage. This definition includes, for example, individuals and families who are participating in the MediCal, MediCal/Medicare, Healthy Families, California Kids and Orange County Medical Services for Indigents programs.

Specifically not included in the above definition are those older populations who are participating in the Medicare program (except for MediCal/Medicare as defined above). Though clearly there is a segment of the low-income elderly for whom even a modest copayment is a burden, it is impossible to determine precise numbers and/or demographic distribution. Complicating the determination of potential “Underinsured” Medicare participants is the fact that many health care providers who are certified as “participating” will accept the Medicare reimbursement as payment in full for services rendered, eliminating a potential barrier to care.

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<sup>1</sup> Definition from “Coverage Matters, Insurance and Health Care”, Institute of Medicine, 2001

<sup>2</sup> Definition from Orange County Health Needs Assessment

<sup>3</sup> Robert Kutter, “The American Health Care System – Health Insurance Coverage”, The New England Journal of Medicine, January 14, 1999, Volume 340, Number 2

### WHY DON'T THE NUMBERS MATCH UP?

By: Heather Dale, Project Coordinator - OCHNA

With the recent release of a report from the Center for Health Policy Research at the University of California, Los Angeles, we at the Orange County Health Needs Assessment (OCHNA) have received a number of phone calls asking about the data, and why the numbers in UCLA's report do not match up with those of OCHNA. There are some real differences in the data, and we want to share with everyone an exploration of these differences and why they occur. The intent of this article is to inform the community about the source of these differences in a simple and easy to understand form.

#### A Look at the Numbers

The Orange County Health Needs Assessment, Spring Report, 1999 was based on our 1998 random digital dial survey of over 5,000 Orange County residents. The results of this survey revealed that 16.9% of adults 18 and older and 12.8% of children age 0 to 17 in Orange County are without any type of health care coverage. UCLA's Center for Health Policy Research's recent report *The State of Health Insurance in California: Recent trends, Future Prospects* revealed a three year average uninsured rate of 23% for residents age 0 to 64 and 19% for children 0 to 17 in Orange County for 1997 - 1999.

#### Possible and Likely Sources of Differences in the Numbers

The Orange County Health Needs Assessment and UCLA provide different types of data. The numbers from the Orange County Health Needs Assessment are based upon primary data collected directly from over 5,000 Orange County residents in our random digital dial survey. Our sample size is large enough for us to generalize these numbers to the general population in Orange County with statistical accuracy. UCLA's numbers at the county level are **estimates** based upon 1998, 1999, and 2000 Current Population Surveys, which are National. Their estimates have proven to be extremely reliable, however, as stated in their report, the data they obtain is, "County-level data on health insurance coverage are, however, very limited."

When available and conducted appropriately, primary survey data is preferable, and more reliable than estimates. It is important to point out however that there is a great deal of data made available by UCLA's Center for Health Policy Research that are not available anywhere else. They provide a number of reports that serve as an invaluable resource for both the county and the state as a whole.

Another source of discrepancy between the data made available by OCHNA and UCLA is target population. When referring to the percentages of uninsured adults, OCHNA's numbers represent the respondents ages 18 older (including seniors). UCLA's percentages of uninsured refer to people ages .0 to 64. Therefore, UCLA's referenced population differs from the population OCHNA reports in that it adds in the uninsured rates for children, and subtracts out the uninsured rate for seniors. This is likely to make uninsured rates reported by UCLA appear much higher, since seniors are much more likely to have some kind of health care coverage through Medi-Care. Keep in mind also that OCHNA provided this data for the first time in 1998, prior to which UCLA was the only source. Our data are best used to compliment each other, taking into consideration the differences in method and population.

UCLA's Center for Health Policy Research Report: *The State of Health Insurance in California: Recent Trend, Future prospects* can be downloaded free of charge from their web site at [www.healthpolicy.ucla.edu](http://www.healthpolicy.ucla.edu). OCHNA's Spring Report, 1999 and Fall Report, 2000 Community Health Working the Puzzle Part 2 are both available for free download on the OCHNA web site at [www.ochna.org](http://www.ochna.org).

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